University Health System

REGULAR MEETING
OF THE BEXAR COUNTY HOSPITAL DISTRICT
BOARD OF MANAGERS

Tuesday, August 25, 2015
6:00 p.m.
Board Room
Texas Diabetes Institute
701 S. Zarzamora
San Antonio, Texas 78207

MINUTES

BOARD MEMBERS PRESENT:

James R. Adams, Chair
Dianna M. Burns, M.D., Secretary
Roberto L. Jimenez, M.D., Immediate Past Chair
Robert A. Gilbert
James C. Hasslocher

BOARD MEMBERS ABSENT:

Ira Smith, Vice Chair
Robert Engberg

OTHERS PRESENT:

George B. Hernández, Jr. President/Chief Executive Officer, University Health System
Bruce Adams, M.D., Medical Director, Emergency Department, University Hospital; and Professor and Chairman, Emergency Medicine, UTHSCSA
Tricia Aleman, Executive Director, Marketing/Corporate Communications, University Health System
Bryan Alsip, M.D., Executive Vice President/Chief Medical Officer, University Health System
Edward Banos, Executive Vice President/Chief Operating Officer, University Health System
James Barker, M.D., Vice President/Clinical Services, University Health System
Ted Day, Senior Vice President/Strategic Planning & Business Development, University Health System
Theresa De La Haya, Senior Vice President, Health Promotion/Clinical Prevention, University Health System - Texas Diabetes Institute
Sergio Farrell, Senior Vice President, Ambulatory Services, University Health System - Robert B. Green Campus
Greg Gieseman, President/Chief Executive Officer, Community First Health Plans, Inc.; and Vice President, Managed Care, University Health System
Francisco Gonzalez-Scarano, M.D, Dean, School of Medicine, The University of Texas Health Science Center at San Antonio
William Henrich, M.D., President, UTHSCSA
Michael Hernandez, Vice President/Chief Legal Officer, University Health System
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Barbara Holmes, Vice President/Chief Financial Officer, Community First Health Plans, Inc.  
Reed Hurley, Executive Vice President/Chief Financial Officer, University Health System  
Daniel Johnson, M.D., Herbert F. Mueller Chair in Ophthalmology, UTHSCSA  
Monika Kapur, M.D., President/Chief Executive Officer, Community Medicine Associates  
Leni Kirkman, Vice President, Strategic Communications & Patient Relations, University Health System  
Ted Lemon, Deputy Chief Information Officer/Information Services, University Health System  
Priti Mody Bailey, M.D., Medical Director, Community First Health Plans, Inc.  
Kristen A. Plastino, M.D., President, Medical/Dental Staff, University Health System; and Associate  
Professor, Department of Obstetrics and Gynecology, UTHSCSA;  
Allen Strickland, Vice President/Hospital Administration-Fiscal, University Hospital  
Mark Webb, Chief Executive Officer, Pediatric Services, University Health System  
Francine Wilson, Senior Vice President, Supply Chain Management, University Health System  
Peggy O’Hare, San Antonio Express News  
And other attendees.

CALL TO ORDER AND RECORD OF ATTENDANCE: JIM ADAMS, CHAIR, BOARD OF MANAGERS:

Mr. Adams called the meeting to order at 6:05 p.m.

INVOCATION AND PLEDGE OF ALLEGIANCE:

Mr. Adams introduced Mr. Rene Alvarado of St. Mary Magdalene Catholic Church, and he led the pledge of allegiance.

CITIZENS’ PARTICIPATION: None. Mr. Adams introduced and welcomed Mrs. Brenda Banos, wife of Chief Operating Officer Edward Banos, to this evening’s meeting.

APPROVAL OF MINUTES OF PREVIOUS MEETING(S):

**Tuesday, May 19, 2015 (Regular Meeting):**

SUMMARY: The minutes of the regular meeting of Tuesday, May 19, 2015 were submitted for approval.

RECOMMENDATION: Staff recommended approval of the minutes as submitted.

ACTION: A MOTION to approve staff’s recommendation was made by Mr. Gilbert, SECONDED by Mr. Hasslocher and PASSED UNANIMOUSLY.

EVALUATION: None.

FOLLOW-UP: None.

**Tuesday, May 26, 2015 (Regular Meeting):**

SUMMARY: The minutes of the regular meeting of Tuesday, May 26, 2015 were submitted for approval.

RECOMMENDATION: Staff recommended approval of the minutes as submitted.

ACTION: A MOTION to approve staff’s recommendation was made by Mr. Hasslocher, SECONDED by Mr. Gilbert, and PASSED UNANIMOUSLY.

EVALUATION: None.

FOLLOW-UP: None.
Tuesday, June 22, 2015 (Regular Meeting):

**SUMMARY:** The minutes of the regular meeting of Tuesday, June 22, 2015 were submitted for approval.

**RECOMMENDATION:** Staff recommended approval of the minutes as submitted.

**ACTION:** A MOTION to approve staff’s recommendation was made by Mr. Gilbert, SECONDED by Mr. Hasslocher, and PASSED UNANIOUSLY.

**EVALUATION:** None.

**FOLLOW-UP:** None.

Tuesday, June 30, 2015 (Regular Meeting):

**SUMMARY:** The minutes of the regular meeting of Tuesday, June 30, 2015 were submitted for approval.

**RECOMMENDATION:** Staff recommended approval of the minutes as submitted.

**ACTION:** A MOTION to approve staff’s recommendation was made by Mr. Hasslocher, SECONDED by Mr. Gilbert, and PASSED UNANIOUSLY.

**EVALUATION:** None.

**FOLLOW-UP:** None.

**REPORT FROM THE HEALTH SCIENCE CENTER – WILLIAM HENRICH, M.D., PRESIDENT:**

**SUMMARY:** Dr. Henrich reported that one of the founding faculty members, Dr. Barry Norling passed away last Friday, August 21, 2015. There will be a memorial service at UTHSCSA’s Holly Auditorium on Friday, August 28. The annual President’s Gala will take place on Saturday, September 26, 2015 at the Grand Hyatt San Antonio Hotel. The theme this year is service and the Health Science Center will very fittingly honor Mollie and Bartell Zachry on this occasion. The faculty and staff will hopefully launch the School of Medicine’s effort on neurodegenerative diseases this same evening, it will be a very happy and historical night. Dr. Henrich yielded the floor to Dr. Gonzalez for introduction of the physician leaders present to include Dr. Marsha Kinney, the interim Chair for the Department of Pathology; and Ms. Hailey Mullican, staff attorney who has been working with the teams on the master affiliation agreement. Dr. Gonzalez reported the sudden passing of Dr. Leroy Knodel also on Friday, August 21. He was clinical associate professor and assistant head for the Division of Pharmacotherapy. Dr. Knodel was responsible for Pharm.D. education and training, and postgraduate training in the San Antonio region. He also held an administrative director position since 1982 at UTHSCSA, and as director of the regional internship program in San Antonio he placed many students at Health System facilities. Dr. Knodel was also a tenured associate professor in the Department of Surgery. His funeral services will be held at 10:00 am on Friday, August 28, 2015. Dr. Roberto Jimenez informed Dr. Gonzalez that during a recent trip to a small town in Poland, he met the family of a patient who had neurosurgery by Dr. David Jimenez. The family was very pleased and expressed gratitude for the neurosurgeon’s talents.
RECOMMENDATION: None.

ACTION: This report was provided for informational purposes.

EVALUATION: After the Dean's report, Mr. Adams called upon Dr. Plastino for her presentation on how south San Antonio has worked together to tackle teen pregnancy.

FOLLOW-UP: None.

PRESENTATIONS AND EDUCATION:

UT TEEN HEALTH COLLABORATION WITH UNIVERSITY HEALTH SYSTEM’S WOMEN & CHILDREN’S PROGRAM—THERESA DE LA HAYA/KRISTEN PLASTINO, M.D.

SUMMARY: Ms. DeLaHaya briefly introduced the UT Teen Health Program and announced, on Dr. Plastino’s behalf, that in July 2015, the Department of Obstetrics and Gynecology received an additional $14 million to further promote the UT Teen Health initiative with a focus on foster care teens, juvenile teens and pregnant/parenting teens throughout the state of Texas. She yielded the floor to Dr. Plastino for the following graphics presentation regarding the program and its history. In 2010, the south side of San Antonio had a teen birth rate of 77.3 compared to the Texas rate of 52 births per 1,000 (15-19 year olds). In 2010, the Centers for Disease Control (CDC) awarded funding to the UTHSCSA’s Department of Ob/Gyn for a community-wide approach to address teen pregnancy utilizing five components:

1. Evidence-based programs (HHS list)
2. Community Mobilization
3. Clinical Linkages
4. Stakeholder Education
5. Working with Diverse Communities

There were a total of nine (9) grantees in the United States given the opportunity to demonstrate the effectiveness of innovative, multicomponent, community-wide initiatives in reducing rates of teen pregnancy, with a focus on Latino/Hispanic 15 to 19 year old youth. The five south side independent school districts selected to participate in the UT Teen Health Program were South San, Southside, Somerset, Southwest, and Harlandale. The goal was to reduce pregnancy rates by 10 percent among this group by 2015, and through a community-wide initiative, the goal was exceeded - teen birth rates were reduced by 24 percent among 15-19 year old youth in the South San Antonio community. Dr. Plastino shared photos of program participants and reported the following details:

- 9 different Evidence-Base Programs (EBP) were implemented;
- 23 community implementation partners established;
- 428 facilitators trained; and
- 6 community partners have trained trainers.
In addition, UT Teen Health worked with the San Antonio AIDS Foundation to develop culturally competent and age appropriate videos to be utilized with one of the EBPs. For the community mobilization portion of the program, the leadership teams established for the community-wide teen pregnancy prevention initiative:

1. Core Partner Leadership Team
2. Community Action Team
3. Community Leadership Team (established in Year 4)
4. Youth Leadership Team

Further, UT Teen Health worked with the San Antonio Teen Pregnancy Prevention Collaborative to establish a logic model that highlighted a united effort to decrease the teen birth rate by maximizing efforts and resources throughout San Antonio. Local clinical partners in these endeavors include the Zarzamora Clinic, Krier Clinic, University Hospital post-partum unit, University Family Health Center – Southeast, La Mision Clinic, South Flores Clinic, and the Bexar County Juvenile Detention Clinic. UT Teen worked with clinics to engage over 100 providers to provide teen friendly services; 9 partnering clinics received training on Motivational Interviewing, Adolescent Brain Development, Adolescent Best Practices, Contraceptives and Quick Start; referral data revealed that 40% of teen referrals were from friends or family and 38% of referrals were from youth who participated in an evidence-based program; 23 Community youth-serving organizations established linkages to partnering clinics for health services, 2 school based health clinics were established in partnering school districts; and a total of 9,086 or 54% of 15-19 year olds were seen at a partnering clinic since 2010.

UT Teen Health also provided stakeholder education and works with diverse communities:

- Data was presented to engage various levels of stakeholder buy-in throughout the initiative.
- Clinic videos produced by the Youth Leadership Team premiered at a local theater and were uploaded on YouTube and Facebook.
- Parent workshops, school board meetings, health fairs, and Chamber of Commerce meetings were attended by UT Teen Health staff to engage the community in teen pregnancy prevention efforts.
- Efforts to engage youth in the juvenile justice system, foster care, faith-based communities and other diverse populations were made.
- Partnerships were established with Women, Infants, and Children (WIC), Nurse Family Partnership, local churches, Bexar County Juvenile Probation Department, and BCFS.

In conclusion, Dr. Plastino summarized the program’s achievements:

- The teen birth rate has decreased by 24% in the target population (based on 2013 data).
- There are over 400 facilitators trained to deliver an EBP.
• There are 9 clinics that are working towards the teen friendly designation.
• There are 23 implementation partners offering EBPs.
• Over 12,600 youth have been served with EBPs!
• UT Teen Health met the CDC project goals set in 2010 thanks to the dedication and outstanding performance of our collaboration partners.
• UT Teen Health received $13.75 million to further promote teen pregnancy prevention in all of San Antonio and the state of Texas through the year 2020

RECOMMENDATION: This report was provided for informational purposes only.
ACTION: None.
EVALUATION: Dr. Jimenez asked how the UT Teen Health Program plans to integrate mental health issues, such as suicide, and drug and substance abuse issues that might lead to sexual promiscuity. The program takes a serious look at the trauma-informed approach because every single teen will interpret sex education differently. In addition, male teens are a very strong focus of the program. Dr. Burns commended the program and asked if it would grow to include East side teens in the next funding phase. Having received a letter of commitment from the East Side Promise Zone, Dr. Plastino reported that those teens will indeed be targeted via the Health System’s new East Side Clinic. On behalf of the Board, Mr. Adams praised Dr. Plastino’s presentation technique and methodology. The timing of the presentation fits very well with the UT/UHS partnership by providing evidence of the type of joint success that is possible. He hopes to achieve the same results upon signing the new affiliation agreement later this evening. The Board of Managers is delighted to work with Dr. Plastino as President of the Health System’s medical and dental staff.

FOLLOW-UP: None.

NEW BUSINESS:

CONSENT AGENDA—JIM ADAMS, VICE CHAIR

CONSIDERATION AND APPROPRIATE ACTION REGARDING MEDICAL-DENTAL STAFF RECOMMENDATIONS FOR STAFF MEMBERSHIP—KRISTEN A. PLASTINO, M.D., PRESIDENT, MEDICAL/DENTAL STAFF

CONSIDERATION AND APPROPRIATE ACTION REGARDING THE APPOINTMENT OF MICHELLE ARANDES, M.D., AS INTERIM CHAIR OF THE DEPARTMENT OF PEDIATRICS—KRISTEN PLASTINO, M.D., PRESIDENT, MEDICAL/DENTAL STAFF

CONSIDERATION AND APPROPRIATE ACTION REGARDING PURCHASING ACTIVITIES (SEE ATTACHMENT A)—FELIX ALVAREZ/FRANCINE WILSON

SUMMARY: The items above were presented for the Board’s consideration as consent items.

RECOMMENDATION: Staff recommended approval of the consent agenda items by the Board of Managers.

ACTION: A MOTION to approve staff’s recommendation by Dr. Burns, SECONDED Mr. Gilbert, and PASSED UNANIMOUSLY.

EVALUATION: None.
FOLLOW-UP: Board members expressed an interest in visiting with Dr. Michelle Arandes. Dr. Alsip will invite Dr. Arandes to a future meeting and also explained that her interim appointment as Chair of the Department of Pediatrics is for approximately one year while Dr. Tom Mayes completes a Robert Wood Johnson fellowship in Washington, DC on public policy.

CONSIDERATION AND APPROPRIATE ACTION REGARDING APPROVAL OF AN AFFILIATION AGREEMENT BETWEEN THE BEXAR COUNTY HOSPITAL DISTRICT D/B/A UNIVERSITY HEALTH SYSTEM AND THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO AND APPROVAL OF THE HEALTH SYSTEM MEDICAL STAFF BYLAWS:

SUMMARY: The Health System and the UT System entered into a Master Affiliation Agreement on June 11, 1992, that established the Health System as a clinical affiliate of the UT System, UT as an academic affiliate of the Health System, and collectively the two as an academic medical center. This Affiliation Agreement was set to expire on December 31, 2014, until the Board of Managers approved a few extensions culminating in a final one, sixty (60) days long at the June 30, 2015 meeting. The new affiliation agreement is slated to run for 15 years beginning on August 31, 2015. The parties have spent a significant amount of time framing a new agreement that would be relevant for that long stretch of time in what is and will continue to be a dynamic healthcare delivery environment. The staff’s premise in this agreement is that the parties share the vision to become a preeminent, world-renowned,学术性医疗中心 that provides outstanding patient experience and outcomes in professional education and research. This agreement does not dictate fiscal terms for the Health System directly, but has significant indirect implications on system financials, especially in implied financial support of UTHSCSA in services provided to the Health System as medical direction, program leadership, call coverage, clinical service provision, and resident oversight. The total current amount for these services is approximately $144M, excluding support of residents. The Affiliation Agreement provides the foundation of the philosophical, financial and legal basis for aligning Health System facilities, physicians and other providers with UT System physicians and providers across the health care continuum. The fundamental principles outlined in this agreement have far-reaching implications for the overall strategic direction of the Health System as it defines the parameters of the relationship with one of the Health System’s principal partners. Physician alignment, including that specifically with the UT System, is a key element of the Health System’s strategic plan. UTHSCSA has provided a copy of their Equal Opportunity plan in lieu of the workforce composition data. Staff recommends the Board of Managers 1) approve and authorize the President/CEO to execute the Affiliation Agreement with The University of Texas Health Science Center at San Antonio; and 2) approve the amendments to the UHS Medical-Dental Staff Bylaws adopted by the Medical Staff.

RECOMMENDATION: A MOTION to approve staff’s recommendation by Dr. Jimenez, SECONDED by Mr. Gilbert, and PASSED UNANIMOUSLY.

ACTION: Upon the Board’s approval, both Dr. Henrich and Mr. Hernandez signed the original Affiliation Agreement in duplicate. Mr. Hernandez
announced that there would be a joint reception to celebrate the renewed, long-term partnership on Wednesday, September 9, 2015 at 5:00 pm, at the Oak Hills Country Club. Board members expressed pride, support and appreciation for the staff's hard work in renewing the partnership.

A signed copy of the Affiliation Agreement and the Medical/Dental Staff Bylaws will be filed with today's Board meeting minutes.

FOLLOW-UP:

CONSIDERATION AND APPROPRIATE ACTION REGARDING SELECTED PURCHASING ITEMS:

CONSIDERATION AND APPROPRIATE ACTION REGARDING A CONTACT RENEWAL WITH SODEXO HEALTHCARE FOR MANAGEMENT OF NUTRITIONAL, VENDING AND GIFT SHOP SERVICES AND THE ADDITION OF MANAGEMENT OF PLANT ENGINEERING AND ENVIRONMENTAL SERVICES – ALLEN STRICKLAND/TIM BRIERTY

SUMMARY:

On April 15, 2011 the Health System entered into a contract with Sodexo Healthcare to provide management oversight for nutritional, vending, and gift shop services. This agreement was approved by the Board of Managers for a three year term with two (2) one year renewal options. The current contract will automatically renew on August 15, 2015, unless terminated, and will be the final renewal year of the existing agreement.

Mr. Strickland reviewed the actions taken to date, programs implemented, and highlighted the following results achieved by Nutritional Services over the past four years:

- Savings of $515,000 from "At Your Request" design and early contract termination of consultant;
- $120,000 in start-up fees and phone system upgrades paid by Sodexo;
- Increased cafeteria check average by 20 percent and reduced waste by 5 percent; and
- Increase in cafeteria revenue from 2011 of $3.6M to $5.1M in 2014.

At this time, staff is proposing that the contract for Nutritional Services be allowed to automatically renew for one year; and also proposing an amendment to add managerial support services for the Plant Engineering and Environmental Services department for the one year term of this final contract renewal.

The System will reimburse Sodexo for the cost of salaries and benefits of Nutritional Services managers in the amount of $539,166 per year, same as previous four years. Additionally, the Health System will continue to pay an annual management fee of $220,666 for Nutritional Services, same as previous four years. These amounts have been more than offset in past years by savings in annual food costs and increases in sales.

The Health System will reimburse Sodexo for the cost of the salaries and benefits of Plant Engineering managers in the amount of $142,080 per year and will pay an annual management fee of $90,312. The Environmental Services salaries and benefits cost will be $59,508 per year with an annual management fee of $99,984. The Health System will
realize cost savings created by the operational efficiencies and techniques brought to the Health System by Sodexo.

**RECOMMENDATION:** Staff recommends Board of Managers approval of the final renewal of Sodexo Healthcare’s contract to manage nutritional, vending and gift shop services as part of the two (2) one year renewal options with an amendment to add management of Plant Engineering and Environmental Services during this final term, and the allocation of funds to support this renewal with a total cost of $1,151,716.

**ACTION:** A MOTION to approve staff’s recommendation by Mr. Hasslocher, SECONDED by Mr. Gilbert, and PASSED UNANIMOUSLY.

**EVALUATION:** None.

**FOLLOW-UP:** None.

**CONSIDERATION AND APPROPRIATE ACTION REGARDING RENEWAL OF A CONTRACT WITH MLC GROUP, LLC FOR MANAGEMENT AND CONSULTATIVE SERVICES FOR THE HEALTH SYSTEM’S HUMAN LEUKOCYTE ANTIGEN (“HLA”) LABORATORY—ALLEN STRICKLAND**

**SUMMARY:** The HLA Laboratory (currently referred to as the Histocompatibility Lab) is an integral part of the extensive laboratory testing that is provided to organ transplant patients, and a requirement for the transplant program. In addition to complex testing and daily operations, the laboratory is participating in the development and implementation of the new Laboratory Information System (LIS), which will go live in November 2015. Because of the complexity of the testing provided by the HLA and the stringent regulatory requirements, knowledgeable leadership of the laboratory is imperative to the success of the transplant program and patient outcomes. HLA medical directors must be certified by the American Board of Histocompatibility and Immunogenetics (ABHI), and this certification requires several years of intensive training for completion. Due to the specialized nature and complex requirements of this position, qualified medical directors are difficult to recruit. Following the retirement of the previous medical director in 2014, the Health System contracted the services of MLC Group to provide medical director oversight for the HLA, as well as consulting services for the implementation of the HLA component of the LIS and other key initiatives. Through consultative services provided by the MLC Group, the HLA lab has progressed to modern evidence-based medicine and quality though improvements in equipment, supplies, processes, and staff training. UTHSCSA has been unsuccessful in their efforts to recruit a permanent HLA lab medical director. The scope of the agreement between MLC Group and the Health System is comprised of two components: medical directorship and consultation for the building and implementation of the HLA component of the LIS. As compensation during the term of this agreement, MLC Group will be paid $15,000 per month for medical directorship service and $300 per hour for consultative services (not to exceed 175 hours per year) plus travel expenses (consultants provide 24 hour per day, 7 day a week support and are on-site a minimum of two days per month). The total value of this contract including travel for services is $265,000. MLC Group is classified as a Small Business Enterprise.
RECOMMENDATION: Staff recommends the Board of Managers approve a one-year contract renewal with MLC Group for medical directorship and LIS implementation consulting services for an amount of $265,000.

ACTION: A MOTION to approve staff's recommendation by Mr. Gilbert, SECONDED by Mr. Hasslocher, and PASSED UNANIMOUSLY.

EVALUATION: None.

FOLLOW-UP: None.

CONSIDERATION AND APPROPRIATE ACTION REGARDING A LEASE AGREEMENT WITH COMMUNICARE HEALTH CENTERS TO ESTABLISH A NEW PEDIATRIC SPECIALTY SERVICES OUTREACH CLINIC—TED DAY/MARK WEBB

SUMMARY: Staff proposes to pursue a new location for deployment of pediatric specialty services in concert with UTHSCSA physicians. The location in question is a new physician office site being developed by CommuniCare Health Centers. CommuniCare has assessed the opportunity to provide pediatric primary care and related services in Boerne, Texas, as one of the fastest growing communities adjoining San Antonio. Their plan is to co-locate three pediatricians coming from that community and elsewhere into a common practice site along with other complementary services at the same time. Based on the number of pediatricians planned for this location and their existing panels of patients in that community, the Health System will gain immediate "referral-relationship access" to an existing and growing primary care panel of approximately 3,500 commercial patients and a growing number of Medicaid patients that will utilize the CommuniCare site as their medical home. This existing primary care panel will help generate referrals to the pediatric specialty services on-site. The proposed lease would enable the pediatric specialty practice to have access to dedicated exam rooms and other dedicated areas along with common area access. To ensure ease of access to these providers, the clinic will be set up as a physician-based clinic, with UTHSCSA Pediatric Specialty providers leased through Community Medicine Associates (CMA) for the portion of their time spent at this site. Given the current availability of pediatric specialists, coupled with those that are interested in working in an outreach clinic setting, the Health System plans to initially stand up the clinic operating four days per week, and move to a four and a half or five day per week operation in 2016. The lease agreement will begin on, or about, November 1, 2015, and will terminate five years hence, unless extended. The total amount due for the five year lease is $350,000, payable upon execution of the lease agreement. This prepaid asset will be expensed over the life of the lease at a rate of $5,833.33 per month. Based on the square footage of the space (approximately 2500 square feet), yields a rate of $28/square foot, which is a market competitive rate.

RECOMMENDATION: Staff recommends that the Board of Managers approve and authorize the President/CEO to negotiate and execute a lease agreement with CommuniCare Health Centers in the amount of $350,000 for a five year term.
ACTION: A MOTION to approve staff’s recommendation by Mr. Hasslocher. There being NO OBJECTION, the MOTION CARRIED.

EVALUATION: Mr. Adams asked for assurance that the staff has previously briefed UTHSCSA partners regarding this proposal; both UTHSCSA and UHS must learn not to undertake such projects without appropriately consulting the other party. Mr. Day confirmed that Dr. Mayes, Dr. Arandes, and Dr. Rosende have all been briefed.

Dr. Burns asked for clarification regarding the existing primary care panel of 3,500. Without knowing all of the details, thirty-five hundred does not sound like a number large enough to generate the specialty referrals needed, unless the CommuniCare pediatricians are part of a PPO or an HMO. The primary care panel is the combined number of patients of two CommuniCare general pediatricians. The practice is adding another (female) pediatrician for a total of three. At the present time, this panel is comprised of commercial insurance patients only; the physicians have not historically seen Medicaid patients. The intent is that they will do so going forward because staff has verified there is a Medicaid demand in that area. Dr. Burns advised that specialty pediatricians must be approved by the various insurance companies so that they will be allowed to render services and get paid for the patients they do see. Patients do not want to pay for services when their insurance does not cover the provider. Further, what is the disease burden in that area? What is the need for specialists such as neurologists, endocrinologist, pulmonology, and gastroenterologists? This may not be same patient population our staff is accustomed to serving with a higher, heavier disease burden. As for internal credentialing of the specialists, that will occur in the usual manner through UTHSCSA. Dr. Burns informed Dr. Gonzalez that she was specifically referring to issues with United Health Care. She urged the staff to carefully consider all options due to insurance restrictions, and reiterated that the market is not as free as it used to be.

Dr. Jimenez cautioned that commercial insurance patients are more predictable than self pay and/or Medicaid patients. The Medicaid part of the business is really hard, their no-show rates are higher. This is worrisome to him because 3 to 5 no shows in one day can really hurt the profit margin. Mr. Hernandez agreed with Dr. Burns’ and Dr. Jimenez’ advise and assured the Board that staff will ensure the UT specialists placed at the Boerne clinic are approved by the appropriate insurance plans.

Dr. Plastino asked the staff to clarify whether the UT/UHS pediatrics program is going to expand pediatric specialists given that there are existing specialty clinics set up downtown. She asked the staff to consider provider satisfaction in that it is stressful for a provider to travel from point A to point B for half day clinics. For the specialists specifically involved in this proposal, they have capacity to provide care but do not have the physical clinic space; therefore the different specialties will rotate through the Boerne clinic, specialty physicians will not be expanded downtown.
Mr. Gilbert expressed appreciation for the fact that the staff is looking at services needed in this developing area, it is important to have a presence there. However, the profit margin for the next five years is thin. Is it realistic to think that you can absorb these costs by moving resources? Staff is assuming a slow ramp and conservative visit volume, and estimates a modest, positive operating margin starting in year three. This return assumes reasonable productivity in clinic operations and excludes any downstream revenue for ancillary or inpatient services. Are there marketing dollars available to support this endeavor? The current budget includes marketing, staff, and information technology infrastructure. Dr. Burns suggested that staff look at the insurance referral process and use marketing dollars in that regard, if needed, since patients cannot self-refer to the various specialties. Is there any thought to providing services out of Kerrville? There are general pediatricians north of Boerne, in Kerrville and Fredericksburg, who currently refer to Austin or San Antonio. UT physicians will do some personal outreach directly to these physicians because they will be new referral bases, from a hospital standpoint. Staff has the tools to track market share and will do so and will be sensitive to the method of advertising used.

Mr. Hasslocher expressed support for the proposal and commended the staff for targeting a growing area; the Northside, Northeast and Northwest sides of town are exploding. In his opinion, the UHS/UT teams will be a permanent fixture in Boerne, he see this arrangement with CommuniCare as an opportunity. Dr. Jimenez agreed and echoed Mr. Hasslocher’s comments regarding the Southside, Southwest, and Southeast sides of town, where he also foresees phenomenal growth in the near future. Mr. Adams reiterated the Board’s expectations for the kind of data discussed today, i.e., disease burden, profit margins, and advertising. He thanked the staff for thinking beyond borders and encouraged them to use Dr. Burns’ capabilities – she is delighted to assist. He further advised that due to the changing atmosphere of health care, it has become necessary to review all matters as any private business would.

CONSIDERATION AND APPROPRIATE ACTION REGARDING OPERATIONS AND FINANCIAL REPORT FOR JULY 2015—ROE GARRETT/REED HURLEY/EDWARD BANOS

SUMMARY: In July clinical activity (as measured based on discharges adjusted for outpatient activity) was up 7.9% for the month compared to budget. Community First Health Plan (CFHP) fully-insured membership was down 5.6% due to lower membership in STAR Medicaid and CHIP. The bottom line gain excluding debt service was $4.6 million, $2.7 million better than budget and was due to higher operating revenues. Debt Service Revenue was $3.7 million which is equal to the budgeted portion of the Debt Service payment of $3.7 million. Mr. Hurley reviewed the following year to date operational highlights:
- Activity exceeded budget by 5 percent.
- Net Patient Revenue over budget by $6.6 million or 2.6 percent
- Maintenance contracts below budget by $4.9 million or 22.2 percent
- Professional services contracts below budget by $3.0 million or 33 percent
- Employee compensation under budget $3.0 million or 1.1 percent, salary expense under by $6.3 million, benefits (health insurance) over by $3.4 million due primarily to increased pharmacy expense.
- Salary Cost per Adjusted Discharge at $7,744 below budget of $8,351 and below prior year of $8,416.
- Supply Expense over budget $3.1 million or 3.4 percent in patient medical supplies and implants due to increased volume which is up 5.0 percent.
- Supply Expense per Adjusted Discharge at $3,345 under budget of $3,396 and over prior year of $3,282.

Mr. Hurley also reviewed notable increases and/or decreases from the Consolidated Balance Sheet in detail with the Board.

Staff recommended acceptance of the financial reports subject to audit.

A MOTION to approve staff’s recommendation by Mr. Gilbert SECONDED by Mr. Hasslocher, and PASSED UNANIMOUSLY.

None.
None.

INFORMATION ONLY ITEMS:

REPORT REGARDING MEDICAL-DENTAL STAFF COMMITTEES AND DEPARTMENTS—KRISTEN A. PLASTINO, M.D., PRESIDENT, MEDICAL/DENTAL STAFF

UPDATE ON CAPITAL IMPROVEMENT PROGRAM ACTIVITIES—MARK WEBB

REPORT ON RECENT RECOGNITIONS AND UPCOMING EVENTS—LENI KIRKMAN

2015 QUARTER 2 SUPPLIER DIVERSITY REPORT—FRANCINE WILSON

SUMMARY: Mr. Adams directed the Board’s attention to the four (4) written reports above. He urged his colleagues to contact staff with specific comments, questions, or suggestions.

RECOMMENDATION: These reports were provided for informational purposes only.

ACTION: No action by the Board of Managers was required.

EVALUATION: None.

FOLLOW-UP: None.
ADJOURNMENT:

There being no further business, the public meeting adjourned at 8:05 p.m. At this time, Mr. Gilbert thanked his Board colleagues and the staff for their professional courtesies during his short tenure as a member of the Board of Managers.

James R. Adams  
Chairman, Board of Managers

Dianna M. Burns, M.D.  
Secretary, Board of Managers

Sandra D. Garcia, Recording Secretary
MASTER AFFILIATION AGREEMENT

This is an affiliation agreement ("Agreement") by and between The University of Texas Health Science Center at San Antonio ("University"), and Bexar County Hospital District d/b/a University Health System ("District") (the University and District are also referred to individually as "Party" and collectively as "Parties").

PREAMBLE AND RECITALS: MISSION, VISION, AND VALUES

WHEREAS, the District is a hospital district established under Article IX, Section 4 of the Texas Constitution and Chapter 281 of the Texas Health and Safety Code, that operates a nationally recognized teaching hospital and network of outpatient centers that are prominent healthcare destinations providing patient-centered culturally competent, and high quality healthcare to the people of Bexar County, South Texas and beyond;

WHEREAS, University, established pursuant to Chapters 65 and 74 of the Texas Education Code, with the statutory mission to create medical educational programs of the first class, conduct cutting-edge scientific research, and provide superior care to patients, is comprised of and schools of medicine ("Medical School"), dentistry ("Dental School"), nursing ("Nursing School"), allied health ("School of Health Professionals"), and graduate education ("The Graduate School of Biomedical Sciences") and also operates numerous outpatient physician offices and clinics;

WHEREAS, District and The University of Texas System, acting on behalf of the University, entered into that certain affiliation agreement dated June 11, 1992, for a primary term of twenty (20) years with an automatic three (3) year renewal term, that continued through December 31, 2014, that has been extended by the Parties through August 30, 2015 ("1992 Agreement");

WHEREAS, the Parties desire by this Agreement to renew and extend their affiliation, set forth in the 1992 Agreement;

WHEREAS, this Agreement will supersede the 1992 Agreement, and amendments if any, as the formal instrument of affiliation between the Parties;

WHEREAS, the primary purpose of the collaboration contemplated by this Agreement is to build a superior and financially sustainable, integrated patient care delivery system within an academic medical center environment that advances knowledge, the health of the community, and improves the delivery of healthcare services by the Parties;

WHEREAS, the Parties are jointly committed to aligning their respective facilities, programs, and staff across the continuum of health care in the common missions of providing outstanding medical-dental education and training for tomorrow's healthcare providers, and evidence-based and patient-centered care to meet the needs of the people of Bexar County, the region, and beyond. Such mission is built on the following common vision and shared goals:

- The advancement of comprehensive, compassionate state-of-the-art patient-centered care for illnesses and diseases afflicting this community and South Texas;
- The creation and maintenance of excellent educational and training programs in undergraduate and graduate medical education, dental, nursing, the allied health professions and other health fields;

- The creation and maintenance of Centers of Excellence in patient care of regional and national distinction; and

- A commitment to the mission of discovery with a focus on multi-disciplinary collaboration in translational research to understand the determinants of illness and well-being and to improve the quality and cost-effectiveness of health care; and

WHEREAS, the Parties' collaborative relationship embraces the concept that, collectively, the District and University share the vision to become a preeminent, world-renowned, academic medical center complex that provides outstanding positive patient experience, and outstanding outcomes in professional education and health care research. To that end, the Parties commit to seek population health improvement through the pursuit of quality and efficient health care in a customer friendly environment that promotes a positive patient experience and outstanding outcomes. As the premier health system in the San Antonio, Texas region, the Parties' academic medical center complex will be locally, nationally and internationally acknowledged as a destination for superior medical care and for the training of future health care leaders to prevent, diagnose, and treat disease in our community and beyond. The Parties' vision embraces developing integrated information systems, joint strategic, financial and operational planning, and strengthening the parties' finances to facilitate reinvestment and innovation;

WHEREAS, the Parties acknowledge that consistent with prior practice, this Master Affiliation Agreement forms the foundation for other ancillary agreements between the Parties, in particular, an annual operating agreement, specific educational and training affiliation agreements, clinical support and educational support agreements, research and recruitment agreements, and interagency service agreements. The Parties share the following common goals regarding such ancillary agreements:

- To make reasonable and good faith efforts to negotiate and complete such agreements in a timely manner to meet recruitment commitment schedules, accreditation requirements and budget timetables;

- To pursue joint regular strategic, operational, financial and programmatic planning to better align our respective budgeting processes; and

- To align incentives between the parties to enhance collaboration on cost-reduction initiatives, global contracting with payers and potentially on revenue-sharing, where appropriate and permitted by law.

WHEREAS, the District agrees to serve as a clinical affiliate of University, and University agrees to serve as an academic affiliate of the District and each Party will in all regards maintain its independent and separate legal existence, but both Parties represent, warrant, and covenant that they collectively will comprise and operate an academic medical center;
NOW THEREFORE, for and in consideration of the foregoing, the covenants made in this Agreement, and other good and valuable consideration, the District and University agree as follows:

1. VISION.

The District and the University collectively embrace the concept and share the vision to become a preeminent, world-renowned, academic medical center that provides outstanding positive patient experience, and outstanding outcomes in professional education and health care research. To that end, the Parties commit to seek population health improvement through the pursuit of quality and efficient health care in a customer friendly environment that promotes a positive patient experience and outstanding outcomes.

As the premier health system in this region, our academic medical center will be locally, nationally and internationally acknowledged as a destination for superior medical care and for the training of health care leaders to prevent, diagnose, and treat disease in our community and beyond. The Parties' vision embraces developing integrated information systems, joint strategic, financial and operational planning, and strengthening our finances to facilitate reinvestment and innovation.

2. VALUES.

2.1 Our patients are our focus. Our daily actions and our long-term strategies are based on a patient-centered culture: enhancing the care, health and welfare of the individual and of the community;
2.2 Our clinical care educational endeavors will be culturally sensitive to the needs of our growing and diverse population;
2.3 We will work to provide University Trainees with superior, state of the art educational and training opportunities;
2.4 We share the common goal of advancing first class clinical research;
2.5 Decisions in medical care and operational processes are data-driven and evidence-based, maximizing quality and value and assuring sustainability;
2.6 An outstanding patient experience is our most important goal. It embraces quality of care, patient safety and customer service. Our practices will be focused on optimizing the patient experience;
2.7 We will work as equal partners in a clinically-aligned environment of cooperation and collaboration, with transparency. We will share information essential for advancing our academic medical center;
2.8 We recognize that the approach of delivering value-based care to a patient population needs to be cooperatively and carefully managed on a long term basis;
2.9 We will operate our facilities and use our resources with due regard for solid business practices and self-sustaining principles; and
2.10 We will work in a spirit of honesty and transparency. We tell the absolute truth about ourselves and our work, reporting both failures and successes with equal discipline.
3. PRIMARY RELATIONSHIP.

The Parties agree that their principal efforts are built on a foundation of collaboration, shared resources, common strategic planning and joint branding and marketing. The overarching aspiration for both organizations is to create, through this affiliation, a top tier integrated health delivery system, one that is synonymous with the best patient care, teaching and clinical research. To that end, the Parties agree to seek true alignment in implementing shared goals. The University and the District understand and recognize that the success and stability of each institution is dependent upon the strength of this affiliation. Trust and fidelity to the overarching shared goals named above allows for joint strategic and business planning that is essential for each of the Parties’ success.

4. DEFINITIONS.

Capitalized words used in this Agreement will have the meanings set forth in this Agreement or in Exhibit A, attached hereto.

5. AFFILIATION FINANCIAL MATTERS.

Consistent with the Parties’ prior practices, the Parties agree to enter into annual operating agreements (“AOA”) and other service agreements (collectively referred to as the “Ancillary Agreements”). The Parties will make reasonable and good faith efforts to complete, agree, and execute the AOA and Ancillary Agreements in a timely way in order that such agreements are included as part of the District’s budgetary process for the subsequent Fiscal Year. The Parties will pursue joint regular strategic, operational, financial, and programmatic planning to better align their efforts and to inform and provide certainty in their respective budgeting processes, including the development of complementary, rolling three (3) year pro-forma budgets for the AOAs, Ancillary Agreements, which will be periodically reviewed by the JCC (as defined in Section 6.1 below).

6. AFFILIATION GOVERNANCE/JOINT CONFERENCE COUNCIL.

6.1 JCC Formation and Composition. The Parties will establish and maintain a Joint Conference Council (“JCC”) composed of an equal number of representatives from the District and the University. The District CEO will appoint the District representatives and the University President will appoint the University representatives. The District CEO and the University President will serve as ex officio members of the JCC, unless the Parties mutually agree otherwise.

6.2 JCC Responsibilities. The JCC will exercise the following responsibilities:

6.2.1 Serve as a standing forum between the Parties for regular strategic, operational, financial, and programmatic planning activities and consultation, including those strategic plans, pro-forma budgets, and related matters specifically referenced elsewhere in this Agreement;

6.2.2 Discuss and address key business and operational issues and opportunities and regularly share financial information regarding the financial condition of each Party;

6.2.3 Discuss, consider, and in good faith pursue emerging health care innovations, new models of alignment and integration between the Parties, and viable mechanisms to share revenue
and savings from alternative models of care that they mutually develop or implement within the academic medical center environment;

6.2.4 Consider and develop recommendations regarding the (a) initiation of new graduate medical education ("GME") programs, clinical programs, and research initiatives between University and District and (b) material changes to existing GME programs, existing clinical programs, and existing research initiatives between University and District;

6.2.5 Review and recommend to University and District for final approval the AOA and material changes to a previously-approved AOA;

6.2.6 Consider and develop recommendations regarding new ventures between the Parties related to this Agreement, including appropriate co-branding arrangements; and

6.2.7 Perform such other duties and responsibilities as the University President and District CEO jointly determine.

6.3 JCC Meetings. The JCC will meet regularly, at least monthly, at such times and meeting locations as agreed to by the District CEO and the University President, to address day-to-day business, operational, financial, and programmatic issues and other matters to assure good communication and an effective and efficient relationship between the parties.

6.4 Executive Review. The members of the JCC will work diligently to reach agreement on issues they consider. If the members of the JCC cannot reach agreement, they will refer the issue, or issues, to the District CEO and the University President for additional consideration and discussion. The District CEO and University President will work together to reach agreement and to compromise to reach mutually beneficial positions.

7. UNDERGRADUATE MEDICAL EDUCATION PROGRAM.

7.1 Approvals and Accreditation. The University will continue to maintain and operate Liaison Committee on Medical Education ("LCME") accredited undergraduate medical educational (UME") program leading to the MD degree.

7.2 Primary UME Program Teaching Site. The Parties acknowledge that the District is the primary teaching site for University’s undergraduate medical education ("UME") programs. Consistent with LCME accreditation standards and requirements and other applicable guidance, District will provide reasonable and appropriate educational and training space at District Facilities for use by UME Trainees. The parties will discuss and must come to mutual agreement before the use of any other District facility as an additional site for UME programs and training. University’s UME programs will have first priority over other non-University operated UME programs for access to District Facilities and additional agreed facilities of the District, and patient populations to ensure that such students receive the best and most appropriate UME experience consistent with LCME accreditation standards. Following advance notice and discussion with University, District may accept and host medical students enrolled in other accredited medical school programs for rotations or temporary assignments to facilities of the District, to which the University has been given priority so long as such rotations or
assignments do not unreasonably limit access of University UME students to appropriate clinical experiences or compromise LCME accreditation.

7.3 UME Trainee Professional Liability Insurance and Healthcare. University will arrange to provide, through The University of Texas System Professional Medical Liability Benefit Plan, professional medical liability insurance coverage for UME Trainees. In the event a UME Trainee is exposed to an infectious or environmental hazard or other occupational injury (e.g., needle stick) while at a District facility, upon notice of such incident from the UME Trainee, University will provide the UME Trainee with such necessary and appropriate emergency medical care, urgent occupational health care, and follow-up care as is provided to University employees; however, if the occupational injury occurs outside of normal University business hours, the District will provide the UME Trainee with appropriate emergency medical care.

7.4 Student Etiquette and Behavior. The University, as the accredited LCME organization, commits to the District that it will instruct, train and supervise its rotating medical students in appropriate patient and staff etiquette and behavior. It being the intent of the Parties that medical students learn to provide care to District patients in a culturally sensitive and compassionate manner, evidencing the mutual values of our respective organizations, as detailed in the UME Handbook and elsewhere in the official policies of the District and University.

8. GME PROGRAMS.

8.1 Sponsorship and Accreditations. University will continue to maintain appropriate accreditation necessary to operate the University’s existing GME programs from the Accreditation Council for Graduate Medical Education (“ACGME”), with University as the ACGME designated Sponsor and the District Teaching Hospital as an ACGME designated major participating site.

8.2 Primary GME Program Clinical Teaching Site. The Parties acknowledge that the District is the primary teaching site for University’s GME programs and will have priority in serving as such primary teaching site. Consistent with ACGME accreditation standards and requirements and other applicable guidance, District will provide reasonable and appropriate educational and training space at District’s Facilities for use by University GME Trainees. The Parties will discuss and come to mutual agreement before the use of any other facility of the District as an additional site for GME programs and training. University’s GME programs will have priority over third-party operated GME programs for access to District Facilities and additional agreed facilities of the District and patient populations to ensure that residents receive the best and most appropriate GME experience consistent with ACGME accreditation standards. District will provide University advance notice and the opportunity for discussion before providing access to third party operated GME program residents or fellows at facilities of the District. The University will provide District advance notice and the opportunity for discussion before starting permanent new University GME resident rotations with third party inpatient hospital facilities in Bexar County.

8.3 GME Trainee Fellows Licensure and Qualifications. Medical School is responsible for confirming that all University GME Trainees maintain necessary permits and licenses to participate in and provide clinical services at District facilities and are eligible to participate in University’s GME programs and related clinical experiences.
8.4 GME Trainee Retention. The District and the University agree to annually review resident and fellow stipend payments and benefits to assure that they are reasonable and appropriately competitive, and the District agrees to pay reasonable stipend rates plus benefits to such UT Residents and/or Fellows, as agreed to between the University and the District subject to annual appropriations. The District also agrees to serve as the common paymaster for University GME Trainees in accordance with the individual Graduate Medical Education Agreements executed by and among University, the District and the University resident and/or Fellows, as agreed to between University and District. However, to assure that the District does not inappropriately assume the cost of residents or Fellows when they rotate to other health systems, the University will provide District with timely advance notice of the specifics of each GME rotation to allow sufficient time for the District and the third party health system to enter into a reimbursement agreement.

8.5 UT Resident and/or Fellows Professional Medical Liability Insurance Coverage. University will arrange to provide, through The University of Texas System Professional Medical Liability Benefit Plan, professional medical liability insurance coverage for University GME Trainees considering the protections and limitations of liability available to such University GME Trainees under Texas law. District will reimburse the University for the costs of such professional medical liability insurance coverage provided for University GME Trainees pursuant to applicable Annual Operating Agreement or Ancillary Agreements.

8.6 Resident Etiquette and Behavior. The University, as GME Sponsor, commits to the District that it will instruct, train and supervise residents and Fellows regarding appropriate patient and staff etiquette and behavior. It being the intent of the Parties that residents and Fellows provide care to District patients in a culturally sensitive and compassionate manner, evidencing the mutual values of our respective organizations, as detailed in the House Staff Manual and elsewhere in the official policies of the District and University.

9. UNIVERSITY NURSING, DENTAL, ALLIED HEALTH PROFESSIONS AND BIOMEDICAL SCIENCES PROGRAMS.

9.1 The Parties acknowledge that District Facilities are the primary inpatient teaching site for University's Trainees in the Nursing School, the Dental School, the School of Health Professions, and the Graduate School of Biomedical Sciences, and District, subject to available resources, will work with the University to identify reasonable and appropriate educational and training space at additional agreed facilities of the District for use by such University Trainees. The parties will discuss and must come to mutual agreement before the use of any other facility of the District as an additional site for University Trainees programs and training.

9.2 The University, as the accredited educational institution, commits to the District that it will instruct, train and supervise its rotating nurse, dental and other health profession University Trainees in appropriate patient and staff etiquette and behavior. It being the intent of the Parties that such University Trainees learn to provide care to District patients in a culturally sensitive and compassionate manner, evidencing the mutual values of our respective organizations.
10. CLINICAL PROGRAMS.

10.1 Clinical Program Objectives. The Parties are committed to develop in a financially sustainable manner within an academic medical center environment, new and effective integrated patient care delivery models and inter-professional patient centered educational models that advance knowledge and the health of the community. Further, District and University will work together to develop nontraditional models of care, and attempt to implement them to improve the delivery of healthcare services. To accomplish this objective, the Parties will strive to implement increasingly stronger joint strategic planning and clinical integration over time with the University and District each retaining ultimate control and accountability for the strategic plans and financial operations of their respective institutions. District and University will also work to establish viable mechanisms to share revenue and savings from alternative models of care that they mutually develop or implement within the academic medical center environment, consistent with any and all applicable federal and state laws and regulations.

10.2 Future Hospital Projects - Right of First Opportunity. Should either Party propose to build, own, or operate a hospital facility on its own or with a third party, at the initiation of the project the proposing Party will (a) immediately communicate and discuss such plans with the other Party, directly and through the JCC, and (b) allow the other Party to offer a reasonable opportunity to participate in a mutually agreeable way. The second Party will have sixty (60) days to respond to the proposing Party, and after receipt of the second Party response by the proposing Party, the District and the University will use reasonable and good faith diligence and effort to agree on the principle terms of the hospital facility opportunity within sixty (60) additional days. If the Parties cannot reach agreement within the second sixty (60) day period, the proposing Party may pursue building, owning, or operating a hospital facility on its own or with a third party, without the participation of the second Party. Both the District and the University will notify a third party, at the time negotiations begin about building, owning, or operating a hospital facility, that the District and the University are primary partners and will offer a notice and right of first opportunity to one another (as outlined above) before pursuing a transaction with a third party.

10.3 Centers of Excellence.

10.3.1 Right of First Opportunity. Should either Party propose to develop a new Center of Excellence related to a Trauma Service, Solid Organ Transplantation, or Neurosciences on its own or with a third Party, at the initiation of the project the proposing Party will (a) immediately communicate and discuss such plans with the other Party, directly and through the JCC, and (b) allow the other Party to offer a reasonable opportunity to participate in a mutually agreeable way. The second Party will have sixty (60) days to respond to the proposing Party, and thereafter both Parties will use reasonable and good faith diligence and effort to agree on the principle terms of the Center of Excellence opportunity within sixty (60) additional days. If the Parties cannot reach agreement by the end of the second sixty (60) day period, the JCC will refer the issue or issues to the District CEO and University President for additional consideration and discussion. The District CEO and University President will work together to reach agreement and to compromise to reach mutually beneficial positions. The Parties agree that they do not intend to disadvantage one another or to materially and adversely affect the existing Centers of Excellence referenced in this Section (e.g., reduce patient volumes and revenue). The JCC will
periodically review Centers of Excellence operated by the Parties and consider the initiation of new Centers of Excellence.

10.3.2 Service Line Development. The University recognizes and appreciates the significant investment by the District in Pediatrics and in the developing Heart and Vascular Institute, and concurs that continued investments are required by both Parties to advance the development of these programs, to protect and increase the return on investment, and to create premier clinical service lines that benefit both Parties and improve the health of the region. The JCC will work to establish a plan with designated milestones and continuing investments by the District and the University, to fully develop joint Pediatric programs and the Heart and Vascular Institute. When further developed and upon mutual agreement of the District and the University, the right of first opportunity and related timelines outlined in Section 7.3.1 will apply to the two service lines referenced in this Section and other service lines similarly developed in the future.

10.4 Managed Care Contracts. The Parties agree to use reasonable efforts to collaborate and strategically align agreements with managed care organizations, in accordance with applicable law, in pursuing effective managed care contracts, including accepting appropriate risk contracts, bundled payments or other market driven accountable care strategies (e.g., health homes and interdisciplinary systems of care).

11. CLINICAL RESEARCH.

University and District agree that clinical research is important to the Parties and may be conducted collaboratively by University and District under appropriate agreements addressing, among other things, responsibilities for grant and study management; the extent of responsibilities and the participation of each sponsor; administration and disposition of research funds; provision of staff and facilities; access to data; ownership of equipment purchased with research funds; and ownership of intellectual property and other research products. It is the intent of the Parties that any income or financial benefits arising from research performed at District facilities will be shared by the Parties and individual physician(s) in accordance with the Board of Regents Rules, the policies of the District and the specific research agreements that take into account consideration for inventorship and the financial contributions of the University and the District. Clinical research conducted at District facilities with the involvement of University Faculty and Trainees will be conducted in accordance with approved clinical trial protocols and applicable federal and state statutes and regulations, in compliance with applicable District patient care and billing policies and procedures, and will conform to applicable institutional review board requirements and University’s policies and procedures for disclosure of financial interests and management of financial conflicts of interest.

12. MEDICAL STAFF CONSIDERATIONS AND MEDICAL DENTAL STAFF BYLAWS.

12.1 The District may retain or employ physicians in administrative or leadership positions necessary for the efficient operation of the District as outlined in the Texas Health and Safety Code 281, Section 281.0281. Nothing in this Agreement may be interpreted to prevent the District from retaining or employing physicians in an exclusively administrative or leadership capacity. The District further agrees that to the extent any such employed or retained physician desires to practice medicine in
any facilities owned or operated by the District, they must be credentialed and seek privileges according to applicable bylaws and policies, if any.

12.2 CMA Physicians. The District and the University recognize the significant value and benefit University Faculty provide to improve the health of District patients and the region, and to advance the mission of the District and the University. CMA or the District on behalf of CMA, may employ, retain, or contract with individual physicians, as needed to assure its obligations to meet patient needs and to manage and operate its health enterprise in a responsible, effective, and efficient way, subject to Sections 12.1, 12.3 and 12.4, below. The District and CMA will make a concerted effort to explore using University employed faculty to address its staffing needs before employing, retaining, or contracting with other hospital based Specialists. The District and CMA have no intention to replace in whole or in part, hospital based Specialists, and the District and the University agree to assure the ongoing vitality and quality of the education and training programs at District facilities.

12.3 Primary Care Physicians and Non-Hospital Based Specialists. CMA may employ, retain, or contract with Primary Care Physicians and non-hospital based Specialists at any time, as needed to carry out the mission of the District. CMA is not required to first explore using University Faculty prior to employing, retaining, or contracting such physicians. CMA physicians may be University Faculty, but are not required to obtain appointments as University Faculty for membership in the District's Medical Dental Staff.

12.4 Hospital Based Specialists. The District will provide notice to the University when it identifies the need for an additional hospital based Specialist at University Hospital. The District will communicate and discuss in advance its needs with the University, directly or through the JCC. The JCC will consider the District's need, and work diligently to reach mutual agreement within not more than sixty (60) days of the University receiving notice. The JCC will first consider whether the University can appropriately and timely address the staffing need before considering other alternatives. If the members of the JCC cannot reach agreement, they will refer the issue to the District CEO and University President for additional consideration and discussion. The District CEO and University President will work together to reach agreement and to compromise to reach mutually beneficial positions.

13. UNIVERSITY FACULTY.

13.1 Faculty Appointments and Clinical Department Chairs and Division Chiefs. All physicians who will teach and supervise University Trainees at District facilities must have University Faculty appointments. University will select and confirm the Faculty appointments of the University’s Medical School clinical department chairs and division chiefs. It is the preferred intent of the Parties, but not a mandatory requirement, for each of the University’s clinical department chairs or division chiefs to serve as the corresponding chiefs of service at the District Teaching Hospital. The District will select the District’s chiefs of service at the District Teaching Hospital following consultation with the University.

13.2 Professional Medical Liability Insurance Coverage For Medical Staff Employed by District. University may cooperate with District to arrange to provide, through The University of Texas System Professional Medical Liability Benefit Plan, professional medical liability insurance coverage for University Faculty that are employed by the District or CMA considering the protections and
limitations of liability available to such University Faculty under Texas law. District will reimburse University for the costs of such professional medical liability insurance coverage pursuant to applicable AOAs or Ancillary Agreements.

14. CO-BRANDING AND MARKETING.

The Parties acknowledge and agree that their respective names, marks, and logo designs are registered trademarks and may not be used except as provided by a license agreement and, when feasible, they may desire to co-brand or to create new brand(s) and to jointly use each other's names, marks, and logo designs as appropriate and mutually beneficial. The Parties may continue to brand independently of each other.

University and District will work together to develop joint marketing and advertising initiatives when possible and use reasonable efforts to cooperate, discuss, and agree in advance concerning any public announcements, advertising, marketing, and other communications regarding this Agreement or the relationship created by or services provided pursuant to this Agreement.

15. TERM AND TERMINATION.

15.1 Term and Termination. The effective date of this Agreement will be the day of execution by the last signatory. The primary term of this Agreement is for a fifteen (15) year period from the effective date. Upon expiration of the primary term, this Agreement shall be automatically renewed for two additional five (5) year term unless prior written notice of termination has been given. Either Party may terminate this Agreement at any time with three (3) years prior written notice to the other.

16. RECORDS.

16.1 Medical Records and Reports. In performing services contemplated by this Agreement, the Parties acknowledge and agree that University Faculty and Trainees will generate medical records and reports pertaining to patients treated at the District Teaching Hospital and other District teaching facilities, which records and reports will be completed timely and kept in the format as determined by District, in accordance with its policies. All such records and reports will be and remain the property of District unless otherwise provided by law. University recognizes that the patient has the legal right to have access to his or her medical records, that all University Faculty and Trainees have the right to consult those records to facilitate the continuity of proper care, and that such records are confidential and privileged under state and federal law. University and District agree that the Parties and University Faculty and Trainees will have access to such patient records at any time necessary for them to fulfill their duties under this Agreement.

16.2 Access to Books and Records. The Parties agree to comply with the following requirements governing the maintenance of documentation to verify the cost of services rendered by or incurred by them, as applicable under this Agreement:

16.2.1 Availability of Records. For so long as required by law the Parties will make available, upon written request of the applicable governmental entity having jurisdiction over such
Party, the books, documents, and records of such Party that are necessary to verify the nature and extent of its services and costs.

16.2.2 Subcontracts. If any Party carries out any of the duties of this Agreement through a subcontract, such subcontract will contain a clause to the effect that, for so long as required by law, after the furnishing of such services pursuant to such subcontract, the subcontractor shall make available, upon written request of any applicable governmental entity having jurisdiction, the subcontract, and books, documents, and records of such organization that are necessary to verify the nature and extent of the subcontractor’s services and costs.

16.2.3 Notice of Request or Demand to Disclose Records. If any Party receives a request or demand from a third party government entity to disclose any books, documents, or records relevant to this Agreement for the purpose of an audit or investigation relating to compliance with federal and state laws, such Party shall immediately (and no later than five (5) business days after receipt of such request or demand) notify the other Party in writing of the nature and scope of such request or demand and shall make available to the other Party, upon written request of the other Party, all such books, documents, or records produced to the government authority.

16.2.4 Confidentiality and Medical Privacy Laws. Each Party will ensure that it maintains the confidentiality of all of its records in accordance with all applicable federal and state confidentiality and privacy laws. Each Party will reasonably and in good faith cooperate with the other Party and execute any agreements with any other party necessary for the Parties to comply with any such laws.

16.2.5 Data Ownership, Management, and Sharing. University and the District collect and store data from the operation and management of their respective institutions and facilities, the provision of clinical care to patients, and their respective education and research endeavors. These data are owned by the respective Parties, and subject to the policies and procedures of the owning Party and applicable federal and state laws and regulations. In anticipation of growing needs for integrated use of data for education, clinical care, and research, University and District agree to share data in compliance with their respective institutions’ policies and procedures, as well as applicable federal and state laws and regulations to support efficient and effective education, clinical care, and research goals.

In cases where one Party’s data are used by the other Party, or jointly by both Parties, and said use results in royalties or other forms of remuneration being paid by third parties to such other Party, the Parties will negotiate and enter into separate Ancillary Agreements addressing the pro rata sharing of that remuneration between the Parties.

16.2.6 HIPAA & HITECH Compliance. To the extent applicable to this Agreement, the Parties shall comply with the Health Insurance Portability and Accountability Act of 1996, Public Law 100-180, as amended (“HIPAA”), the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (Privacy Rule”), Subparts A and E, and the federal security standards contained in 45 C.F.R., Parts 160 and 164; Subparts A and C (“Security Rule”); the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162; Subtitle D of the Health Information Technology for Economic and Clinical Health Act, Public Law 111-5 (“HITECH”), including implementing regulations at 45 C.F.R. Part 164, Subpart D (“Breach Notification Rule”); and the Texas Medical Record Privacy Act codified at Title 2, Subtitle I, Chapter 181, Subchapter A of the Texas Health &
Safety Code; all as they may be amended from time to time and collectively referred to herein as “HIPAA Requirements.” The Parties agree to enter into any further agreements as necessary to facilitate compliance with the HIPAA Requirements and their related regulations, and all applicable state privacy and security laws.

17. GENERAL PROVISIONS.

17.1 Relationship of Parties. District and University acknowledge and agree that (a) each Party is a separate and independent organization from the other Party and, accordingly, shall, except as otherwise provided by this Agreement, maintain sole jurisdiction over all of its activities, operations, and internal matters; and (b) as a result of this Agreement, District and University are neither partners nor co-participants in a joint venture nor agents (either in fact, apparent, or ostensible) of each other.

17.2 Conformance with Law. District and University recognize that this Agreement is subject to, and agree to comply with, applicable local, state, and federal statutes, rules and regulations. Any provisions of applicable statutes, rules, or regulations that invalidate any term of this Agreement, that are inconsistent with any term of this Agreement, or that would cause any Party to be in violation of law shall be deemed to have superseded the terms of this Agreement; provided, however, that District and University will use their best efforts to accommodate the terms and intent of this Agreement to the greatest extent possible consistent with the requirements of applicable statutes, rules, and regulations and negotiate in good faith toward amendment of this Agreement in such respect.

17.3 No Referral. Nothing contained in this Agreement shall require (directly or indirectly, explicitly or implicitly) any Party to refer any patients to any other Party or to use any other Party’s facilities as a precondition to receiving the benefits set forth herein. Specifically, University Faculty may refer and admit patients in their sole discretion and medical judgment to any health care facility; there is no duty or obligation on their part to refer or admit any patients to the District Teaching Hospital or other District teaching facilities.

17.4 AMC Exception. The Parties desire that their business and legal relationship generally (and this Agreement specifically) qualify under and comply with the “academic medical center” exception set forth in the Stark law. Accordingly, the parties acknowledge and agree that (a) all transfers of monies contemplated by this Agreement must be used by University directly or indirectly to support University’s missions of teaching, patient care, research, and related matters, (b) all monies paid to University Faculty who admit or refer to or utilize District must be set in advance, not exceed fair market value, must comply with applicable laws (including but not limited to federal and state anti-kickback laws), and may not take into account admissions or referrals to District, and (c) all monies paid to any referring University Faculty for research must be used solely to support bona fide research or related teaching activities and must be consistent with terms and conditions of the research grant.

17.5 Additional Documents. Each of the Parties hereto agrees to execute any document or documents that may be requested from time-to-time by any other Party to implement, carry out, or complete such Party’s obligations pursuant to this Agreement.

17.6 Governing Law and Venue. This Agreement shall be governed by and construed in accordance with the laws of the State of Texas. The venue of any lawsuit between the Parties shall be Bexar County, Texas.
17.7 **Benefit/Assignment.** This Agreement shall inure to the benefit of and be binding upon the Parties and their respective legal representatives, successors and permitted assigns; provided, however, that no Party hereto may assign this Agreement (or sub-contract to a third party any of its duties under the Agreement) without the prior written consent of the other Party.

17.8 **No Third Party Beneficiary.** The terms and provisions of this Agreement are intended solely for the benefit of the Parties and their respective permitted successors or assigns, and it is not the intention of the Parties to confer third-party beneficiary rights upon any other person or entity.

17.9 **Waiver of Breach.** The waiver by any Party hereto of a breach or violation of any provision of this Agreement shall not operate as, or be construed to constitute, a waiver of any subsequent breach of the same or any other provision hereof. All remedies, either under this Agreement, or by law or otherwise afforded, will be cumulative and not alternative.

17.10 **Notices.** Any notice, demand or communication required, permitted, or desired to be given pursuant to this Agreement shall be in writing and shall be deemed effectively given when personally delivered, when received by telegraphic or other electronic means (including facsimile or email) (provided that the Party giving the notice has confirmation of such delivery or sending), when delivered by overnight courier or five (5) days after being deposited in the United States mail, with postage prepaid thereon, certified or registered mail, return receipt requested, addressed as follows:

If to District: 
President/Chief Executive Officer  
University Health System  
4502 Medical Drive  
San Antonio, Texas 78229-4493

With a copy to:  
Vice President – Legal Services  
University Health System  
4502 Medical Drive  
San Antonio, Texas 78229-4493

If to University:  
President  
The University of Texas Health Science Center at San Antonio  
7703 Floyd Curl Drive  
San Antonio, TX 78229-3900

With a copy to:  
Senior Legal Officer  
The University of Texas Health Science Center at San Antonio  
7703 Floyd Curl Drive  
San Antonio, TX 78229-3900

or to such other address or number, and to the attention of such other person or officer, as any Party hereto may designate, at any time, in writing in conformity with these notice provisions.
17.11 Severability. If any provision of this Agreement is held to be illegal, invalid, or unenforceable under any present or future law, and if the rights or obligations of any Party under this Agreement will not be materially and adversely affected thereby: (a) such provision will be fully severable; (b) this Agreement will be construed and enforced as if the illegal, invalid, or unenforceable provision had never comprised a part hereof; (c) the remaining provisions of this Agreement will remain in full force and effect and will not be affected by the illegal, invalid, or unenforceable provision or by its severance here from; and (d) in lieu of the illegal, invalid, or unenforceable provision, there will be added automatically as a part of this Agreement a legal, valid, and enforceable provision as similar in terms to the illegal, invalid, or unenforceable provision as may be possible.

17.12 Entire Agreement/Amendment. Subsequent to the effective date, this Agreement supersedes all previous affiliation agreements between the Parties, and constitutes the entire agreement of every kind or nature existing between or among the Parties in respect of the within subject matter, and no Party hereto shall be entitled to benefits other than those specified in this Agreement. This Agreement may be executed in two or more counterparts, each of which shall be deemed an original and all of which together shall constitute but one and the same instrument. No terms, conditions, warranties, or representations other than those contained in this Agreement and no amendments or modifications to this Agreement shall be binding unless made in writing and signed by all Parties.

The Parties have caused this Agreement to be executed by their duly authorized officers on the dates set forth below:

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO

By: William L. Henrich, MD, MACR
   President

Date: August 25, 2015

BEXAR COUNTY HOSPITAL DISTRICT
   d/b/a University Health System

By: George B. Hernández, Jr.
   President/Chief Executive Officer

Date: August 25, 2015

APPROVED AS TO FORM:

Michael Hernandez
Vice President/Chief Legal Officer
EXHIBIT A

DEFINITIONS

“Board of Regents” means the Board of Regents of The University of Texas System as set forth in Section 65.11 of the Texas Education Code.

“Centers of Excellence” means one or more co-branded specific packages of services aimed at a specific disease or co-branded continuum of care packages of services for a specific type patient that includes (a) dedicated infrastructure, administrative support, and long-term financial support and pro-forma budget commitments from each Party, (b) University Faculty leadership, (c) clinical quality objectives and measurable criteria, (d) outcome monitoring, and (e) medical education and research components.

“CMA” means Community Medicine Associates, a Texas nonprofit corporation, certified as a nonprofit health organization by the Texas Medical Board pursuant to Texas Occupations Code, Section 162.001 and controlled and operated by District.

“CMA Physician” means a physician employed or otherwise retained by CMA to provide physician professional services at District facilities.

“District” means the Bexar County Hospital District of the University Health System, a county hospital district and political subdivision of the State of Texas, created by a special act of the Legislature and established pursuant to Article IX, Section 4 of the Texas Constitution to provide medical and hospital care to the needy and indigent residents of Bexar County, Texas, and its wholly-owned or wholly-controlled affiliates including entities for which it is the sole member as of the effective date or thereafter.

“District CEO” means the person holding the position titled, as of the effective date, “President Chief Executive Officer” of the District, or subsequent equivalent title.

“District Facilities” means those clinical facilities of the District used by University Trainees for education and training on the Effective Date of this Agreement but also including future pediatric facilities.

“District Teaching Hospital” means University Hospital operated by District and located, as of the effective date, at 4502 Medical Drive, San Antonio, Texas.

“Effective Date” means the day of execution by the last signatory of this Agreement.

“Fiscal Year” means the twelve (12) month period beginning January 1 and ending the next December 31; provided, however, the initial Fiscal Year shall be the period commencing on the effective date and continuing through December 31, 2015, and the final Fiscal Year shall be the period commencing on the last January 1 prior to the termination of this Agreement and continuing through the termination of this Agreement.
“Medical School” means The University of Texas School of Medicine at San Antonio, a
cOMPONENT SCHOOL OF AND OPERATED BY THE UNIVERSITY.

“Primary Care Physician(s)” means family practice, general pediatric, and general medicine
physicians.

“Specialist(s)” means other physicians who are not Primary Care Physicians.

“Trainees” means individuals enrolled in one of University’s education training programs, and
shall include students, residents, and fellows.

“University” means The University of Texas Health Science Center at San Antonio that
includes, as required by the context in which such term is used, its schools of medicine (“Medical
School”), dentistry (“Dental School”), nursing (“Nursing School”), allied health (“School of Health
Professionals”), and graduate education (“The Graduate School of Biomedical Sciences”).

“University Faculty” means individuals holding faculty appointments in one of University’s
schools.

“University President” means the person holding the position titled, as of the effective date,
“President” of the University, or subsequent equivalent title.

“UT System Institutions” means the institutions in the system of higher education governed by
the Board of Regents of The University of Texas System as set forth in Chapter 65 of the Texas
Education Code.
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PREAMBLE

WHEREAS, Bexar County Hospital District ("BCHD") is a political subdivision of the State of Texas established through the Constitution of the State of Texas and approved by the voters of Bexar County in 1955 to provide medical and hospital care to the indigent and needy persons residing in the hospital district; and

WHEREAS, the Bexar County Commissioners appoint the Board of Managers to oversee the administration of the BCHD; and

WHEREAS, one of BCHD's primary purposes is to promote the good health of the community by providing the highest quality of care and to teach the next generation of health professionals; and

WHEREAS, BCHD's self-governing organized Medical-Dental Staff is responsible for providing the oversight of the quality of care, treatment and services provided by individuals credentialed and privileged in BCHD and must accept and discharge this responsibility subject to the authority of the Board of Managers; and that the cooperation of the Medical-Dental Staff, Chief Executive Officer, and Board of Managers is necessary to fulfill BCHD's obligations to its patients; and

NOW THEREFORE, the Physicians, Dentists and Podiatrists permitted by law and BCHD to provide patient care services thereby organize themselves into a Medical Staff in conformity with these Bylaws.
DEFINITIONS

1. ALLIED HEALTH PROFESSIONAL (AHP) means an individual, other than a member of the Medical-Dental Staff, who exercises judgment within the area of his professional competence and the limits established by the Board of Managers, the Medical-Dental Staff, and the appropriate Texas state practice act, who is qualified to render direct or indirect care under the supervision or direction of a Staff member possessing privileges; and who may be eligible to exercise practice privileges and prerogatives in conformity with the rules adopted by the Board of Managers, these Bylaws, and the Medical-Dental Staff Rules and Regulations. An AHP is not eligible for Staff membership.

2. BOARD CERTIFICATION means certified by a member board of the American Board of Medical Specialties, the American Osteopathic Association, American Board of Podiatric Surgery, a board organization recognized by the Commission on Dental Accreditation or equivalent board certification as determined by the policy of the Credentials Committee.

3. BOARD OF MANAGERS ("Board") means the Governing Body of the University Health System (the "Health System").

4. BY LAWS: The Bylaws of the Medical-Dental Staff of University Health System define the obligations of the organized Medical-Dental Staff and its officers, persons and groups within its structure; the self-governance functions of the organized Medical-Dental Staff; and the organized Medical-Dental Staff’s working relationship with and accountability to the Board of Managers. The Bylaws are adopted by the Medical-Dental Staff and approved by the Board of Managers.

5. CEO or CHIEF EXECUTIVE OFFICER means the individual appointed by the Board of Managers to act in its behalf in the overall management of the University Health System and its facilities.

6. CHIEF OF STAFF means the President of the Medical-Dental Staff.

7. COMMUNITY MEDICINE ASSOCIATES ("CMA") means a certified 162.001(b) non-profit health organization by the Texas Medical Board. Its sole member is the Bexar County Hospital District doing business as University Health System.

8. DAYS mean business days, Monday through Friday, exclusive of holidays.

9. DEAN means the Dean of the School of Medicine, the University of Texas Health Science Center at San Antonio.
10. DISTANT-SITE HOSPITAL means a Medicare-participating hospital that provides the practitioner who is providing the telemedicine services.

11. DISTANT-SITE TELEMEDICINE ENTITY includes a non-Medicare participating hospital or entity that provides contracted services in a manner that enables a hospital using telemedicine services to meet all applicable Conditions of Participation; these include teleradiology providers, telepathology providers and ambulatory surgical centers.

12. DOCTORAL LEVEL RESEARCH means healthcare researcher with doctoral level credentials who is investigating various aspects of patient care and outcome within the policies and procedures of University Health System.

13. EXECUTIVE COMMITTEE means the Executive Committee of the Medical-Dental Staff.

14. EX OFFICIO means membership by virtue of an office or position held. An Ex Officio appointment is without vote unless specified otherwise.

15. HEALTH SCIENCE CENTER means University of Texas Health Science Center at San Antonio.

16. HE/HIS/HIM/MAN refers to a person of either gender.

17. HOUSE STAFF (otherwise known as “Resident”) means a physician, dentist or podiatrist participating in an accredited graduate-training program whose practice requires supervision. The University of Texas Health Science Center at San Antonio must accept a person for clinical supervision under its active, provisional or courtesy staff prior to a person’s designation as House Staff.

18. LIMITED HEALTHCARE PRACTITIONER means a healthcare specialist such as an optometrist, psychologist, pharmacologist, or a biochemist who is appropriately licensed, certified, or legally authorized under the laws of the State of Texas to provide patient care services within the scope of the license, certificate or legal authorization.

19. MAIL means a written document or an electronic communication (e-mail).

20. MEDICAL-DENTAL STAFF or STAFF means the formal organization of all allopathic and osteopathic physicians, dentists, and other medical specialists as required by law who are privileged to attend patients. It includes those practitioners that hold faculty appointments with The University of Texas Health Science Center, San Antonio, “faculty staff,” as well as those practitioners that hold appointments with
Community Medicine Associates, “non-faculty staff.” STAFF (with voting privileges) is also responsible for adopting and amending the Bylaws and for overseeing the quality of care, treatment and services provided by all individuals with clinical privileges.

21. MEDICAL-DENTAL STAFF YEAR means the period from January 1st to December 31st.

22. PHYSICIAN means a doctor of medicine or osteopathy.

23. POLICIES: The corporate policies of University Health System.

24. PRACTITIONER means a duly licensed physician, dentist, or podiatrist holding a current Texas license to provide patient care services within the scope of the license (except as otherwise determined by the Executive Committee in accordance with these Bylaws).

25. PRIVILEGES means the permission granted to a practitioner to perform those diagnostic, therapeutic, medical, surgical, or dental services specifically delineated to him. For House Staff, privileges must be performed under the supervision of a faculty member of the Active, Provisional or Courtesy staff.

26. RESIDENCY PROGRAM means a graduate medical, dental, or podiatric education program accredited by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, the Commission on Dental Accreditation, or the Council on Podiatric Medical Education.

27. RULES AND REGULATIONS: The Rules and Regulations of the Medical-Dental Staff are comprised of a compendium of Health System Corporate Policies that relate to specific roles of Staff. See also UHS Policy No. 10.015.

28. STAFF ORGANIZATION means all staff officers, department chairman, and committee chairman/vice-chairman of the Medical-Dental Staff.

29. TELEHEALTH means the use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education, public health and health administration.

30. TELEMEDICINE means the use of medical information exchanged from one site to another via electronic communication to improve patients’ health status. Telemedicine is a subcategory of telehealth.
ARTICLE I
NAME

The name of this organization is the Medical-Dental Staff of the University Health System. The organized Medical-Dental Staff is accountable to the Board of Managers.

ARTICLE II
PURPOSES AND RESPONSIBILITIES OF THE STAFF

2.1 PURPOSE

The purposes of the Staff are:

2.1-1

To assure that all patients are admitted and treated without regard to race, color, religion, sex, age, national origin, disability, or ability to pay and receive care and treatment in keeping with appropriate medical, ethical and scientific standards.

2.1-2

To constitute a professional collegial body, providing for its members mutual education, consultation and professional support, to the end that patient care provided at University Health System facilities is consistently maintained at that level of quality which is optimally achievable given the state of the healing arts and the available resources.

2.1-3

To provide a means of liaison and effective communication among the Staff, Board of Managers and Administration for discussion and resolution of issues of mutual concern.

2.1-4

To ensure a high level of professional performance of all practitioners and allied health professionals authorized to practice in University Health System facilities through the appropriate delineation of the clinical privileges that each practitioner or AHP may exercise and through a regular review and evaluation of each practitioner's or AHP's performance.
2.1-5
To maintain rules, regulations, and guidelines for behavior for the Staff to carry out its responsibilities with respect to the professional work performed in University Health System facilities, pursuant to the authority delegated by the Board of Managers.

2.1-6
To provide a mechanism for accountability to the Board of Managers, through defined Staff components, for the appropriateness of the patient care services, professional and ethical conduct of each individual practitioner appointed to the Staff and allied health professionals.

2.1-7
To participate in programs of continuing medical education, both internal and external. Part of the continuing education activities should relate to the individual’s clinical privileges.

2.1-8
To participate in measuring, assessing and improving the education of patients and families.

2.2 RESPONSIBILITIES

2.2-1
To participate in the University Health System’s Quality Improvement Program by conducting all required and necessary activities for assessing and improving the quality, appropriateness and efficiency of medical care provided.

2.2-2
To make recommendations to the Board of Managers concerning appointments, reappointments, Staff membership category, clinical privileges, corrective action, and specified privileges for allied health professionals.

2.2-3
To maintain sound professional practices.
2.2-4

To develop or participate in and to monitor the House Staff's education and training programs and clinical activities (faculty staff only).

2.2-5

To develop, administer and recommend amendments to these Bylaws and the Rules and Regulations of the Staff as provided in UHS Policy No.10.015 and its various components. This responsibility to amend the Bylaws cannot be delegated.

2.2-6

To enforce compliance with the Bylaws and Rules and Regulations of the Staff as provided in University Health System Policy No.10.015 and of its administrative and clinical components, as well as with the University Health System Bylaws and policies.

2.2-7

To exercise the authority granted by these Bylaws as necessary to fulfill the foregoing responsibilities in a proper and timely manner.

2.2-8

To assure an appropriate level of professional performance by all practitioners authorized to practice in University Health System facilities through an ongoing review and evaluation of each practitioner's performance. To ensure the adequate supervision, oversight and training of residents, medical and dental students, and allied health professional trainees (faculty staff only).

2.2-9

To provide an appropriate educational setting that will maintain standards consistent with accreditation requirements of the Medical, Dental, and Allied Health Programs which are offered in cooperation with The University of Texas Health Science Center at San Antonio.

2.2-10

To perform and complete a history and physical (H&P) to include sufficient information to identify the chief complaint, details of the present illness, relevant medical history and
physical examination of the patient to justify the treatment and to document the results accurately as outlined in the Rules and Regulations of the Staff. See UHS Policy No. 10.03, Medical Records, for further details.

(a) Admission: The H&P must be completed and documented for each patient no more than 30 days prior to admission or registration, or within 24 hours after admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia. If the H&P is conducted within 30 days before admission or registration, an update must be completed and documented in the medical record within 24 hours after admission or registration, but in all cases involving surgery or a procedure requiring anesthesia, prior to the surgery or procedure. The update note must document an examination for any changes in the patient’s condition subsequent to the time that the H&P was performed that might impact the planned course of treatment. If, upon examination, no change in the patient’s condition since the H&P was completed is found, the practitioner may indicate in the medical record that the H&P was reviewed, the patient was examined, and that “no change” has occurred since the H&P was completed. Documentation regarding the updated examination and any changes in the patient’s condition must be placed in the patient’s medical record within 24 hours after admission or registration, but in all cases prior to surgery or a procedure requiring anesthesia services.

If the H&P from a previous visit is being referenced, then the Practitioner must include a copy of that H&P in the visit by submitting a copy to the medical records department or by moving it electronically to the record regarding the current visit. The documentation must be placed in the patient’s medical record within 24 hours after admission or registration and in all cases prior to surgery or a procedure requiring anesthesia services.

Readmission: If a patient is readmitted within 30 days for the same or a related problem, an interval H&P reflecting any subsequent changes may be used in the medical record, provided the original information is readily available in the medical record. The interval H&P must be completed and documented in the medical record within 24 hours after admission or registration, but in all cases involving surgery or a procedure requiring anesthesia, prior to the surgery or procedure.

If the physical examination from the previous visit is being referenced, then the Practitioner must include a copy of that physical examination and history in the visit by submitting a copy to the medical records department or by moving it electronically to the record regarding the current visit.
ARTICLE III
MEMBERSHIP

3.1 GENERAL QUALIFICATIONS

Appointment to the Staff is a privilege that shall be extended only to professionally competent practitioners who continuously meet the qualifications, responsibilities and requirements set forth in these Bylaws and conform to the standards of patient care imposed by law and herein. Every practitioner who seeks or enjoys Staff appointment must, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the Staff and the Board of Managers the following qualifications:

3.1-1

A currently valid license issued by the State of Texas. Current Drug Enforcement Agency (DEA) and Texas Department of Public Safety (DPS) Certificates, if applicable.

3.1-2

Background, professional education, training, experience, demonstrated competence and ability to work with others that would document a continued ability to provide optimally achievable patient care services.

3.1-3

Have no physical or mental health problems that will adversely affect the care of patients for whom they are responsible.

3.1-4

Adhere to the standards of character and ethics established by their respective professions.

3.1-5

Appointment of the practitioner to the faculty of The University of Texas Health Science Center at San Antonio is highly preferred.
3.1-6

The practitioner holds appointment in a Department in University Health System facilities.

3.1-7

No practitioner is automatically entitled to appointment to the Staff or to the exercise of particular clinical privileges merely because the practitioner is licensed to practice in this or any other state, is a member of any professional organization, certified by any clinical board, has Staff membership or privileges at another health care facility, or holds appointment to the faculty of The University of Texas Health Science Center at San Antonio. Staff members who do not participate in the teaching program are not subject to denial or limitation of privileges for this reason alone. Nor is any practitioner automatically entitled to appointment, reappointment or particular privileges merely because he had, or presently has, Staff membership or those privileges with University Health System.

3.1-8

No aspect of Staff membership or particular clinical privileges shall be granted or denied on the basis of race, religion, color, sex, age, national origin, or any other criterion lacking professional justification.

3.2 BASIC RESPONSIBILITIES OF INDIVIDUAL STAFF APPOINTMENT

Each appointee to the Staff and each practitioner exercising temporary privileges under these Bylaws shall:

(a) Provide care consistent with the generally recognized professional level of quality and efficiency;

(b) Abide by these Staff Bylaws and all other standards, policies and rules and regulations of University Health System;

(c) Respect and support Patients’ Rights in all patient care activities;

(d) Discharge such Staff, committee, and department functions for which he is responsible by Staff category, appointment, and election or otherwise;
(e) Prepare and complete in a timely fashion according to the University Health System and Medical-Dental Staff Rules and Regulations as provided in the University Health System’s Policy No.10.015 and Policy No. 10.03, the medical and other required records for all patients the practitioner admits or in any way provides care to in University Health System facilities;

(f) Strictly abide by generally recognized standards of professional ethics;

(g) Satisfy the continuing education requirements of the Staff;

(h) Satisfy the meeting attendance requirements as established by these Bylaws and Staff Rules and Regulations as provided in University Health System Policy No.10.015;

(i) Maintain an ethical practice, and within the limits of clinical privileges, to provide continuous and appropriate care to all patients;

(j) Report immediately, in writing, to the Office of the Chief Executive Officer and Chief of Staff:

(1) Failure of the practitioner to maintain the required professional liability insurance coverage established by the Board of Managers;
(2) Receipt of notice of any complaint filed against the individual with the applicable licensing body, including but not limited to, the Texas Medical Board, the Texas Physician Assistant Board, the Texas State Board of Dental Examiners and the Texas Board of Nurse Examiners;
(3) Involvement of the practitioner in a professional liability action at the time of occurrence, and
(4) As soon as practicable, final judgments or settlements of professional liability action involving the practitioner, at any hospital, clinic, or health care facility.

(k) Report immediately, in writing, to the Office of the Chief Executive Officer and Chief of Staff:

(1) Results and circumstances of any professional review action or investigation or any peer review action or investigation, including sanctions and corrective actions, that adversely affects, or has adversely affected, the clinical privileges of the practitioner, or
(2) The acceptance of the reduction, restriction, suspension, revocation, denial, non-renewal or voluntary surrender of medical staff membership or clinical privileges, or the acceptance of any restriction of such privileges by the practitioner, at any hospital, clinic or health care facility or membership or fellowship in any professional organization.
(l) Report immediately, in writing, to the Office of the Chief Executive Officer and Chief of Staff the commencement of a formal investigation, the filing of charges, or any final action by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any State, including but not limited to any and all regulatory bodies responsible for the licensure and discipline of the practitioner;

(m) Abide by the University Health System’s core values:

(1) Our patients come first;
(2) We work as a team;
(3) We work for the community;
(4) We do everything with:
   a. Respect;
   b. Dignity;
   c. Sensitivity; and
   d. Trust;
(5) We will be experts at our jobs; and
(6) Education and research are important to excellent patient care.

(n) Abide by the University Health System’s Notice of Privacy Practices.

3.3 CONDITIONS OF APPOINTMENT

3.3-1

Initial appointments and reappointments to the Staff shall be made by the Board of Managers. The Board of Managers shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Executive Committee.

3.3-2

Appointment to the Staff as a faculty staff member shall remain in effect only so long as the practitioner holds appointment to the faculty of The University of Texas Health Science Center at San Antonio.
Appointment to the Staff as a non-faculty staff member shall remain in effect only so long as the practitioner holds appointment to Community Medicine Associates.

3.4 TERM OF APPOINTMENT

3.4-1 Duration of Initial Appointment and Modifications

The term of an initial Staff appointment or a modification to a Staff appointment shall be for a period not to exceed two (2) years.

3.4-2 Reappointment

Reappointment to any category of the Staff shall be for a period of not more than two (2) years.

3.5 OBSERVATION REQUIREMENT

3.5-1 Initial Appointments

All initial appointments shall be subject to a period of focused professional practice evaluation as provided in University Health System’s Policy No. 10.025. Upon successful completion of the focused professional practice evaluation, all initial appointees shall continue under observation for an additional period of one year (“initial observation”). Each initial appointee shall be assigned to a department where the appointee’s performance shall be observed by the Clinical Department Chairman or the Chairman’s designee, to determine eligibility for continued Staff membership and for exercising the clinical privileges initially granted. If the appointee exercises clinical privileges in any other department, the appointee shall also be subject to observation by that Clinical Department’s Chairman or designate. If the initial appointee is the Clinical Department Chairman, the focused professional practice evaluation and subsequent initial observation period will be carried out by the Vice Chairman, or designate, for the department.

Upon completion of twelve (12) months of the observation period, the Chairman of the Clinical Department to which the practitioner was assigned shall furnish the Chief Executive Officer and the Executive Committee through the Credentials Committee, a signed statement indicating that:
(a) The practitioner meets all the qualifications, and discharged all the responsibilities of the Staff category to which the practitioner was appointed; and has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted; or

(b) The practitioner has not had enough cases to be evaluated and recommendation that the Executive Committee extend the term of that observation for not more than six months.

3.5-2 For Continued Staff Membership

As provided in University Health System Policy No. 10.025, ongoing professional practice evaluations will be performed every six months and the Chairman of the Clinical Department or designee to which the practitioner is assigned shall furnish the Chief Executive Officer and the Executive Committee through the Credentials Committee, a signed statement indicating that:

(a) The practitioner meets all the qualifications and discharged all the responsibilities of the Staff category to which the practitioner was appointed; and has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted; or

(b) The practitioner has not had enough cases to be evaluated and a recommendation that the Executive Committee extend the term of that observation for not more than six additional months.

3.5-3 For Modification of Membership Status or Privileges

A change in Staff category of a current Staff member or the granting of additional privileges to a current Staff member may be made subject to observation in accordance with the procedures outlined in Section 3.5-1 for initial appointees. Upon successful completion of the required observation, the Executive Committee may recommend to the Board of Managers that the requested change in Staff category of a current Staff member or the granting of additional privileges to a current Staff member be made.

3.5-4 For Peer Review

In accordance with University Health System Policy No. 10.025, a period of focused evaluation is also required as a result of a peer review for special circumstances such as sentinel events, complaints, significant variances from acceptable practice patterns, or significant variances from comparative peer performance data. In cases where immediate/urgent focused evaluation is needed to assure patient safety, the case may be referred directly to the Clinical Department Chairman and to the CMA Medical Leadership with respect to non-faculty staff.
3.5-5 Term of Observation Period

The Executive Committee may extend the initial period of observation for not more than six (6) months. If the practitioner fails within this period of time to satisfy the requirements of Section 3.5-1(a), the practitioner’s Staff membership or particular clinical privileges will automatically terminate. If a Staff member requesting modification of privileges fails to furnish the required documentation within that period, the change in Staff category or additional privileges, as applicable, shall automatically terminate. In either case the affected practitioner shall be provided the rights set forth in Article X.

3.6 LEAVE OF ABSENCE

3.6-1 Leave Status

A Staff member may obtain a voluntary leave of absence from the Staff by (1) submitting written notice to the Executive Committee through the Chief of Staff, stating the approximate period of time of the leave, which may not exceed two years, or the Staff member’s next reappointment date, whichever occurs first and (2) receiving the approval of the Executive Committee. The Executive Committee shall make a recommendation to the Board of Managers regarding the requested leave of absence. During the period of the leave, the Staff member’s clinical privileges and responsibilities shall be suspended.

3.6-2 Termination of Leave

At least forty-five (45) days prior to the of the leave of absence, the Staff member may request reinstatement of his privileges by submitting a written notice outlining his activities during this absence to the Chief Executive Officer through the Chief of Staff for review by the Executive Committee. The Executive Committee shall make a recommendation to the Board of Managers concerning the re-establishment of the member’s privileges. If the leave of absence was for medical reasons, the Staff Member shall include a physician’s report in his request for reinstatement. If a Staff Member’s appointment expires during a leave of absence, the Staff Member, prior to his return, is responsible for completing an application for reappointment to the Medical Staff and for providing information in conjunction with his activities in the reappointment application. Failure without good cause to return from a leave of absence and resume professional activities shall be considered a voluntary resignation from the Staff and shall result in automatic termination of Staff appointment and privileges and shall constitute a waiver of any procedural rights provided in Article X hereof.
3.7 TELEHEALTH

3.7-1 When University Health System facilities are Originating Site

The University Health System may use the privileging and credentialing decision from the distant site to make a final privileging decision provided all of the following requirements are met:

1. The distant site is a Joint Commission-accredited hospital or ambulatory care organization;

2. The practitioner is privileged at the distant site for those services to be performed at the University Health System facility;

3. The distant site provides the originating site with a current list of the practitioners’ privileges; and

4. The University Health System has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed practitioner from patients, practitioners or staff.

When the distant site is not a Joint Commission-accredited hospital or ambulatory care organization, the University Health System will fully privilege and credential the practitioner through the mechanism as set forth in Article VI.

3.7-2 Scope of Services Provided

In all cases, the Medical Staffs at both the originating and distant sites recommend the clinical services to be provided by practitioners through a telemedical link at their respective sites. All services delivered via this medium will be delivered consistent with commonly accepted quality standards. The use of telehealth for proctoring or procedural supervision must be pre-approved by the Executive Committee.

3.7-3 Notice and Consent

Prior to providing telemedicine medical services, physicians must give their patients notice regarding telemedicine services, including the risks and benefits of being treated
via telemedicine, how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of technological equipment failure. This must be appropriately documented in the patient’s medical record.

Physicians who provide or facilitate the use of telemedicine or telehealth services shall ensure that the informed consent of the patient, or another appropriate individual authorized to make healthcare treatment decisions for the patient, is obtained and documented before such services are provided as required by University Health System Policy No. 9.02.

3.8 WAIVER OF QUALIFICATIONS

Every practitioner who seeks or enjoys Staff membership, except Honorary Staff membership, must satisfy, at the time of appointment and continuously thereafter, the basic qualifications set forth in Section 3.1 as well as any additional qualifications that are attached to the Staff category to which the practitioner seeks appointment or of which the practitioner is a member. The Board of Managers, at the recommendation of the Executive Committee, may waive any qualification when in its discretion such waiver will serve the best interests of patient care or is appropriate to the orderly administration of University Health System.

ARTICLE IV
CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The Staff shall consist of individuals credentialed and privileged in the Active, Provisional, Courtesy, Honorary, Consulting, Affiliate, Associate, and House Staff categories. Allied health professionals may be selected and participate in the Staff organization as provided in Article V.

4.2 ACTIVE STAFF

4.2-1 Membership

Active Staff membership shall be reserved for practitioners who have at least twenty-five (25) patient contacts (an admission, consultation, or out-patient contact) per calendar year.
and have successfully completed the requirements set forth in 4.3 below or for practitioners who make significant contributions to University Health System facilities as determined by the Executive Committee. In all cases, to be appointed by the Board of Managers as Active Staff, a practitioner must:

(a) Meet the basic qualifications set forth in Section 3.1-1 through 3.1-5;

(b) Have Board Certification and/or provide evidence of recertification in their chosen specialty or in the case of general (i.e., non-specialty) dentists, evidence of completion of a non-specialty residency/postgraduate clinical educational program which is fully accredited by the Commission on Dental Accreditation. If a member’s board certification lapses, their status will automatically revert from Active to Provisional. At the date of the member’s next reappointment, the member may be continued in Provisional status for a two year period. If at the end of that two year period recertification has not been obtained, an exception to the requirement to be board certified may be requested by submitting a letter through the Clinical Department Chairman to the Credentials Committee for endorsement by the Executive Committee and approval by the Board of Managers. Members whose status reverts to Provisional as a result of a lapse of certification do not fall under the provisions outlined for initial appointment application in Section 4.3-1. However, if the member fails to become recertified and an exception to the board certification requirement is not granted as provided herein, Staff membership shall automatically terminate and the practitioner will not be entitled to the rights set forth in Article X;

(c) Have completed one year of satisfactory performance on the Provisional Staff;

(d) Demonstrate the ability to meet the basic responsibilities as outlined in Section 3.2;

and

(e) Demonstrate eligibility to participate in Medicare, Medicaid and other federally sponsored health programs.

4.1-2 Prerogatives

The prerogatives of an Active Staff member shall be to:

(a) Admit patients without limitation and within the scope of their delineated privileges, unless otherwise provided in the Staff Rules and Regulations;

(b) Exercise such clinical privileges as are granted to the practitioner pursuant to Article VII;
(c) Vote on all matters presented at general and special meetings of the Staff and of the department, or clinical unit and committees of which the practitioner is a member, unless otherwise provided; and

(d) Hold office in the Staff Organization unless otherwise provided.

4.2-3 Responsibilities

Each member of the Active Staff shall:

(a) Continue to meet the basic responsibilities set forth in Section 3.2;

(b) Retain responsibility within practitioner's area of professional competence for the continuous care and supervision of each patient for whom the practitioner is providing services, or arrange a suitable alternative for such care and supervision;

(c) Contribute to the organization and administrative affairs of the Staff, including service in Staff, department, or other clinical unit offices and on University Health System or Staff committees, faithfully performing the duties of any office or position to which elected or appointed;

(d) Participate actively in the patient care audit, utilization review and other quality review and monitoring activities required of the Staff;

(e) Discharge the recognized functions of Staff membership by engaging in continuing education programs, attending service patients as required, giving consultation to other Staff members consistent with the practitioner's delineated privileges, supervising practitioners during the provisional period, and fulfilling such other Staff functions as may reasonably be required; and

(f) Satisfy the requirements set forth in Article XII for attendance at meetings of the Staff and of the department and committee of which the practitioner is a member. Staff members, because of age, health, and/or long standing service to University Health System, may be excused from specific responsibilities of Active Staff membership by action and discretion of the Executive Committee.

4.2-4

Practitioners applying for Active Staff must, in addition to the general requirements of membership, submit the following:

(a) A Delineation of Clinical Privileges form;
(b) Appropriate current Texas Medical, Dental, or Podiatry license;

(c) Six originally signed pharmacy cards;

(d) Evidence of completion of an accredited residency program;

(e) Evidence of Board Certification, as appropriate, or, in the case of general (i.e. non-specialty) dentists, evidence of completion of a non-specialty residency/postgraduate clinical educational program which is fully accredited by the Commission on Dental Accreditation, as appropriate;

(f) For a faculty staff appointment, a letter of recommendation from the Department Chairman with a statement concerning clinical competence and health status; for a non-faculty staff appointment, a letter of recommendation from the appropriate CMA medical leadership with a statement concerning clinical competence and health status;

(g) Three reference letters from peers are obtained from practitioners in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice;

(h) A copy of his Federal Drug Enforcement Agency certificate and Texas Controlled Substance Registration Form, if appropriate;

(i) Evidence of appropriate malpractice insurance;

(j) Evidence of any malpractice claim pending or settled;

(k) Acknowledgment of medical staff membership or clinical privileges having ever been voluntarily or involuntarily reduced, revoked or suspended by other hospitals or institutions;

(l) Acknowledgment of previous or current challenges to any licensure or registration, termination or suspension of license, or Drug Enforcement Administration registration, or the voluntary or involuntary relinquishment of such licensure or registration; and

(m) Action by government or third-party payors challenging practice patterns including, but not limited to, Medicare/Medicaid fraud and/or abuse claims.
4.3 PROVISIONAL STAFF

4.3-1 Membership

Satisfactory completion of an initial term of Provisional Staff membership is a prerequisite for Active Staff membership. Practitioners who have received Board Certification in the specialty in which practitioner seeks clinical privileges, or, in the case of general (i.e., non-specialty) dentists, evidence of completion of a non-specialty residency/postgraduate clinical education program which is fully accredited by the Commission on Dental Accreditation shall be appointed to the Provisional Staff during the term of the initial appointment and observation.

Practitioners who are pending Board Certification in the specialty in which the practitioner seeks clinical privileges at the time of their initial application shall be appointed to the Provisional Staff during the term of the initial appointment and observation and shall remain a member of the Provisional Staff until becoming Board Certified or upon the expiration of four (4) years from the date of the initial application, whichever event occurs first. To be appointed by the Board of Managers as Provisional Staff, a practitioner must:

(a) Meet the basic qualifications set forth in Section 3.1-1 through 3.1-5;

(b) Have demonstrated the ability to meet the basic responsibilities as outlined in Section 3.2; and

(c) Demonstrate eligibility to participate in Medicare, Medicaid and other federally sponsored health programs.

4.3-2 Prerogatives

Prerogatives of a Provisional Staff member shall be to:

(a) Admit patients without limitation within the scope of their delineated privileges, unless otherwise provided in the Staff Rules and Regulations;

(b) Exercise such clinical privileges as are granted to the practitioner pursuant to Article VII;

(c) Vote on all matters presented at general and special meetings of the Staff and of the department, clinical unit, or committee of which the practitioner is a member, unless otherwise provided; and
(d) Provisional Staff shall not be eligible to hold office in the Staff Organization unless otherwise provided.

4.3-3 Responsibilities

Each member of the Provisional Staff shall:

(a) Continue to meet the basic responsibilities set forth in Section 3.2;

(b) Retain responsibility within the practitioner's area of professional competence for the continuous care and supervision of each patient for whom the practitioner is providing services, or arrange a suitable alternative for such care and supervision;

(c) Contribute to the organization and administrative affairs of the Staff, including service in Staff, department, or other clinical unit offices and on University Health System or Staff committees, faithfully performing the duties of any office or position to which elected or appointed;

(d) Participate actively in the patient care audit, utilization review and other quality review and monitoring activities required of the Staff;

(e) Discharge the recognized functions of Staff membership by engaging in continuing education programs, attending service patients as required, giving consultation to other Staff members consistent with the practitioner's delineated privileges, and fulfilling such other Staff functions as may reasonably be required;

(f) Satisfy the requirements set forth in Article XII for attendance at meetings of the Staff and of the department and committee of which the practitioner is a member, and

(g) Fulfill the above responsibilities. Failure to fulfill these obligations is ground for denial of advancement to Active Staff status.

4.3-4 Practitioners applying for Provisional Staff must, in addition to the general requirements of membership, submit the following:

(a) A Delineation of Clinical Privileges form;

(b) Appropriate current Texas Medical, Dental, or Podiatry license;

(c) Six originally signed pharmacy cards;
(d) Evidence of completion of an accredited residency program;

(e) Evidence of Board Certification, as appropriate, or, in the case of general (i.e., non-specialty) dentists, evidence of completion of a non-specialty residency/postgraduate clinical educational program which is fully accredited by the Commission on Dental Accreditation, as appropriate;

(f) For a faculty staff appointment, a letter of recommendation from the Department Chairman with a statement concerning clinical competence and health status; for a non-faculty staff appointment, a letter of recommendation from the appropriate CMA medical leadership with a statement concerning clinical competence and health status;

(g) Three reference letters from peers are obtained from practitioners in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice;

(h) A copy of his Federal Drug Enforcement Agency certificate and Texas Controlled Substance Registration Form, if appropriate;

(i) Evidence of appropriate malpractice insurance;

(j) Evidence of any malpractice claim pending or settled;

(k) Acknowledgment of medical staff membership or clinical privileges having ever been voluntarily or involuntarily reduced, revoked or suspended by other hospitals or institutions;

(l) Acknowledgment of previous or current challenges to any licensure or registration, termination or suspension of license, or Drug Enforcement Administration registration, or the voluntary or involuntary relinquishment of such licensure or registration; and

(m) Action by government or third-party payors challenging practice patterns including, but not limited to, Medicare/Medicaid fraud and/or abuse claims.

4.4 COURTESY STAFF

4.4-1 Membership

The Courtesy Staff membership shall be reserved for practitioners who have fewer than twenty-five (25) patient contacts (an admission, consultation, or out-patient contact) per
calendar year or as specified by the Executive Committee. To be appointed by the Board of Managers as Courtesy Staff, a practitioner must:

(a) Meet the basic qualifications set forth in Section 3.1-1 through 3.1-5;

(b) Have Board Certification and/or provide evidence of recertification in their chosen specialty or in the case of general (i.e., non-specialty) dentists, evidence of completion of a non-specialty residency/postgraduate clinical educational program which is fully accredited by the Commission on Dental Accreditation. If a member’s board certification lapses, their status will automatically revert to Provisional. At the date of the member’s next reappointment, the member may be continued in Provisional status for another two year period. If at the end of that two year period recertification has not been obtained, an exception to the requirement to be board certified may be requested by submitting a letter through the Clinical Department Chair to the Credentials Committee for endorsement by the Executive Committee and approval by the Board of Managers. Members whose status reverts to Provisional as a result of a lapse of certification do not fall under the provisions outlined for initial appointment application in Section 4.3-1. However, if the member fails to become recertified and an exception to the board certification requirement is not granted as provided herein, Staff membership shall automatically terminate and the practitioner will not be entitled to the rights set forth in Article X;

(c) Demonstrate the ability to meet the basic responsibilities as outlined in Section 3.2; and

(d) Demonstrate eligibility to participate in Medicare, Medicaid and other federally sponsored health programs.

4.4-2 Prerogatives

The prerogatives of the Courtesy Staff members shall be to:

(a) Admit patients without limitation within the scope of their delineated privileges, unless otherwise provided in the Staff Rules and Regulations or by the Executive Committee;

(b) Exercise such clinical privileges as are granted to the practitioner pursuant to Article VII;

(c) Attend meetings of the Staff and department of which the practitioner is a member and any Staff or University Health System education programs; and

(d) Courtesy Staff members shall not be eligible to vote or hold office in the Staff Organization.
4.4-3 Responsibilities

Each member of the Courtesy Staff shall:

(a) Continue to meet the basic responsibilities set forth in Section 3.2;

(b) Retain responsibility within the practitioner's area of professional competence for the continuous care and supervision of each patient for whom the practitioner is providing services, or arrange a suitable alternative for such care and supervision; and

(c) Discharge the recognized functions of Staff membership by engaging in continuing education programs, attending service patients as required, giving consultation to other Staff members consistent with the practitioner's delineated privileges, and fulfilling such other Staff functions as may reasonably be required.

4.4-4

Practitioners applying for Courtesy Staff must, in addition to the general requirements of membership, submit the following:

(a) A Delineation of Clinical Privileges form;

(b) Appropriate current Texas Medical, Dental, or Podiatry license;

(c) Six originally signed pharmacy cards;

(d) Evidence of completion of an accredited residency program;

(e) Evidence of Board Certification, or, in the case of general (i.e., non-specialty) dentists, evidence of completion of a non-specialty residency/postgraduate clinical educational program which is fully accredited by the Commission on Dental Accreditation;

(f) For a faculty staff appointment, a letter of recommendation from the Department Chairman and Chief of Staff with statements concerning clinical competence and health status; for a non-faculty staff appointment, a letter of recommendation from the appropriate CMA medical leadership with a statement concerning clinical competence and health status;

(g) Three reference letters from peers are obtained from practitioners in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice;
(h) A copy of his Federal Drug Enforcement Agency certificate and Texas Controlled Substance Registration Form, if appropriate;

(i) Evidence of appropriate malpractice insurance;

(j) Evidence of any malpractice claim pending or settled;

(k) Acknowledgment of medical staff membership or clinical privileges having ever been voluntarily or involuntarily reduced, revoked or suspended by other hospitals or institutions;

(l) Acknowledgment of previous or current challenges to any licensure or registration, termination, or suspension of license, or Drug Enforcement Administration registration, or the voluntary or involuntary relinquishment of such licensure or registration; and

(m) Action by government or third-party payors challenging practice patterns including, but not limited to, Medicare/Medicaid fraud and/or abuse claims.

4.5 HONORARY STAFF

4.5-1 Membership

The Honorary Staff shall consist of physicians, dentists, and podiatrists, each of whom is recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service as Active members of the Staff. Nominations are put forward by either the Department Chairman or CMA Medical Leadership and approved by the Executive Committee and Board of Managers. There is no initial appointment requirement for Honorary Staff Members.

4.5-2 Prerogatives

The prerogatives of the Honorary Staff shall be to:

(a) Attend Staff and department, or other clinical unit meetings and any Staff or University Health System education meetings without vote;

(b) Attend all committee meetings that the practitioner may wish to attend as a non-voting visitor by invitation of the Committee Chair and approval of the Chief of Staff;
(c) Honorary Staff members are not eligible to admit patients to University Hospital, provide any direct patient care or exercise clinical privileges in University Hospital; and

(d) Honorary Staff members shall not be eligible to vote, serve on committee or hold office in the Staff Organization.

4.5-3 Responsibilities

Each member of the Honorary Staff shall be limited solely to attendance at Staff and University Health System functions.

4.6 AFFILIATE STAFF

4.6-1 Membership

The Affiliate Staff shall consist of limited healthcare practitioners. To be appointed by the Board of Managers as an affiliate staff member, the limited healthcare practitioner must:

(a) Meet the basic qualifications set forth in Section 3.1-1 through 3.1-5; and

(b) Have demonstrated the ability to meet the basic responsibilities as outlined in Section 3.2.

4.6-2 Prerogatives

The prerogatives of the Affiliate Staff members shall be to:

(a) Consult on patients by special invitation of an Active or Provisional Staff member in relation to patients on whom their specific skills may be useful;

(b) Exercise such clinical privileges as are granted to the limited healthcare practitioner pursuant to Article VII; and

(c) Affiliate Staff members shall not be eligible to vote or hold office in the Staff Organization.

4.6-3 Responsibilities

Each member of the Affiliate Staff shall:
(a) Meet those responsibilities required by the Staff Rules and Regulations, and if not so specified, meet those responsibilities specified in Section 3.2 as are generally applicable to more limited practice of the AHP;

(b) Retain appropriate responsibility within the limited healthcare practitioner's area of professional competence for the care of each patient for whom the limited healthcare practitioner is providing services; and

(c) Be involved in patient care audit and other quality review, evaluation, and monitoring activities appropriate to Affiliate Staff.

4.6-4

Practitioners applying for Affiliate Staff must, in addition to the general requirements of membership, submit the following:

(a) A Delineation of Clinical Privileges form;

(b) Appropriate current professional license, if applicable;

(c) For a faculty staff appointment, a letter of recommendation from the Department Chairman with a statement concerning clinical competence and health status; for a non-faculty staff appointment, a letter of recommendation from the appropriate CMA medical leadership with a statement concerning clinical competence and health status;

(d) Three reference letters from peers are obtained from practitioners in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice and/or other hospitals;

(e) Evidence of appropriate malpractice insurance;

(f) Evidence of any malpractice claim pending or settled;

(g) Acknowledgment of medical staff membership or clinical privileges having ever been voluntarily or involuntarily reduced, revoked or suspended by other hospitals or institutions;

(h) Acknowledgment of previous or current challenges to any licensure or registration, termination or suspension of license, or Drug Enforcement Administration registration, or the voluntary or involuntary relinquishment of such licensure or registration; and
(i) Action by government or third-party payors challenging practice patterns including, but not limited to, Medicare/Medicaid fraud and/or abuse claims.

### 4.7 ASSOCIATE STAFF

#### 4.7-1 Membership

The Associate Staff shall consist of physicians, dentists, and podiatrists, or doctoral level researchers, each of whom is active in the teaching or research activities of The University of Texas Health Science Center at San Antonio; however, does not admit, attend, or provide care to patients. To be appointed by the Board of Managers as Associate Staff, a practitioner must:

(a) Meet the basic qualifications set forth in Section 3.1-1 through 3.1-4;

(b) Hold appointment to the faculty of The University of Texas Health Science Center;

(c) Hold appointment in a Department in University Health System facilities; and

(d) Be active in the teaching or research activities of The University of Texas Health Science Center at San Antonio, however, does not admit or attend patients.

#### 4.7-2 Prerogatives

The prerogatives of an Associate Staff member shall be to:

(a) Conduct teaching and research activities at University Health System facilities in accordance with University Health System Policy, however, shall not take part in patient care or admit or consult on patients;

(b) Use University Health System facilities, as made available by University Health System, for teaching and research; and

(c) Shall not be eligible to vote or hold office in the Staff Organization.

#### 4.7-3 Responsibilities

Each member of the Associate Staff shall:

(a) Be limited solely to the practitioner's teaching or research and be under the auspices and sponsorship of a specific University Hospital Department;
(b) Continue to meet the basic responsibilities set forth in Section 3.2;

(c) Retain responsibility within the practitioner's area of professional competence; and

(d) Discharge the recognized functions of Staff membership by engaging in continuing education programs, and fulfilling such other Staff functions as may reasonably be required.

4.7-4

Practitioners applying for Associate Staff must, in addition to the general requirements of membership, submit the following as applicable:

(a) Appropriate current Texas license;

(b) Evidence of completion of an accredited training program;

(c) Evidence of Board Certification, as appropriate, or, in the case of general (i.e., non-specialty) dentists, evidence of completion of a non-specialty residency/postgraduate clinical educational program which is fully accredited by the Commission on Dental Accreditation;

(d) For a faculty staff appointment, a letter of recommendation from the Department Chairman with a statement concerning clinical competence and health status;

(e) Three (3) reference letters from peers are obtained from practitioners in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice;

(f) Evidence of appropriate malpractice insurance;

(g) Acknowledgment of medical staff membership or clinical privileges having ever been voluntarily or involuntarily reduced, revoked or suspended by other hospitals or institutions;

(h) Acknowledgment of previous or current challenges to any licensure or registration, termination or suspension of license, or Drug Enforcement Administration registration, or the voluntary or involuntary relinquishment of such licensure or registration; and

(i) Action by government or third-party payors challenging practice patterns including, but not limited to, Medicare/Medicaid fraud and/or abuse claims.
4.8 HOUSE STAFF

4.8-1 Membership

The House Staff shall consist of physicians, dentists or podiatrists participating in an accredited graduate-training program in which the University Health System serves as a participating institution with The University of Texas Health Science Center at San Antonio. House Staff members are designated by a residency program level. A House Staff member takes on greater responsibility for patient care throughout the course of a residency, consistent with individual growth in clinical experience, knowledge and skill.

A person must be accepted by the graduate training program of The University of Texas Health Science Center at San Antonio, or an affiliated program, prior to a person's designation as a member of the House Staff. A House Staff member may be designated a resident or fellow. To be appointed to the House Staff, the practitioner must:

(a) Meet the basic qualifications set forth in Section 3.1-1 through 3.1-4;

(b) Be under the supervision of an active or provisional faculty staff member of the Department in which the House Staff member is appointed;

(c) Be appropriately licensed to practice medicine, dentistry, or podiatry in the State of Texas; or be covered by a Physician-in-Training Permit as provided for by the Texas Medical Board (Chapter 171, Texas Medical Board Rules), a Dental Training Permit as provided by the Texas State Board of Dental Examiners, or a Temporary Permit as provided for by the Texas State Board of Podiatric Examiners;

(d) Maintain Basic Cardiac Life Support (BCLS) or higher certification if providing direct patient care; and

(e) Demonstrate the ability to meet the basic responsibilities as outlined in Section 3.2.

4.8-2 Prerogatives

The prerogatives of a House Staff member shall be to:

(a) Have privileges to treat patients under the supervision of the Active or Provisional Faculty Staff;
(b) Serve on standing or special committees of the Staff; and

(c) Members of the House Staff shall be appointed to a specific Department but shall not be eligible to vote or hold office in the Staff Organization.

4.8-3 Responsibilities

Each member of the House Staff shall:

(a) Continue to meet the basic responsibilities set forth in Section 3.2;

(b) Contribute to the organization and administrative affairs of the Staff, including service in Staff, department, or other clinical unit offices and on University Health System or Staff committees, faithfully performing the duties of any office or position to which elected or appointed; and

(c) Participate actively in the patient care audit, utilization review and other quality review and monitoring activities required of the Staff.

4.8-4

Practitioners applying for House Staff must, in addition to the general requirements of membership, submit the following:

(a) Appropriate current Texas Medical, Dental, or Podiatry license or permit, if applicable;

(b) Six (6) originally signed pharmacy cards;

(c) Evidence of completion of an approved medical school, or, in the case of general (i.e., non-specialty) dentists, evidence of completion of a non-specialty residency/postgraduate clinical educational program which is fully accredited by the Commission on Dental Accreditation;

(d) A letter of recommendation from the Department Chairman with statement concerning clinical competence and health status;

(e) A copy of his Federal Drug Enforcement Agency certificate and Texas Controlled Substance Registration Form, if applicable;

(f) Evidence of any malpractice claim pending or settled;
(g) Evidence of appropriate malpractice insurance;

(h) Acknowledgment of medical staff membership or clinical privileges having ever been voluntarily or involuntarily reduced, revoked or suspended by other hospitals or institutions;

(i) Acknowledgment of previous or current challenges to any licensure, permit or registration, termination or suspension of license or permit, or Drug Enforcement Administration registration, or the voluntary or involuntary relinquishment of such licensure or registration; and

(j) Action by any government or third-party payors challenging practice patterns including, but not limited to, Medicare/Medicaid fraud and/or abuse claims.

4.8-5 Supervision of House Staff

The supervision of House Staff shall be conducted according to the Resident Supervision Policy for Graduate Medical Education at The University of Texas Health Science Center.

4.9 LIMITATION OF PREROGATIVES

The prerogatives set forth under Staff Categories and for Allied Health Professionals are general in nature and may be subject to limitation by special conditions attached to a practitioner’s appointment or to any privilege granted to Allied Health Practitioners by other sections of these Bylaws and by other policies of the University Health System. The prerogatives of Dentist members of the Staff, Podiatrist members of the Staff, Optometrist members of the Staff and Allied Health Professionals are limited to those for which they have demonstrated the requisite level of education, training experience and ability.

ARTICLE V
ALLIED HEALTH PROFESSIONALS

5.1 GENERAL

Allied Health Professionals (AHPs) consist of those duly licensed individuals who have been licensed or certified by their respective licensing or certifying agency or entity to render direct patient care under the supervision of the appropriate member of the Staff. They are not members of the Staff and are not entitled to the rights, privileges and
responsibilities of appointment to the Staff unless otherwise indicated in these Bylaws. They may only engage in acts within the scope of practice specifically approved for them by the Board of Managers.

5.2 CATEGORIES

5.2-1 Advanced Practice Nurse

Advanced practice nurses, including, but not limited to Nurse Practitioners, Certified Registered Nurse Anesthetists, Nurse Midwives and Clinical Nurse Specialists, function within a Clinical Department as their specialty training indicates and provide patient care for University Health System patients. Advanced practice nurses function under Active, Provisional, or Courtesy Staff supervision using established protocols of practice approved by the Clinical Department, Credentials Committee, Executive Committee, and Chief Executive Officer.

5.2-2 Physician Assistant

Physician assistants function within a Clinical Department as their specialty training indicates and provide patient care for University Health System patients. Physician Assistants function under Active, Provisional, or Courtesy Staff supervision using established protocols of practice approved by the Clinical Department, Credentials Committee, Executive Committee, and Chief Executive Officer.

5.2-3 Clinical Associate

Clinical Associates function within a Clinical Department as their specialty training indicates and provide patient care for University Health System patients. Clinical associates function under Active, Provisional, or Courtesy Staff supervision using established protocols of practice approved by the Clinical Department, Credentials Committee, Executive Committee, and Chief Executive Officer.

5.2-4 Research Associate

Research associates function within a Clinical Department as their specialty training indicates and provide patient care research activities for University Health System patients. The research associate functions under Active, Provisional or Courtesy Staff supervision using established research protocols approved by the Research Committee.
5.3 DESCRIPTION

5.3-1 Qualifications

Allied Health Professionals are eligible for practice privileges in University Health System only if they:

(a) Hold a license, certificate or other legal credential as required by Texas State Law in a category of AHP which the Board of Managers has identified as eligible to apply for practice privileges;

(b) Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by University Health System, and that they are qualified to exercise practice privileges within University Health System facilities;

(c) Have no physical or mental health problems that will adversely affect the care of patients for whom they are responsible;

(d) Are determined, on the basis of three documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others; and to be willing to commit to and regularly assist University Health System in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials;

(e) Hold appointment on the faculty of The University of Texas Health Science Center at San Antonio, employment on the staff of University Health System or are otherwise credentialed and privileged through Community Medicine Associates;

(f) Have proven their ability to meet those responsibilities specified in Section 3.2 as are generally applicable to the more limited practice of an AHP; and

(g) Maintain Basic Cardiac Life Support (BCLS) or higher certification if providing direct patient care.

5.3-2

Practitioners applying for AHP Staff who are not practitioners as defined in these Bylaws must, in addition to the general requirements of membership, submit the following:

(a) A job description;
(b) Appropriate current professional license, if applicable;

(c) If holding an appointment on the faculty of The University of Texas Health Science Center at San Antonio, a letter of recommendation from the Department Chairman with a statement concerning clinical competence and health status; if employed on the staff of University Health System or are otherwise credentialed and privileged through Community Medicine Associates, a letter of recommendation from the appropriate CMA medical leadership with a statement concerning clinical competence and health status;

(d) Three (3) reference letters from members of the applicant’s specialty who are familiar with the applicant and have observed his professional performance and ethical character and/or other hospitals;

(e) Evidence of appropriate malpractice;

(f) Evidence of any malpractice claim pending or settled;

(g) Acknowledgment of medical staff membership or clinical privileges having ever been voluntarily or involuntarily reduced, revoked or suspended by other hospitals or institutions;

(h) Acknowledgment of previous or current challenges to any licensure or registration, termination or suspension of license, or Drug Enforcement Administration registration, or the voluntary or involuntary relinquishment of such licensure or registration; and

(i) Action by government or third-party payers challenging practice patterns, including but not limited to, Medicare/Medicaid fraud and/or abuse claims.

5.3-3 Prerogatives

The prerogatives which may be extended to an AHP may include:

(a) Provision of specified patient care services under the supervision or direction of an Active, Provisional, or Courtesy Staff consistent with the practice privileges granted to the AHP and within the scope of the AHP’s license or certification; and

(b) As permitted by the department’s rules and regulations, attendance at meetings of the department to which he is assigned.
5.3-4 Responsibilities

Each AHP shall:

(a) Meet those responsibilities required by the Staff Rules and Regulations, and if not so specified, meet those responsibilities specified in Section 3.2 as are generally applicable to the more limited practice of an AHP;

(b) Retain appropriate responsibility within his area of professional competence for the care of each patient for whom he is providing services; and

(c) Be involved in patient care audit and other quality review, evaluation, and monitoring activities appropriate to AHP's.

5.4 PROCEDURES FOR GRANTING PRACTICE PRIVILEGES

An AHP must apply and qualify for practice privileges. Applications for initial granting of practice privileges and subsequent renewal thereof, shall be submitted and processed in a parallel manner to that provided in Articles VI and VII for practitioners unless otherwise specified in the Staff Rules and Regulations.

Each AHP shall be assigned to the clinical department appropriate to his occupational or professional training and, unless otherwise specified in the Rules and Regulations, shall be subject to terms and conditions paralleling those specified in Article III, as they may logically be applied to AHP's and appropriately tailored to the particular AHP's profession.

The granting of practice privileges to AHP's are at the discretion of the Executive Committee and Board of Managers and may be terminated upon the recommendation of the Executive Committee and approval by the Board of Managers.

5.5 CREDENTIALS

Maintaining credentialing files for all AHP's will be the responsibility of the Staff Office of University Health System.
ARTICLE VI
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL PROCEDURE

For those practitioners seeking appointment or reappointment as a faculty staff member, the Department Chairman through its designated departments, committees, and officers shall consider each application for appointment or reappointment to the Staff, and for clinical privileges, and each request for modification of Staff membership status or clinical privileges, utilizing the resources of the Chief Executive Officer and his Staff to investigate and validate the contents of each application, before adopting and transmitting its recommendation to the Board of Managers.

For all other practitioners seeking appointment or reappointment, the appropriate Medical Leadership of Community Medicine Associates shall consider each application for appointment or reappointment to the Staff, and for clinical privileges and each request for modification of Staff membership status or clinical privileges, utilizing the resources of the Chief Executive Officer and his Staff to investigate and validate the contents of each application before adopting and transmitting its recommendation to the Credentials Committee.

The Board of Managers shall take final action on all appointments. All appointees shall be subject to an ongoing professional practice evaluation to determine professional competence. Appointees requesting additional clinical privileges shall be subject to a period of focused professional practice evaluation to determine competence.

6.2 APPLICATION FOR APPOINTMENT

6.2-1 Content

All applications for appointment to the Staff shall be in writing, signed by the applicant and submitted on a form prescribed by the Executive Committee and approved by the Board of Managers. The application shall require the applicant to provide, at a minimum, the following information:

(a) Identifying information, including name, social security number, date of birth, citizenship status, any aliases, office and residence offices as well as a government issued photo identification;
(b) Detailed information concerning the applicant's education, training, professional qualifications and competency;

(c) Evidence of current licensure in the State of Texas and information regarding any current or past licensure in any healthcare profession in any other state;

(d) The names of at least three (3) persons from members of the applicant's specialty who are familiar with the applicant, have personal knowledge of the applicant's ability to practice and who have had extensive experience in observing and working with the applicant so that they can provide adequate references pertaining to the applicant's professional qualifications, competency, and ethical character;

(e) Information regarding specialty board certification including the name of the specialty board(s) and certification dates;

(f) Information as to whether any action or investigation has ever been undertaken, which involves (whether voluntarily or involuntarily) challenge, denial, revocation, suspension, reduction, limitation, probation, non-renewal, or relinquishment by resignation, withdrawal, or expiration of the applicant's: (1) membership status at any other hospital or healthcare entity; (2) clinical privileges or prerogatives at any other hospital or healthcare entity; (3) membership or fellowship in any local, state, or national professional organizations; (4) license to practice any profession in any jurisdiction; (5) drug enforcement administration or other controlled substance registration; or (6) Specialty Board certification, and/or professional school faculty position or membership;

(g) Information including a certificate of insurance pertaining to the applicant's professional liability insurance coverage in amounts as required by the Board of Managers and any professional liability claims, complaints, or causes of action that have been lodged against him in the last five years and the status or outcome of such matters;

(h) Information as to any administrative agency or court cases or judgments in which the applicant is alleged either to have violated any criminal law (other than a minor traffic violation) or to be liable for any injury caused by the applicant's negligent or willful act or omission in rendering services;

(i) Information on any government agency or third party payer proceeding or litigation reviewing or challenging patient admission patterns, treatment, discharge, charging and collection practices or utilization practices, including but not limited to, Medicare/Medicaid fraud and/or abuse claims;
(j) Information pertaining to the health status of the applicant to determine his ability to perform essential functions of Staff membership and exercise the clinical privileges the applicant is requesting;

(k) Acknowledgment of the applicant's agreement to terms and conditions set forth in Section 6.2-2 regarding the effect of this application;

(l) An acknowledgment that the applicant has received and read the Staff Bylaws, Rules and Regulations and that applicant specifically agrees to be bound by the terms thereof if he is granted membership and/or clinical privileges. Additionally, a statement is to be included that he is bound by the terms thereof, without regard to whether or not he is granted membership, in all matters relating to consideration of his application;

(m) An indication of the Staff category, clinical department, and checklist of clinical privileges for which the applicant wishes to be considered; and

(n) Each application for faculty staff membership must be endorsed by the Chairman of the Clinical Department recommending the appointment, by the Dean of the School of Medicine, or his designee, by the Dean of the School of Dentistry, or his designee, for dental practitioners, and by the President of the University of Texas Health Science Center at San Antonio, or his designee. All other applications for membership must be endorsed by the CMA Medical Leadership recommending the appointment.

6.2-2 Effect of Application

By applying for appointment to the Staff, each applicant thereby signifies his willingness to appear for interviews in regard to his application; consents to and authorizes the University Health System Staff, Community Medicine Associates Staff and/or their agents and designees to consult with members of Staffs and/or administrations of other hospitals/healthcare entities with which the applicant has been associated and/or with others who may have information bearing on his competence, character and ethical qualifications, and further authorizes such persons to provide all such information; consents to University Health System's and/or Community Medicine Associates' inspection of all records and documents that may be material to any evaluation of his professional qualifications, competency, personality, ability to cooperate with others, moral and ethical qualifications for membership, and physical, mental and professional competence to carry out the clinical privileges he requests, and directs individuals who have custody of such records and documents to permit inspection and/or copying of said records and documents; agrees to submit to a medical, cognitive and/or psychiatric examination if requested by the Executive Committee; agrees that if he receives an adverse final decision regarding membership or privileges, he will not seek legal action until exhausting the administrative remedies set forth in these Bylaws and he will not file
another application for such membership or privileges for at least two (2) years after the final decision; certifies that he will promptly report any changes in the information submitted on the application form, which may subsequently occur, to the Credentials Committee and the Chief Executive Officer; and releases from any liability, to the fullest extent permitted by law, any and all individuals and organizations providing information to the University Health System and/or Community Medicine Associates concerning the applicant, including otherwise privileged or confidential information, as well as any and all University Health System and/or Community Medicine Associates representatives for their acts performed in connection with evaluating the applicant and his credentials. The applicant further consents to the disclosure to other hospitals, medical associations, licensing boards, local or national data banks and/or other entities to which disclosure is mandated by law, information regarding his professional or ethical standing in University Health System and on Staff.

Action on an individual’s application for clinical privileges will be withheld until such information is made available and is verified.

6.3 PROCESSING THE APPLICATION

6.3-1 Applicant’s Burden

The applicant shall have the burden of producing accurate and adequate information for a proper evaluation of his qualifications for membership and/or clinical privileges. Neither the Staff nor the Board of Managers shall have any obligation to review or consider any application for Staff appointment until it is complete as defined herein and of his compliance with standards and criteria set forth in the Staff Bylaws and Rules and Regulations and for resolving any doubts about these matters. Once all required information, including references and verifications of the applicant’s data has been received by the Staff Office of University Health System the application shall be deemed to be “complete.”

The completed application for faculty staff membership, including all supporting data, shall be submitted by the Staff Office to the Chairman of the Department or designee in which the applicant seeks appointment. Failure to provide a complete application, as defined in the Staff Bylaws and Rules and Regulations, after being provided with an application for appointment, reappointment or clinical privileges or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the application process. In no event shall an application remain incomplete for more than 180 days from the date of submission. Voluntary withdrawal from the application process shall not entitle the applicant to the procedural rights as provided in Article X. The provision of information containing significant misrepresentations or admissions, that is false or
misleading and/or the applicant’s failure to sustain the burden of producing adequate information, shall be grounds for denial of the application or immediate dismissal from the Staff.

The completed application for all other practitioners, including all supporting data, shall be submitted by the Credentialing Specialist for Community Medicine Associates to the appropriate CMA Medical Leadership. Failure to provide a complete application, as defined in the Staff Bylaws and Rules and Regulations, after being provided with an application for appointment, reappointment or clinical privileges or failure to appear for any requested interview, shall be deemed a voluntary withdrawal from the application process. In no event shall an application remain incomplete for more than 180 days from the date of submission. Voluntary withdrawal from the application process shall not entitle the applicant to the procedural rights as provided in either these Bylaws or the policies of Community Medicine Associates. The provision of information containing significant misrepresentations or admissions, that is false or misleading and/or the applicant’s failure to sustain the burden of producing adequate information, shall be grounds for denial of the application or immediate dismissal from the Staff.

6.3-2 Verification of Information

(a) The Chairman of the Department in which the applicant seeks appointment as a faculty staff member is charged with the responsibility of investigating the credentials, health status (physical and mental fitness), current competence, character, qualifications, and standing of the applicant whom he proposes. For all other practitioners, the appropriate Medical Leadership in Community Medicine Associates is charged with this responsibility. The Department Chairman, in the case of faculty staff applications, and the CMA Medical Leadership in the case of all other applications, shall include a memorandum with the original, completed application in which he shall recommend the type of appointment and the delineation of clinical privileges of the applicant prepared in accordance with Section 6.3-7. The application shall then be endorsed by the Dean and the President of The University of Texas Health Science Center at San Antonio, or their designees for those practitioners seeking faculty staff appointments. They shall recommend the application be accepted, rejected, or deferred, and then submit the completed application with all supporting data to the Chief Executive Officer through the Staff Office. Applications for all other practitioners shall be endorsed by the appropriate CMA Medical Leadership. They shall recommend that the applicant be accepted, rejected or deferred and submit the completed application with all supporting data to the Chief Executive Officer through the Staff Office.

(b) Upon receipt of a completed application, the Chief Executive Officer through the Staff Office, shall, in a timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted. The Chief Executive Officer, through the Staff
Office, shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. Any applicant whose application with supporting materials is not completed within 180 days from the date of submission to the Staff Office shall be automatically removed from consideration for Staff membership. Such an applicant's application may, thereafter, be reconsidered only if all information therein, which may change over time, including, but not limited to, University Health System reports and personal references, has been resubmitted.

(c) After determining that all required information has been presented, and appropriately verified, the Chief Executive Officer, through the Staff Office, shall transmit the application and all supporting materials to the Credentials Committee.

6.3-3 Credentials Committee Action

The Credentials Committee shall review the completed application, the supporting documentation, the reports and recommendations submitted by the Department Chairman or CMA Medical Leadership, and such other relevant information as may be available. The Credentials Committee shall investigate the character, qualifications and professional standing of the applicant and may interview the applicant and assure that the applicant is familiar with the Staff Bylaws, Rules and Regulations and applicable University Health System Bylaws. The Credentials Committee may ask the applicant for further documentation. The Credentials Committee shall transmit to the Executive Committee its report and recommendations prepared in accordance with Section 6.3-7 within sixty (60) days of receipt of all required reports and recommendations.

6.3-4 Executive Committee Action

At its next regular meeting after receipt of the completed application for a faculty staff appointment, report, and recommendation of the Department Chairman, the Dean, and the President of The University of Texas Health Science Center at San Antonio or his designee, or the receipt of the completed application for all other practitioners applying for appointment, report, and recommendation of the appropriate CMA Medical Leadership and upon the recommendation of the Credentials Committee, the Executive Committee shall then consider the applicant and decide what recommendations to take to the Board of Managers.

The Executive Committee shall then forward to the Chief Executive Officer, for transmittal to the Board of Managers, its written report and recommendations prepared in accordance with Section 6.3-7. The committee may also defer action on the application pursuant to Section 6.3-5 (a).
6.3-5 Effect of Executive Committee Action

No adverse recommendation will be forwarded to the Board of Managers until after the practitioner has exercised or has been deemed to have waived his right to a hearing as provided in Article X of these Bylaws.

(a) Interviews, Further Documentation, Deferral:
Action by the Executive Committee to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up in an expeditious manner and without unnecessary delay. Within 60 days of receipt of the Credentials Committee's initial recommendation regarding the applicant, the Executive Committee shall make a subsequent recommendation for appointment with specified clinical privileges, or denial of the request for Staff appointment.

(b) Favorable Recommendation:
When the Executive Committee's recommendation is favorable to the applicant, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board of Managers. For the purposes of this section "all supporting documentation" includes the application form and its accompanying information and the reports and recommendations of the Department Chairman, the reports and recommendations of the CMA Medical Leadership, the Credentials Committee, and the Executive Committee.

(c) Adverse Recommendation:
When the Executive Committee's recommendation is adverse to the applicant, the Chief Executive Officer shall give the applicant written notice by hand delivery or by certified mail, return receipt requested of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Article X and the applicant shall be entitled to the procedural rights as provided therein. For the purposes of this Section, an "adverse recommendation" by the Executive Committee is as defined in Article X. The Board of Managers shall be informed of, but not take action on, the pending adverse recommendation until the applicant has exhausted or waived his procedural rights.

6.3-6 Action by the Board of Managers

(a) Accept, Refer or Reject Favorable Executive Committee Recommendation:
The Board of Managers may accept, reject or refer a recommendation to the Executive Committee. If the Board of Managers adopts a favorable recommendation of the Executive Committee, then it shall become the final decision of the Board of Managers. The Board of Managers may refer the recommendation back to the Executive Committee for further interviews, documentation, or consideration stating the reasons for such
referral back and setting a time limit within which a subsequent recommendation may be made.

The Board of Managers may reject an Executive Committee recommendation which is favorable to the applicant. If the decision of the Board of Managers is contrary to the final recommendation of the Executive Committee, the governing body shall refer the matter to the Joint Conference Committee for further review and recommendation, setting a time limit within which a subsequent recommendation must be made. The Joint Conference Committee shall consist of two members appointed by the Chairman of the Board of Managers, two members appointed by the Chief of Staff and the Chief Executive Officer, who shall serve as Chairman of the Committee without vote. Recommendations from the Joint Conference Committee must be forthcoming within forty-five (45) calendar days and shall be considered by the Board of Managers prior to taking final action.

If, following the receipt of the report of the Joint Conference Committee, the recommendation of the Board of Managers is considered adverse to the applicant as set forth in Article X, Section 9.1, the Secretary of the Board of Managers shall give the applicant written notice of the tentative adverse recommendation and of the applicant’s right to request a hearing in the manner specified in Article X; and the applicant shall be entitled to the procedural rights as provided in Article X before any final adverse action is taken.

(b) On Adverse Executive Committee Recommendation:

If the Board of Managers decision is also adverse to the practitioner in respect to appointment, the Chief Executive Officer shall promptly notify the practitioner of such adverse decision by hand delivery or certified mail, return receipt requested. Such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his rights under Article X of these Bylaws.

The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

At the next regular meeting at which the Executive Committee recommendation is presented to the Board of Managers after all of the practitioner’s rights under Article X have been exhausted or waived, the Board of Managers or its duly authorized committee shall act in the matter. The Board of Managers decision shall be final.

Whenever the Board of Managers decision will be contrary to the recommendation of the Executive Committee, the Board of Managers shall submit the matter to a Joint Conference Committee for review and recommendation and shall consider such recommendation before making its decision final.
When the Board of Managers decision is final, it shall send notice of such decision regarding a faculty staff appointment through the Chief Executive Officer to the Secretary of the Staff, Chairman of the Executive Committee and of the Department concerned, and by certified mail to the practitioner.

When the Board of Managers decision is final as to all other appointments, it shall send notice of such decision through the Chief Executive Officer to the Secretary of the Staff, Chairman of the Executive Committee, the CMA Medical Leadership and by certified mail to the practitioner.

(c) Without Benefit of Executive Committee Recommendation:
If the Board of Managers does not receive an Executive Committee recommendation within the time period specified in Section 6.3-11, it may, after notifying the Executive Committee, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Board of Managers. If the recommendation is one of those set forth in Article IX, Section 1, the Secretary of the Board of Managers shall give the applicant written notice of the tentative adverse recommendation and of the applicant's right to request a hearing in the manner specified in Article IX; and the applicant shall be entitled to the procedural rights as provided in Article IX before any final adverse action is taken.

(d) After Procedural Rights:
In the case of an adverse Executive Committee recommendation pursuant to Section 6.3-6 (b) or an adverse Board of Managers recommendation pursuant to Section 6.3-9 (a) or (b), the Board of Managers shall take final action in the matter only after the applicant has exhausted or has waived his procedural rights as provided in Article IX. Action thus taken shall be the conclusive decision of the Board of Managers.

6.3-7 Appointment Reports

The reports and recommendations of the Department Chairman, the CMA Medical Leadership, Credentials Committee, and Executive Committee shall be submitted in the form prescribed by the Executive Committee. Each report and recommendation shall specify whether Staff appointment is recommended, and, if so, the membership category, department affiliation, and clinical privileges to be granted and any special conditions to be attached to the appointment. The reasons for such recommendations shall be stated and supported by reference to the completed application and all other documentation which was considered, all of which shall be transmitted with the report.
6.3-8 Basis for Appointment

Each recommendation concerning an applicant for Staff membership and clinical privileges shall be based upon whether the applicant meets the qualifications specified in Section 3.1, can carry out the responsibilities specified in Section 3.2, and meets all of the standards and requirements set forth in all sections of these Bylaws and in the Staff Rules and Regulations. Specifically, recommendations shall also be based upon the applicant's compliance with legal requirements applicable to the practice of his profession and other hospitals' Staff Bylaws, Rules and Regulations, and policies, rendition of services to his patients, any physical or mental impairment which might interfere with the applicant's ability to practice medicine with reasonable skill and safety, and his provision of accurate and adequate information to allow the Staff to evaluate his competency and qualifications.

6.3-9 Notice of Final Decision

(a) Notice of the Board of Managers' final decision regarding a faculty staff appointment shall be given, through the Chief Executive Officer, or his designee, to the Executive Committee, the Credentials Committee, the Chairman of each department concerned, and the applicant. Notice of the Board of Managers' final decision regarding all other appointments shall be given, through the Chief Executive Officer, or his designee, to the Executive Committee, the Credentials Committee, and the appropriate CMA Medical Leadership.

(b) The decision and notice to appoint shall include: (1) the Staff category to which the applicant is appointed; (2) the department to which he is assigned; (3) the clinical privileges he may exercise; and (4) any special conditions attached to the appointment.

6.3-10 Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment or privileges shall not be eligible to reapply to the Staff for a period of two years following such final adverse action. Any such reapplication following the two year period shall be processed as an initial application and the applicant shall submit such additional information as the Staff or Board of Managers may require in demonstration that the basis for the earlier adverse action no longer exists.

6.3-11 Time Period for Processing

Applications shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section.
The Chief Executive Officer, through the Staff Office, shall transmit an application to the Chief of Staff and the Department Chairman after all information, collection and verification tasks are completed and all relevant materials have been received. In the event that the relevant materials are not received within 60 days after the application is received, the applicant shall be notified, and the application shall remain pending until either the materials are received by the Chief Executive Officer, through the Staff Office, or the expiration of 180 days from the date the application was received, whichever comes first. Applications which are not completed within 180 days after receipt shall automatically be removed from consideration.

The Credentials Committee, upon receipt of a complete application, shall then review it at its next regularly scheduled meeting and make its recommendations to the Executive Committee. The Executive Committee shall review all applications and make its recommendations to the Board of Managers within 120 days of receipt by the Chief of Staff of (a) the complete application and (b) the recommendation of the Credentials Committee. The Board of Managers shall then take final action at its next regularly scheduled meeting at which the Executive Committee recommendations are presented. The failure by any person or committee described in this Section to meet its responsibility to consider and forward an application in a timely manner shall enable the next person or committee in the application process to consider the application without first receiving the report of the delinquent person or committee. Time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have his application processed within those periods.

6.4 REAPPOINTMENTS

6.4-1 Reappointment Generally

Only the Board of Managers has the power to take final action on reappointment to Staff membership and renewal or revision of clinical privileges. The fact that a practitioner has had Staff membership or clinical privileges in the past or that the Executive Committee has previously made a favorable recommendation shall not be deemed to renew Staff membership or privileges in the absence of action by the Board of Managers.

6.4-2 Reappointment Process

(a) The Executive Committee shall review all pertinent information available on each practitioner scheduled for reappointment to the Staff, and shall develop recommendations for submission through the Chief of Staff to the Board of Managers.
Where non-reappointment is recommended, the reason for such recommendation shall be stated and documented.

(b) Each recommendation concerning the reappointment of a Staff member shall be based upon his professional competence and clinical judgment in the treatment of patients, clinical and/or technical skills, as indicated in part by the results of quality improvement activities, ethics and conduct, attendance at Staff meetings, participation in Staff affairs, participation in continuing education activities related to, in part, clinical privileges granted as documented by the respective Department, his compliance with applicable University Health System policies, the Bylaws of the Board of Managers and the Bylaws and Rules and Regulations of the Medical-Dental Staff, cooperation with University Health System personnel, relations with other practitioners, his general attitude toward his patients, students, the University Health System, its employees, and the public, and his physical and mental capabilities.

(c) Each recommendation for reappointment will contain a professional practice evaluation profile. The Chairman of the Clinical Departments will recommend approval to the Executive Committee, who will approve or disapprove the recommendation.

(d) Thereafter, the procedure, provided in Section 6.2 relating to recommendations on applications for initial appointment, shall be followed.

6.4-3 Application for Reappointment

On or before 120 days prior to the expiration of each member’s current Staff appointment, the Chief Executive Officer, through the Staff Office, shall mail a reappointment application to the Staff member. The reappointment application shall be in writing on a form prescribed by the Executive Committee and it shall require detailed information concerning any changes in the applicant’s qualifications since his last review. Specifically, the reappointment application form shall request an update on all of the information and certification requested in the appointment application form, as described in Section 6.2 except for that information which cannot change over time. The form shall also require information as to whether the applicant requests any changes in his Staff status and/or his clinical privileges, including any reduction, deletion or additional privileges. Request for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application for the same. The member seeking reappointment must submit his reappointment application no later than 60 days prior to the expiration of his current Staff reappointment.
6.4-4 Failure to Reapply

Failure without good cause to provide timely information shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of membership and privileges at the expiration of the current term. A practitioner whose membership is so terminated is entitled to the procedural rights provided in Article X hereof for the sole purpose of determining the issue of good cause for failure to provide timely information to support his reappointment.

6.4-5 Department Action

The Department Chairman and Division Chief, if applicable, shall review the complete application for faculty staff reappointment and the professional practice evaluation profile and shall transmit to the Staff Office their written report and recommendations prepared in accordance with Section 6.4-9, within thirty (30) days of its receipt of the complete application and supporting materials.

The CMA Medical Leadership shall review the complete application for non-faculty staff reappointment and the professional practice evaluation profile and shall transmit to the Staff Office their written report and recommendations prepared in accordance with Section 6.4-9, within thirty (30) days of its receipt of the complete application and supporting materials.

6.4-6 Verification of Information

The Chief Executive Officer, through the Staff Office, shall in a timely fashion seek to collect or verify the additional information made available on each reappointment application form and to collect any other materials or information deemed pertinent. After determining the application is complete, the Chief Executive Officer, through the Staff Office, shall transmit the completed reappointment form and supporting materials to the Credentials Committee.

6.4-7 Credentials Committee Action

Following receipt of the Department Chairman’s report or CMA Medical Leadership’s report referenced in 6.4-5 above concerning the application for reappointment, the Credentials Committee shall at its next regularly scheduled meeting review the application, the Department Chairman’s report, and all other pertinent information available on the member who is being considered for reappointment and shall transmit to the Executive Committee its report and recommendations prepared in accordance with Section 6.4-9.
6.4-8 Executive Committee Action

At its next regularly scheduled meeting following receipt of the Credentials Committee report, the Executive Committee shall review the Credentials Committee's report, all other relevant information available to it and may, in its sole discretion, request an interview of the applicant. It shall then forward to the Board of Managers through the Chief Executive Officer, its favorable report and recommendations, prepared in accordance with Section 6.4-9.

When the Executive Committee recommends adverse action, as defined in Article X, either in respect to reappointment or clinical privileges, the Secretary of the Staff shall, within 10 business days, give the applicant written notice by hand delivery or certified mail, return receipt requested, of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in Article X. The applicant shall be entitled to the procedural rights as provided in Article X of these Bylaws.

Thereafter, the procedure specified in Section 6.3-6 (Action by the Board of Managers), 6.3-9 (Notice of Final Decision), and 6.3-10 (Reapplication after Adverse Decision) will be followed. The Executive Committee may also defer action. However, any such deferral must be followed up within 60 days with a subsequent recommendation to the Board of Managers.

6.4-9 Reappointment Reports

The reports and recommendations of the Department Chairman, CMA Medical Leadership, Credentials Committee, and Executive Committee shall be written and shall be submitted in the form prescribed by the Executive Committee. The failure by any person or committee described in this Section to meet its responsibility to consider and forward an application in a timely manner shall enable the next person or committee in the application process to consider the application without first receiving the report of the delinquent person or committee. Each report and recommendation shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, department affiliation, and/or clinical privileges, or terminated. Where non-reappointment, denial of requested privileges, reduction in status, or change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

6.4-10 Basis for Reappointment

Each recommendation concerning the reappointment of a Staff member and the clinical privileges granted upon reappointment shall be based upon whether such member has met the qualifications specified in Section 3.1, carried out the responsibilities specified in
Section 3.2, and met all of the standards and requirements set forth in all sections of these Bylaws and in the Staff Rules and Regulations. Specifically, recommendations shall also be based on the practitioner's compliance with legal requirements applicable to the practice of his profession, the Staff Bylaws and Rules and Regulations and University Health System policies, provision of services to his patients, any physical or mental impairment which might interfere with the applicant's ability to practice medicine with reasonable skill and safety, his documented ability to work harmoniously with University Health System personnel, other practitioners and with patients, evidence of malpractice insurance coverage as required, attendance at meetings, completion of medical records, and his provision of accurate and adequate information to allow the Staff to evaluate his competency, qualifications and his ability and willingness to contribute to appropriate patient care. In addition to the failure to meet the above qualifications, the absence of candor by the applicant, the failure to provide any requested information pertinent to the reapplication process or information obtained from the National Practitioner Data Bank may also be the basis for denial of renewal of appointment to the Staff.

6.5 REQUEST FOR MODIFICATION OF MEMBERSHIP STATUS OR PRIVILEGES

A Staff member, either in connection with reappointment or at any other time, may request modification of his Staff membership category, department, section or other clinical unit assignment, or clinical privileges by submitting a written request to the Chief Executive Officer through the Staff Office. Requests for modification of membership status or privileges are processed in the same manner as a reappointment application.

ARTICLE VII
CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every practitioner providing clinical services at University Health System facilities by virtue of Staff appointment or otherwise shall be entitled to exercise only those clinical privileges specifically granted by the Board of Managers. Said privileges must be within the scope of the license, certificate or other legal credentials authorizing him to practice in this state and consistent with any restrictions thereon. Regardless of the level of privileges granted, each practitioner must obtain consultation when necessary for the safety of his patients or when required by the Rules, Regulations or other policies of the Staff.
7.2 Delineations of Privileges

7.2-1 Requests

Each application for appointment to the Staff will contain a request for the specific clinical privileges desired by the applicant. Request by Staff member pursuant to Section 6.5 for a modification of privileges must be supported by documentation of additional training and/or experience supportive of this request.

7.2-2 Basis for Privilege Determination

(a) Requests for clinical privileges shall be evaluated on the basis of the applicant's education, training, experience, demonstrated competence, ability and judgment, references, and other relevant information. The basis for privilege determination to be made in connection with periodic reappointment or otherwise shall include observed clinical performance and the documented results of the quality review and monitoring activities of the Staff. Privilege determination shall also be based on pertinent information concerning clinical performance obtained from review of the records of patients treated in this or other hospitals.

(b) Delineated clinical privileges are subject to approval by the Board of Managers and include the following criteria: evidence of current licensure, relevant training and/or experience, current competence and health status, previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration, and/or applicable licensing board) or the voluntary relinquishment of such licensure or registration; the voluntary or involuntary termination of Staff memberships or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or health care facility. Sex, race, creed, and/or national origin are not used in making decisions regarding the granting or denying of clinical privileges. Peer and Departmental recommendations are part of the basis for the development of recommendations. Action on an individual's application for clinical privileges is withheld until such information is made available and is verified. This information is verified by University Health System from the primary source(s) whenever feasible. Privileges are related to an individual's documented experience in categories of treatment areas or procedures, the results of treatment, and the conclusions drawn from quality assurance activities.

(c) Clinical privileges of the Active, Provisional, Courtesy Affiliate Staff, as well as Allied Health Professionals, shall be based on recommendations of the Department Chairman or appropriate CMA Medical Leadership and approval by the Executive Committee following review by the Credentials Committee. The Department Chairman has
 responsibility for recommending the criteria the department will use for clinical privileges that are relevant to the care provided in the department.

7.2-3 Procedure

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article VI.

7.3 CONDITIONS FOR DENTAL PRIVILEGES

7.3-1 Scope of Dental Care

Requests for clinical privileges from dentists shall be processed in the manner specified in this Article. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by the dentist shall be under the overall supervision of the Chairman of the Department of Hospital Dentistry. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. Patients admitted for dental services by dentists except as stated below in Section 7.3-2 must have a current history and physical exam at the time of admission performed by a physician member of the active, courtesy or provisional Staff. Dentists may perform the physical and history of the dental problem. Such physician member of the Staff shall be responsible for the care of any medical problems that may arise during hospitalization and shall determine the risk, effect and appropriateness of the proposed surgical procedure on the total health status of the patient. When a significant medical abnormality is present the final decision on whether to proceed with the proposed dental surgery must be agreed upon by the dentist and by the physician consultant. The Chairman of the Department of Hospital Dentistry will decide the issue in case of dispute.

7.3-2 Scope of Oral and Maxillofacial Surgery Care

Qualified oral and maxillofacial surgeons who admit patients may perform the history and physical examination on those patients, if they have been granted such privileges, and may assess the medical risks of the proposed surgical procedures.

All patients admitted by qualified oral and maxillofacial surgeons who have medical problems shall receive the same basic medical appraisal as patients admitted for other services. All patients admitted by oral and maxillofacial surgeons shall be assigned to the Department of Oral and Maxillofacial Surgery and shall receive the same basic medical evaluation as patients admitted to other surgical sections. All other dental patients shall
be assigned to Hospital Dentistry and shall receive the same basic medical evaluation as patients admitted to other surgical sections. Criteria to be used in identifying such a qualified oral and maxillofacial surgeon shall include, but shall not necessarily be limited to the following: successful completion of a post-graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the United States Department of Education; and, as determined by the Staff, evidence that the oral and maxillofacial surgeon who admitted the patient is currently competent to conduct a complete history and physical examination to determine the patient's ability to undergo the surgery.

7.3-3 Criteria

Privileges in this Section shall be determined by the Executive Committee and Board of Managers, after recommendation from the Credentials Committee. Privileges for dentists and oral and maxillofacial surgeons shall be based on the same criteria in effect for other members of the Staff.

7.3-4

Oral and Maxillofacial surgeons and dentists who are members of the Staff may admit, care for and discharge their patients from University Hospital. All patients admitted by oral and maxillofacial surgeons shall be assigned to the Department of Oral and Maxillofacial Surgery and shall receive the same basic medical evaluation as patients admitted to other surgical sections. A physician member (M.D. or D.O.) of the Active, Courtesy, or Provisional Staff shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during the hospitalization of the Hospital Dentistry patient. The medical evaluation may be done by the patient's physician with Active, Courtesy or Provisional Staff privileges. Indicated consultations shall be held in accordance with established medical standards. Members of the Hospital Dentistry Section will provide and record a dental history and examination and this shall be a part of the patient's record.

7.4 CONDITIONS FOR PODIATRIC PRIVILEGES

Request for clinical privileges from podiatrists shall be processed in the manner specified in this Article. The scope and extent of surgical procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists shall be under the supervision of the Chairman of the Department of Orthopaedics. All podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services. Patients admitted for podiatry services must be co-admitted by a physician.
member of the Active, Courtesy or Provisional Staff who will be responsible for the care of any medical problems or conditions that may exist or develop during hospitalization and for the determination of the risk and effect of the podiatric surgical procedure on the total health status of the patient. Each patient must have a current history and physical exam at the time of admission done by a physician member of the active or provisional Staff. When significant medical abnormality is present, the final decision on whether to proceed with the surgery must be agreed upon by the podiatrist and by the physician consultant. The Chairman of the Department of Orthopaedics will decide the issue in case of dispute. The extent of privileges granted to podiatrists shall be specifically delineated and granted by the Executive Committee on the recommendation of the Chairman of the Department of Orthopaedics. Podiatrists are responsible for the part of their patients' history and physical examinations that relates to Podiatry.

7.4-1

Podiatrists who receive appointment to the Staff shall be assigned to the Department of Orthopaedics.

7.4-2

Podiatrists shall conform to the standards of care established for the Staff. Privileges shall be determined by the Executive Committee and Board of Managers after recommendation from the Credentials Committee.

7.4-3

All patients admitted by podiatric members of the Staff shall be co-admitted on the Orthopaedic service by a physician member of the Active, Courtesy or Provisional Staff. An adequate medical evaluation will be done and documented by the physician member prior to podiatric surgery. The medical evaluation should be performed by the patients regular physician whenever feasible. Indicated consultations shall be held in complicated cases. A complete and thorough podiatric evaluation shall also be documented prior to surgery.

7.4-4

Podiatrist members of the Staff may render podiatric consultations for other members of the Staff only for those privileges for which they have approved credentials.
7.5 CONDITIONS FOR OPTOMETRIC PRIVILEGES

The extent of privileges granted to optometrists shall be specifically delineated and granted by the Executive Committee to manage outpatients and provide consultation for inpatients on the recommendation of the Chairman of the Department of Ophthalmology. Optometrists are responsible for the part of their patient's history and eye examinations that relates to optometry.

7.6 TEMPORARY PRIVILEGES

7.6-1 Circumstances

After consultation with the Chief of Staff and the Chairman of the appropriate department, or CMA Medical Leadership, the Chief Executive Officer or designee may grant the applicant temporary admitting and clinical privileges in the following circumstances:

(a) Pendency of Approval:
When the new applicant for Staff membership or privileges with a complete and satisfactory application is waiting for a review and recommendation by the Executive Committee and approval by the Board of Managers, temporary privileges may be granted for a limited period of time, not to exceed 120 days.

(b) Care of Specific Patient:
Upon receipt of a written request for temporary privileges when there is an important patient care need that mandates an immediate authorization to practice for a limited period of time and when the current license and current competence has been verified, an appropriately licensed practitioner of documented competence who is not an applicant for membership may, at the discretion of the Chief Executive Officer or designee, in consultation with the Chief of Staff and the Chairman of the appropriate department, be granted temporary privileges for care of a specific patient. In exercising such privileges, the applicant shall act under the supervision of the Chairman of the department to which he is assigned. Temporary privileges granted under this section shall be for a limited period of time, not to exceed 30 days, or the discharge of the patient, whichever shall occur first.

7.6-2 Conditions

(a) Temporary privileges shall be granted only to an appropriately licensed physician, dentist, podiatrist, advance practice nurse, physician assistant or a dentist covered by
exception under the Texas Dental Practice Act. The practitioner must first provide a signed acknowledgment that he has received, read and agrees to be bound by the terms of the Bylaws of the Board of Managers, as well as the Bylaws and Rules and Regulations of the Medical-Dental Staff. The categories of Clinical Associate and Research Associate identified within the Article V, Allied Health Professional, shall be included in the granting of temporary privileges. The information available must reasonably support a favorable determination regarding the requesting applicant’s qualifications, ability and judgment to exercise the privileges requested, and only after the applicant has satisfied the professional liability insurance requirements of these Bylaws. Upon the discovery of any information or the occurrence of any event, the nature of which raises a question about an applicant’s professional qualifications or ability to exercise any and all of the temporary privileges granted, the Chief Executive Officer or designee or the Chief of Staff and the Chairman of the appropriate department may terminate any and all such individual’s temporary privileges. Temporary privileges granted under this Article are for the purpose of accommodating special temporary needs of practitioners or their patients. Accordingly, neither the refusal to grant temporary privileges nor the modification or termination of temporary privileges shall entitle an affected practitioner to a hearing or appeal under Article X of these Bylaws.

(b) The Chief Executive Officer or designee may at any time, upon the recommendation of the Chief of Staff or Chairman of the department concerned, terminate an individual’s temporary privileges. This shall be effective as of the discharge from University Hospital of the patient(s) then under his care in the hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Section 8.2, of Article VIII of these Bylaws, and the same shall be immediately effective. The appropriate Department Chairman or, in his absence, the Chief of Staff, shall assign a member of the Staff to assume responsibility for the care of such terminated practitioner’s patient(s) until they are discharged from University Hospital. The wishes of the patient(s) shall be considered where feasible in the selection of such a substitute practitioner.

(c) Special requirements of supervision and reporting may be imposed by the Chief of Staff or Department Chairman on any individual granted temporary privileges. Temporary privileges shall, with the concurrence of any Medical Staff Officer or appropriate Department Chairman, be immediately terminated by the Chief Executive Officer or designee upon notice of any failure by the physician, dentist, podiatrist, physician assistant or advance practice nurse to comply with such special conditions.
7.7 EMERGENCY PRIVILEGES

7.7-1 Circumstances

Emergency privileges may be granted in the following circumstances:

(a) In case of any emergency in which serious permanent harm or aggravation of an injury or disease is imminent, or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that danger, any Staff member is authorized and should be assisted to do everything possible to save the patient's life or to save the patient from serious harm, using every facility of University Health System necessary including the calling of any consultation necessary or desirable to the degree permitted by the member's license, but regardless of service affiliation, Staff category, or level of privileges. When the emergency situation no longer exists, such Staff member must request the privileges necessary to continue to treat the patient or see that the patient be assigned to an appropriate member of the Staff.

(b) In case of an emergency disaster response, emergency privileges may be granted when the emergency management plan has been activated and University Hospital is unable to handle the immediate patient needs. The Chief Executive Officer or designee, in consultation with the Chief of Staff, may grant emergency disaster response privileges. The volunteering practitioner will be required to provide a current state license to practice and a valid picture ID issued by a state, federal, or regulatory agency and one of the following to the Staff Office of University Health System:

1. A current hospital photo ID;
2. Identification indicating that the individual is a member of the Disaster Medical Assistance Team;
3. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances by a federal, state or municipal entity; or
4. Presentation by current hospital or medical staff member with personal knowledge regarding practitioner’s identity and qualification.

The University Health System will immediately primary source verify the state license and query the National Practitioner Data Bank for actions or sanctions. Any problems identified during this process will be immediately brought to the attention of the Chief of Staff, who may recommend to the Chief Executive Officer or designee the immediate termination of emergency privileges. The Chief Executive Officer, or designee, may, at his discretion and in consultation with the Chief of Staff, terminate or restrict a volunteering practitioner’s emergency privileges at any time without reason or cause. Any such termination or restriction shall not give rise to any hearing or mediation rights afforded by these Bylaws or any other authority. Emergency privileges will otherwise
ARTICLE VIII
CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1-1 Criteria for Initiation

Whenever any practitioner, allied health professional or any other individual with clinical privileges and/or research privileges engages in, activities or professional conduct, that is, or is reasonably likely to be, detrimental to patients' safety, to the delivery of appropriate patient care, disruptive to University Health System operations, in disregard of the Staff Bylaws or the Staff Rules and Regulations, or University Health System policies, corrective action against such person may be requested by any officer of the Staff, by the Chair of any clinical department or standing Staff Committee, or by the Chief Executive Officer. All requests for corrective action shall be in writing, shall be made to the Chief of Staff on behalf of the Executive Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Chief of Staff shall promptly notify the Chief Executive Officer in writing of all requests and shall ensure that the Chief Executive Officer is kept fully apprised of the status of the investigation and any resulting actions.

8.1-2 Investigation

The Executive Committee shall forward the request for corrective action to the Chairman of the Department of the individual whose actions or professional conduct is in question. The Chairman of the Department shall immediately investigate the matter or appoint an ad hoc committee to do so. The individual requesting corrective action shall not be appointed to investigate the matter. The Chairman shall also notify the practitioner/allied health professional in writing of the nature of the actions or conduct that forms the basis of the request. No such investigative process shall be deemed to be a hearing as described in Article X (Fair Hearing and Appellate Review) of these Bylaws. Within fifteen (15) business days of the receipt of the request from the Executive Committee, a written report of the results of the investigation shall be forwarded to the Executive Committee by the investigating individual or entity.

(a) If the request for corrective action is initiated against the Chairman of a Department, then the Chief of Staff shall immediately investigate or appoint an ad hoc committee to do so. The Chief of Staff shall also notify the Chairman of the Department in writing
of the nature of the actions or conduct that forms the basis of the request for the investigation. Within fifteen (15) days of the receipt of the request from the Executive Committee, a written report of the results of the investigation shall be forwarded to the Executive Committee by the investigating individual or entity.

(b) As a part of its investigation, the investigating individual or entity shall afford the affected individual an opportunity for an interview. At such interview, the individual shall again be informed of the general nature of the request for corrective action and shall be invited to discuss, explain, or refute said problem. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules and rights provided in these Bylaws with respect to hearing and appeal shall apply thereto. The investigating individual or entity may name such non-voting advisory members to assist in its investigation as it deems necessary. A record of such interview shall be made by the investigating individual or entity and included with its report to the Executive Committee.

8.1-3 Executive Committee Action

As soon as practical after the conclusion of the investigative process but in any event within thirty (30) days after the report to the Executive Committee, unless deferred pursuant to Section 8.1-5, the Executive Committee shall act thereon. Such action may include, without limitation:

(a) No corrective action;

(b) Rejection or modification of the proposed corrective action;

(c) Letter of Admonition, Letter of Reprimand, or Warning;

(d) Recommending terms of probation or individual requirements of consultation;

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

(f) Recommending suspension of clinical privileges until completion of specific conditions or requirements;

(g) Recommending reduction of staff membership status or limitation of any prerogatives directly related to the individual’s delivery of patient care;

(h) Recommending suspension of staff membership until completion of specific conditions or requirements;
(i) Recommending revocation of staff membership; and/or

(j) Other actions appropriate to the facts which prompted the investigation.

8.1-4 Deferral

If additional time is needed to complete the investigative process, the Executive Committee may defer action on the request and it shall so notify the affected individual in writing. The Executive Committee should attempt to make the recommendation within thirty (30) days of deferral.

8.1-5 Procedural Rights

Any recommendation by the Executive Committee pursuant to Section 8.1-3 which constitutes grounds for a hearing as set forth in Article X, Section 1, shall entitle a practitioner/advanced practice nurse/physician assistant to the procedural rights as provided in Article X. In such cases, the Chief of Staff shall give the practitioner/advanced practice nurse/physician assistant written notice of the adverse recommendation and of his rights to request a hearing in the manner specified in Article X.

8.1-6 Other Actions

(a) If the Executive Committee's recommended action is to recommend no corrective action, such recommendation, together with such supporting documentation required, shall be transmitted to the Board of Managers. In all other cases, the practitioner/advanced practice nurse/physician assistant may request an interview with the Executive Committee as provided in Section 8.5. Following the interview, when requested, the Executive Committee's final recommendation(s) shall be forwarded to the Board of Managers. The Board of Managers may make any modification to the recommended action of the Executive Committee it deems appropriate. Any recommendation of the Board of Managers which constitutes grounds for a hearing as set forth in Article X, Section 1, shall entitle the practitioner to the procedural rights as provided in Article X. In such cases, the Board of Managers shall give the practitioner written notice of the tentative adverse recommendation and his right to request a hearing in the manner specified in Article X.

(b) Should the Board of Managers determine that the Executive Committee has failed to act in timely fashion on the proposed corrective action, the Board of Managers, after notifying the Executive Committee, may take action on its own initiative. If such action is favorable to the individual, or constitutes an admonition, reprimand, or warning to the individual, it should become effective as the final decision of the Board
of Managers. If such action is one of those set forth in Article X, Section 1, the Board of Managers shall give the practitioner written notice of the adverse recommendation and of his right to request a hearing in the manner specified in Article X and his rights shall be as provided in Article X.

8.2 SUMMARY SUSPENSION

8.2-1 Criteria for Initiation

The Staff appointment or any portion of an appointee’s clinical privileges and/or research privileges may be suspended summarily when the failure to take such action would reasonably result in imminent danger to the health or safety of any individual present in University Health System facilities; would reasonably result in disruption of the operation of University Health System; or when the individual has acted in willful disregard of these Bylaws or other written policies such that patient care of University Health System operations are, or reasonably could be, adversely impacted in a significant manner. The Chief Executive Officer, or his designee, in consultation with the Chief of Staff, the Chairman of the Clinical Department where the individual has clinical privileges and the Board of Managers shall each have the authority to impose summary suspension. A summary suspension shall be effective immediately upon imposition. The Chief of Staff shall immediately inform the individual in writing of the suspension, as well as, the Executive Committee, the Chief Executive Officer and the Board of Managers.

In the event of such suspension, patients whose treatment by such practitioner/advanced practice nurse/physician assistant is terminated by the summary suspension shall be assigned to another practitioner/advanced practice nurse/physician assistant by the appropriate Department Chairman or the Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner/advanced practice nurse/physician assistant.

8.2-2 Executive Committee Action

Within fourteen (14) days of receiving notice of the summary suspension, the Executive Committee shall investigate the matter and determine whether or not professional review action is required. The suspended individual may request an interview, as provided in Section 8.5, in conjunction with the Executive Committee’s investigation of the matter. If the Executive Committee determines that there is no need for professional review, the suspension is immediately lifted and the individual is not entitled to a hearing. If, however, the Executive Committee recommends an action adverse to the individual or is unable to take action within the fourteen (14) days, the process outlined in Article X shall
be followed (i.e., the summarily suspended practitioner/advanced practice nurse/physician assistant may appeal). The summary suspension shall remain in effect pending the notice and hearing process if imminent danger to the health or safety of any individual continues. Upon conclusion of the review and investigation, the Executive Committee shall inform the Board of Managers of its recommendations. Upon concurrence by the Board of Managers with the Executive Committee’s recommendation, the matter shall be considered final.

8.2-3 Procedural Rights

Unless the Executive Committee terminates the suspension, it shall remain in effect during the pendency of and the completion of the corrective action process and of the hearing and appellate review process. The practitioner/advanced practice nurse/physician assistant shall not be entitled to the procedural rights afforded by Article X until such time as the Executive Committee or Board of Managers has taken action pursuant to Section 8.1-4 through 8.1-7, and then only if the action taken constitutes grounds for a hearing as set forth in Article X, Section 1.

8.3 IMMEDIATE SUSPENSION

8.3-1 License

(a) Revocation, Suspension or Expiration. A practitioner, allied health professional or any other individual with clinical privileges and/or research privileges whose license, certificate or legal credential authorizing him to practice in the state is revoked, suspended or has expired, shall have his Staff membership, prerogatives and clinical privileges and/or research privileges immediately and automatically terminated and he shall automatically be suspended from practicing in University Health System facilities as of the date notice of such revocation, suspension or expiration is actually received by University Health System.

(b) Restriction. Whenever a practitioner, allied health professional or any other individual with clinical privileges and/or research privileges whose license, certificate or legal credential authorizing him to practice in this state is limited or restricted by the applicable licensing authority, those clinical privileges and/or research privileges which he has been granted rights to perform that are within the scope of said limitation or restriction, shall be immediately and automatically terminated.

(c) Probation. Whenever a practitioner, allied health professional or any other individual with clinical privileges and/or research privileges is placed on probation by the applicable license authority, his applicable membership status, prerogatives, privileges
and responsibilities, if any, shall immediately and automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation.

8.3-2 Department of Public Safety/Drug Enforcement Administration

(a) Revocation, Suspension, Probation or Expiration. Whenever an individual’s DPS/DEA certificate is revoked, suspended or is subject to an order of probation, he shall immediately and automatically be divested of his right to prescribe medications covered by that certificate as of the date notice of such revocation, suspension, probation or expiration is actually received by University Health System. As soon as possible after such automatic suspension, the Executive Committee shall convene to review and consider the facts under which the DPS/DEA number was revoked, suspended or expired. The Executive Committee may then take such further action as is appropriate to the facts disclosed in its investigation.

8.3-3 Clinical Case Review

An individual, who fails, without good cause, to appear and satisfy the requirements of Section 12.8, may be immediately and automatically suspended by the Chief Executive Officer. Any such suspension shall remain in effect until the individual has appeared and satisfied the requirements of Section 12.8.

8.3-4 Professional Liability Insurance

For failure to maintain the amount of professional liability insurance, as required by the Board of Managers, a practitioner’s membership and clinical privileges and/or research privileges shall be immediately and automatically suspended, and shall remain so suspended until the practitioner provides evidence to the Executive Committee that he has secured professional liability coverage in the amount required by the Board of Managers. A failure to provide such evidence within six months after the date the automatic suspension becomes effective shall be deemed to be a voluntary resignation of the practitioner’s Staff membership.

8.3-5 Medical Records

For failure to complete medical records within the time limits established by the Staff Rules and Regulations and University Health System policies, the individual’s clinical privileges (except with respect to his patients already in University Hospital) and his rights to admit patients and to provide any other professional services, and/or research privileges shall be immediately and automatically suspended, and shall remain so suspended until all delinquent medical records are completed. A failure thereafter to
complete the medical records within the time specified in the Staff Rules and Regulations shall be deemed to be a voluntary resignation of the individual’s Staff membership.

8.3-6 Basic Life Support (BLS)

House Staff and Allied Health Professionals who provide direct patient care shall maintain a current BLS or higher certification at all times. If within thirty (30) days after the expiration date, a current certificate is not obtained or the course has not been scheduled, they shall be automatically suspended from the Medical-Dental Staff.

8.3-7 Procedural Rights

Any individual whose clinical privileges and/or research privileges are immediately and automatically suspended and/or who have resigned their Staff membership pursuant to the provisions of 8.3-1 (License), 8.3-2 (DEA), 8.3-3 (Failure to Attend Clinical Case Review), 8.3-4 (Failure to Maintain Malpractice Insurance), 8.3-5 (Failure to Complete Medical Records), 8.3-6 (Failure to Maintain BLS), shall not be entitled to procedural rights as set forth in Article X.

8.3-8 Notice of Immediate Suspension: Transfer of Patients

Whenever clinical privileges and/or research privileges are immediately suspended in whole or in part, notice of such suspension shall be given to the individual, the Executive Committee, the Chief Executive Officer and the Board of Managers. Giving of such notice shall not, however, be required in order for the immediate suspension to become effective; in the event of any such suspension, the individual’s patients, whose treatment by such practitioner is terminated by the immediate suspension, shall be assigned to another practitioner by the Department Chairman or the Chief of Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

8.4 PROVIDER IMPAIRMENT

8.4-1 Criteria for Initiation

In the event a Staff member appears at University Health System facilities with the intention of directly or indirectly participating in patient care, and in the opinion of University Health System personnel or another Staff member appears impaired, the Chief of Staff will be immediately notified. Confidentiality of the individual making the notification and/or referral to the Chief of Staff shall be maintained to the extent allowed by law. A provider may also confidentially self-refer to the Chief of Staff. Behavior suggestive of impairment may include:
(a) Drug seeking behavior;

(b) Suspected intoxication from any substance;

(c) Reports of illegal drug use; or

(d) Unusual or abnormal behavior suggesting possible impairment.

When behavior suggestive of impairment is evident, the Chief of Staff may refer the provider to the Physician’s Health and Rehabilitation Committee of Bexar County Medical Society or other equivalent peer assistance program appropriate to the individual’s licensure. However, when potential impairment is suspected, but convincing evidence is not present, the Chief of Staff may refer the provider to the Standing Ad-Hoc Investigating Committee.

8.4-2 Standing Ad-Hoc Investigating Committee

The Standing Ad-Hoc Investigating Committee consist of two (2) members of the Department of Psychiatry, one (1) dentist and five (5) members appointed from five (5) different clinical departments. A quorum of three (3) committee members is required for the committee to reach a decision. The Chief of Staff shall appoint the chair of the committee. The Chief Medical Officer shall be an ex-officio member of the Standing Ad-Hoc Investigating Committee. This committee is considered to be a formally-constituted peer review committee with a primary charge of identifying and managing matters of individual health of providers to protect patients, Staff and other persons in University Health System facilities from harm. Confidentiality of any individual seeking referral or being referred for assistance shall be maintained except as limited by applicable law, ethical obligations or when the health and safety of a patient is threatened.

When the Standing Ad-Hoc Investigating Committee is activated, the committee shall investigate any potential impairment and the credibility of a complaint, allegation or concern. If convincing evidence is identified of potential impairment, the Standing Ad-Hoc Investigating Committee will directly notify the Physician’s Health and Rehabilitation Committee of Bexar County Medical Society or other equivalent peer assistance program appropriate to the individual’s licensure, the responsible Department Chairman and the Chief of Staff to arrange a rapid intervention. If convincing evidence is not identified, the Chief of Staff and the responsible Department Chairman will be notified of the findings.

The Standing Ad-Hoc Investigating Committee shall also serve as the University Health System liaison to the Physician’s Health and Rehabilitation Committee of Bexar County
Medical Society and any other equivalent peer assistance program to receive progress reports regarding providers that are participating in a rehabilitation program. The Standing Ad-Hoc Investigating Committee shall also report in a confidential manner to the Credentials Committee and Executive Committee instances in which the individual is providing unsafe treatment and will initiate appropriate actions when an individual fails to complete any required rehabilitation program. It shall also educate the Staff and other organizational staff about health, well-being, illness and impairment recognition issues specific to Staff.

8.5 INTERVIEWS

Interviews shall neither constitute, nor be deemed, a "hearing" (as described in Article X), shall be preliminary in nature, and shall not be conducted according to the procedural rights applicable with respect to hearings. The Executive Committee shall be required, at the individual’s request, to grant him an interview only when so specified in this Article VIII. In all other cases, and when the Executive Committee or the Board of Managers has before it an adverse recommendation, as defined in Article X, Section 1, it may, but shall not be required to, furnish an interview. In the event an interview is granted, the individual shall be informed of the general nature of the circumstances leading to such recommendation and may present information relevant thereto. A record of the matters discussed and findings resulting from such interview shall be made.

ARTICLE IX
MEDIATION

9.1 INITIATION OF MEDIATION

(a) A practitioner may require the University Health System to participate in mediation in the following circumstances:

(1) The practitioner is subject to a professional review action that may adversely affect his medical staff membership or privileges as defined in Article X, Fair Hearing and Appellate Review, Section 10.1(a); or

(2) The Credentials Committee has failed to take action on the practitioner’s completed application within 90 days after the date on which the completed application is received.
Mediation may not be requested for any reason other than those provided above and must be requested prior to exercising any hearing rights and appellate review described in Article X that may be available to the practitioner.

(b) A practitioner entitled to request mediation under 9.1 (a) (1) shall do so within 30 calendar days following the date of his receipt of notice of an adverse recommendation or action. A request for mediation pursuant to 9.1(a) (2) shall be made within 30 calendar days following the Credentials Committee failure to timely act on the practitioner’s completed application (i.e., after the completed application has been on file for 90 days without action). In both instances, such notice shall be made in writing to the Chief Executive Officer, or designee, and shall be delivered by hand delivery or certified mail, return receipt requested. Failure to request mediation within the time frame provided herein or in the manner set forth in these Bylaws will waive the practitioner’s right to request mediation. Waiver of the right to request mediation does not constitute a waiver of the practitioner’s rights to a hearing and appellate review as provided in Article X of these Bylaws. If mediation is requested, all deadlines contained in Article X shall be stayed pending the outcome of the mediation.

(c) A practitioner is allowed only one mediation on any single matter. Mediation is to be conducted pursuant to Chapter 154, Civil Practices and Remedies Code, as amended, and conducted by a person meeting the qualifications required by Section 154.052.

(d) The parties shall mutually agree on a mediator within thirty (30) calendar days from the date the request for mediation is received. If the parties are unable to agree on a mediator, the University Health System shall select a mediator.

(e) Mediation shall take place within thirty (30) calendar days after the selection of a mediator, absent a waiver in writing of this deadline by both parties. Mediation shall be conducted in San Antonio, Bexar County, Texas.

(f) The cost of the mediation shall be borne solely by the practitioner.

(g) Any proposed resolution reached through the mediation process provided herein must be approved by the Board of Managers in order to finally resolve the matter. If the parties are unable to resolve the matter through mediation to the satisfaction of both parties, the mediator shall declare an impasse and the practitioner may request a hearing be initiated as provided in Article X of these Bylaws. The request for a hearing must be provided within thirty (30) calendar days from the declaration of an impasse and in the manner set forth in Article X. Failure of the practitioner to request a hearing within the time frame provided and in the manner set forth in these Bylaws will constitute a waiver of the practitioner’s right to a hearing.
(h) Confidentiality of documents and communications relating to mediation conducted pursuant to this Article is governed by the applicable provisions of Chapter 154 of the Civil Practice and Remedies Code, as amended.

ARTICLE X
FAIR HEARING AND APPELLATE REVIEW

10.1 INITIATION OF HEARING

(a) The following recommendations by the Executive Committee or actions by the Board of Managers shall entitle the practitioner/advanced practice nurse/physician assistant affected thereby to a hearing:

(1) Denial of initial Staff appointment or reappointment;

(2) Suspension or revocation of Staff membership or clinical privileges;

(3) Denial of requested clinical privileges; or

(4) Reduction of existing clinical privileges.

With regard to any other recommendation or action, including but not limited to any automatic suspension, revocation of temporary privileges, probation, mandatory consultation, and reprimand, the practitioner/advanced practice nurse/physician assistant will not have the right to a hearing and appellate review.

(b) A practitioner/advanced practice nurse/physician assistant against whom an adverse recommendation or action has been taken pursuant to this Article shall promptly be given notice of such action. Such notice shall:

(1) Advise of the adverse recommendation or action that has been taken;

(2) Advise of the right to a hearing pursuant to the provisions of the Staff Bylaws;

(3) Advise that not more than thirty days (30) following the date of receipt of this notice the individual must submit a written request for a hearing;

(4) State that failure to request a hearing within the specified time period shall constitute a waiver of the right to a hearing;
(5) State that following receipt of a hearing request, the individual will be 
notified of the date, time, and place of the hearing;

(6) State the reasons for the recommendation or action; and

(7) Provide a summary of the individual’s rights in a hearing.

(c) A practitioner/advanced practice nurse/physician assistant shall have thirty (30) days 
following his receipt of a notice to file a written request for a hearing. Such request 
shall be delivered to the Chief Executive Officer either in person or by certified or 
registered mail.

(d) A practitioner/advanced practice nurse/physician assistant who fails to request a 
hearing within the time and in the manner specified above waives any right to such a 
hearing and to any appellate review to which he might otherwise have been entitled.

(e) The notice described above may be supplemented at a later date if necessary.

10.2 HEARING PREREQUISITES

(a) Upon receipt of a timely request for hearing, the Chief Executive Officer shall deliver 
such request to the Executive Committee or to the Board of Managers, depending on 
whose recommendation or action prompted the request for hearing. The Chief 
Executive Officer shall send the practitioner/advanced practice nurse/physician 
assistance special notice of the time, place and date of the hearing and a list of 
witnesses expected to testify on behalf of the Executive Committee or Board of 
Managers. The notice may be supplemented at a later date if necessary. The hearing 
date shall not be less than thirty (30) days from the date of this special notice of 
hearing. A hearing for a practitioner/advanced practice nurse/physician assistant who is 
under suspension then in effect shall be held as soon as reasonably practicable.

(b) The Hearing Committee shall be appointed as follows:

If occasioned by an adverse Executive Committee recommendation, the hearing shall 
be conducted by a hearing committee appointed by the Chief Executive Officer, in 
consultation with the Executive Committee, and composed of five (5) members of the 
Staff who are fair, objective and unbiased and are not in direct economic competition 
with the individual. The Chief Executive Officer has the option to appoint a hearing 
officer or outside panel of physicians/advanced practice nurses/physician assistants 
(depending upon the credentials of the individual requesting the hearing) in
conformance with Section 10.7. One of the members so appointed shall be designated by the Chief Executive Officer as Chairman.

If occasioned by an adverse action of the Board of Managers, the hearing shall be conducted by a hearing committee appointed by the Chairman of the Board of Managers and composed of five (5) persons who are fair, objective and unbiased. At least three (3) Staff members who are not in direct economic competition with the individual shall be included. The Chief Executive Officer shall designate one (1) of the appointees to the Committee as Chairman. A Staff or Board of Managers member shall be disqualified from serving on a hearing committee if he has participated in initiating or investigating the underlying matter at issue.

10.3 HEARING PROCEDURE

(a) The personal appearance of the practitioner/advanced practice nurse/physician assistant who requested the hearing shall be required. A practitioner/advanced practice nurse/physician assistant who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights in the same manner and with the same consequence as provided in Section 10.1.

(b) Either the hearing officer, if one is appointed pursuant to Section 10.7, or the Chairman of the Hearing Committee, shall be the Presiding Officer. The Presiding Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters, including procedural issues (before, during, and after the hearing), and the admissibility of evidence.

(c) The individual who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Staff in good standing or by a member of his local professional society. The Executive Committee or the Board of Managers, depending on whose recommendation or action prompted the hearing, shall appoint an individual to represent the facts in support of its adverse recommendation or action, and to examine witnesses. Representations of either party by an attorney at law shall be governed by the provisions of Section 10.7.

(d) During a hearing, each of the parties shall have the right to:

(1) Call and examine witnesses.
(2) Present evidence and introduce exhibits subject to the provisions set forth below.

(3) Cross-examine any witness on any matter relevant to the issues.

(4) Impeach any witness.

(5) Rebut any evidence.

(6) Request that the record of the hearing be made by use of a court reporter or an electronic recording unit.

(7) Submit a written statement at the close of the hearing.

If the individual who requested the hearing does not testify in his own behalf, he may be called and examined as if under cross-examination.

(e) The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law.

The Presiding Officer may, but shall not be required to, order that oral evidence be taken only on oath. A witness may be entitled to be represented at the hearing by his own attorney.

(f) The committee shall be entitled to consider all other information that can be considered, pursuant to the Staff Bylaws, in connection with applications for appointment or reappointment to the Staff and for clinical privileges.

(g) When a hearing relates to an individual’s application for appointment, reappointment, or additional privileges, the individual who requested the hearing shall have the burden of proof. When a hearing relates to a individual’s existing membership or privileges, the body whose adverse recommendation or action occasioned the hearing shall have the burden of proof.

(h) A record of the hearing shall be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee may select whether the method to be used for making the record, should be by a court reporter or electronic recording unit. The affected individual shall have the right to a
copy of such record upon payment of any reasonable charges associated with the preparation thereof.

(i) The Hearing Committee may postpone or recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the Hearing Committee shall declare the hearing finally adjourned.

10.4 HEARING COMMITTEE REPORT AND FURTHER ACTION

(a) Within thirty (30) days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendation in the matter, including a statement of the basis for the recommendation, and shall forward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or action occasioned the hearing and to the affected practitioner/advanced practice nurse/physician assistant.

(b) Within fourteen (14) days after receipt of the report of the Hearing Committee, the Executive Committee or the Board of Managers, as the case may be, shall consider the same and affirm, modify, or reverse its prior recommendation or action in the matter. It shall transmit its decision, together with the hearing record, the report of the Hearing Committee and all other documentation considered, to the Chief Executive Officer.

(c) The Chief Executive Officer shall promptly send a copy of the decision described in (b) above to the practitioner/advanced practice nurse/physician assistant by special notice, either by hand-delivery or certified mail, return receipt requested and to the Board of Managers.

(1) If the Board of Managers initiated the action, the above result shall become the final decision of the Board of Managers and the matter shall be considered finally closed.

(2) If the Executive Committee's decision is favorable to the practitioner/advanced practice nurse/physician assistant, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board of Managers for its final action. The Board of Managers shall take action thereon by adopting or rejecting the Executive Committee's result in whole or in part, or by referring the matter back to the Executive Committee for
further reconsideration. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board of Managers must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board of Managers shall take final action. The Chief Executive Officer shall promptly send the individual special notice informing him of each action taken pursuant to this Section. The Board of Manager's action shall become its final decision, and the matter shall be considered finally closed.

(3) If the final recommendation of the Executive Committee is adverse to the individual, the Chief Executive Officer shall provide a written notice to the individual of his right to request an appellate review by the Board of Managers as provided in Section 10.5 below.

10.5 INITIATION AND PREREQUISITES OF APPELLATE REVIEW

(a) A practitioner/advanced practice nurse/physician assistant shall have fourteen (14) days following his receipt of the notice described in Section 10.4 to file a written request for an appellate review. Such request shall be delivered to the Chief Executive Officer either in person or by certified or registered mail.

(b) A practitioner/advanced practice nurse/physician assistant who fails to request an appellate review within the time and in the manner specified above waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 10.1.

(c) Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board of Managers. As soon as practicable, the Board of Managers shall schedule and arrange for an appellate review which shall not be less than thirty (30) days from the date of receipt of the appellate review request; provided, however, that an appellate review for an individual who is under a suspension then in effect shall be arranged as soon as practicable. The Chief Executive Officer shall send by hand-delivery or certified mail to the individual special notice of the time, place and date of the review. The time for the appellate review may be extended by the Board of Managers for good cause and if the request is made as soon as is reasonably practicable.
10.6 APPELLATE REVIEW PROCEDURE

(a) The proceedings by the Board of Managers shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, that Committee’s report, all subsequent results and actions thereon, and all other relevant materials from the proceedings. The Board of Managers shall also consider the written statements, if any, submitted pursuant to this Section and such other material as may be presented and accepted under this Section.

(b) The individual seeking the review may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees, and his reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Board of Managers through the Chief Executive Officer at least fourteen (14) business days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Executive Committee.

(c) The Chairman of the Board of Managers shall be the presiding officer. He shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

(d) The Board of Managers in its sole discretion may allow the affected individual and Executive Committee or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the Board of Managers.

(e) New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only in the discretion of the Board of Managers following an explanation by the party requesting the consideration of such matter or evidence as to why it was not presented earlier.

(f) The Board of Managers shall have all the powers granted to the Hearing Committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

(g) The Board of Managers may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The Board of Managers shall thereupon, at a time convenient to itself, conduct its deliberations outside the
presence of the parties. Upon the conclusions of those deliberations, the Board of Managers shall declare that the appellate review is finally adjourned.

(h) The Board of Managers may affirm, modify or reverse the adverse result or action taken by the Executive Committee or in its discretion, may refer the matter back to the Hearing Committee for further review and recommendation to be returned to it.

(i) The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

(j) Within fourteen (14) business days after its adjournment, the Board of Managers shall render its final decision in the matter in writing, including a statement of the basis for the decision, and shall send notice thereof to the individual by hand-delivery or registered mail, to the Executive Committee.

10.7 GENERAL PROVISIONS

(a) The use of a hearing officer or outside panel to preside at an evidentiary hearing is optional. The use and appointment of such an officer or outside panel shall be determined by the Chief Executive Officer after consultation with the Chief of Staff. A hearing officer may or may not be an attorney of law. He shall act as the presiding officer of the hearing.

(b) If the affected individual desires to be represented by an attorney or other person at any hearing or at any appellate review appearance, his initial request for the hearing must state the wish to be so represented at either or both of such proceedings in the event they are held. The Chief Executive Officer, Executive Committee or the Hearing Committee has the discretion to grant such request. The Executive Committee and Board of Managers will be allowed representation by an attorney at any hearing or appellate review appearance only if the individual is allowed representation.

(c) By requesting a hearing or appellate review under this Article, an individual agrees to be bound by the provisions of this Article.

(d) The Chief Executive Officer shall make all reports required by law as a result of any adverse recommendation or action taken pursuant to these Bylaws.

(e) Any practitioner/advanced practice nurse/physician assistant whose association with University Health System requires membership on the Staff shall not have his Staff Privileges terminated without the same due process provisions as provided for any member of the Staff, unless otherwise stated in the contract.
ARTICLE XI
OFFICERS

11.1 OFFICERS OF THE STAFF

The Officers of the Staff shall be the President, Past President, Vice-President, Secretary, and the Members-at-Large of the Executive Committee.

11.2 QUALIFICATION OF OFFICERS

11.2-1

Officers must be members in good standing of the Active and Provisional Staff at the time of nomination and election, must be approved by the Board of Managers, and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Nominees must possess the ability and experience required to fill such positions and be willing to devote the time and effort needed to fulfill the responsibilities of office.

11.2-2

An officer may be removed from office:

(a) Upon two-thirds majority vote of the Executive Committee, a special meeting of the Staff may be called to consider or act upon the removal of any officer. Officers may be removed from their office for failure to fulfill his responsibilities while in office, physical or mental infirmity to a degree that renders him incapable of fulfilling the duties of the office or conduct detrimental to the interests of the University Health System and/or Staff.

(b) Removal of an officer during his term of office may be initiated by a two-thirds majority vote of all Active and Provisional Staff members attending the special meeting, but no such removal shall be effective unless, and until, it has been ratified by the Board of Managers. Upon ratification by the Board of Managers of the removal of an officer, membership on the Executive Committee is also terminated.
11.3 ELECTION OF OFFICERS

11.3-1

Officers shall be elected by mail as provided in Section 13.2-2. Only members of the Active and Provisional Staff shall be eligible to vote. When conducted by mail, the vote shall be by written ballot distributed to Active and Provisional Staff members.

11.3-2

In case there are three or more candidates for one office, and no candidate receives a majority, the candidate receiving the fewest votes will be omitted from the next slate and successive ballots will be cast in this manner until one candidate receives a simple majority.

11.3-3

The Nominating Committee shall consist of three members of the Active Staff appointed by the Chief of Staff and shall offer one or more nominees for each office.

11.3-4

Additional nominations may be submitted by petition signed by at least ten members of the Active and Provisional Staff and filed with the Secretary of the Staff. Such nominations are subject to prior approval by the nominee. The ballots will be tallied and those candidates receiving the majority of votes will be elected to the office.

11.4 TERM OF OFFICE

All officers shall serve for a term of two (2) years. Officers shall take office on the first day of the Staff year following their election. The President, Vice-President, Secretary, and two (2) Members-at-Large of the Executive Committee shall be elected during even-numbered years and two (2) Members-at-Large of the Executive Committee shall be elected during odd-numbered years.

11.5 VACANCIES IN OFFICE

Vacancies in office during the Staff year except for the President or Vice-President shall be filled by the Executive Committee of the Staff. If there is a vacancy in the office of
President, the Vice-President shall serve out the remaining term. If there is a vacancy in the office of Vice-President, the nominating and electing procedures as described in Section 10.3 shall be instituted as soon as possible.

11.6 DUTIES OF OFFICERS

11.6-1 President

The President of the Staff shall serve as chief administrative officer of the Staff and will:

(a) Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within University Health System;

(b) Call, preside at, and be responsible for the agenda of all general meetings of the Staff and Executive Committee;

(c) Serve as Chairman of the Executive Committee;

(d) Serve as Ex-Officio member of all other Staff committees and management teams without vote;

(e) Facilitate enforcement of Staff Bylaws, Rules and Regulations; implement sanctions when indicated; and ensure Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a provider;

(f) Appoint committee members to all standing, special, and multidisciplinary Staff committees, except the Executive Committee;

(g) Represent the views, policies, needs and grievances of the Staff to the Chief Executive Officer and Board of Managers;

(h) Receive and interpret the policies of the Board of Managers on behalf of the Staff and report to the Board of Managers on the performance and maintenance of quality with respect to the Staff's delegated responsibility to provide medical and dental care; and

(i) Serve as the designated spokesperson for the Staff in its external professional and public relations activities.

11.6-2 Vice-President

The Vice-President of the Medical-Dental Staff shall:
(a) In the absence of the President, assume the duties and have the authority of the President;

(b) Be a member of the Executive Committee of the Staff and shall automatically succeed the President if that position becomes vacant for any reason; and

(c) Serve as Chairman of the Quality/Risk Management Committee.

11.6-3 Secretary

The Secretary of the Medical-Dental Staff shall:

(a) Be a member of the Executive Committee;

(b) Keep accurate and complete minutes of all Staff, Executive Committee Meetings and meetings called on order of the President;

(c) Attend to all correspondence; and

(d) Perform such other duties as ordinarily pertain to the office.

11.6-4 Past-President

The Past-President of the Medical-Dental Staff shall:

(a) Be the immediate past president of the Staff;

(b) Be a member of the Executive Committee;

(c) Serve as Chairman of the Bylaws Committee;

(d) Serve as Chairman of the Nominating Committee; and

(e) Serve as Staff Parliamentarian.

11.6-5 Members-at-Large of the Executive Committee

The Members-at-Large shall:

(a) Be a member of the Executive Committee.
ARTICLE XII
CLINICAL DEPARTMENTS

12.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND SERVICES

12.1-1

Each Clinical Department shall be organized as a separate part of the Staff and shall have a Chairman who shall be responsible for professional medical administration of the department. Departments may be created or deleted from the organizational structure by action of the Executive Committee, with approval of the Board of Managers. Clinical Department Chairman may create or dissolve divisions and services dependent upon the needs of patient care and/or teaching activities, with the approval of the Executive Committee and the CEO. Should any conflict arise, the matter shall be referred to the Board of Managers for decisions.

12.1-2

The departments of the staff shall be:

(a) Anesthesiology
(b) Cardiothoracic Surgery
(c) Emergency Medicine
(d) Family and Community Medicine
(e) Hospital Dentistry
(f) Medicine
(g) Neurology
(h) Neurosurgery
(i) Obstetrics and Gynecology
(j) Ophthalmology
(k) Oral and Maxillofacial Surgery
(l) Orthopaedics
(m) Otolaryngology - Head & Neck Surgery
(n) Pathology
(o) Pediatrics
(p) Psychiatry
(q) Radiation Oncology
(r) Radiology
(s) Rehabilitation Medicine
(t) Surgery
(u) Urology
12.2 SPECIALTY SECTIONS WITHIN DEPARTMENTS

For the purpose of monitoring and assuring the quality and appropriateness of care, divisions will be considered as subsections of their respective departments, and fulfill in all respects the meeting requirements of the departments.

12.3 ASSIGNMENT TO DEPARTMENTS

Assignment to a department(s) shall be made by the Executive Committee. Each member of the Staff shall be assigned to a department which most closely reflects his professional training, experience and current practice. Every practitioner must have a primary affiliation with a department, but may be granted clinical privileges in one or more of the departments or divisions, and his exercise of clinical privileges within the jurisdiction of any department or divisions is always subject to the rules and regulations of that department and section.

12.4 APPOINTMENT OF DEPARTMENT OFFICERS

12.4-1

The recommendation of Clinical Department Chairman is a joint decision between University Health System and the School of Medicine. The goal to select the best qualified candidate whose personal qualifications and clinical practice experience can best lead the department’s operations, assure high quality care, patient satisfaction and efficiency. The recommended Clinical Department Chairman is subject to Executive Committee and Board of Managers approval. All Chairman must be members in good standing of the Active or Provisional Staff at the time of nomination and appointment. They must remain active members in good standing during their term of office.

12.4-2

The Chief of each division shall be appointed by the Department Chairman. This individual shall be a member of the Active or Provisional Staff. The Chief shall be responsible to the Department Chairman and through him to the Executive Committee for the functioning of his division and shall have general supervision of the clinical work of its members. Removal of a Division Chief may be effected upon recommendation of the Department Chairman.
12.5 FUNCTIONS OF THE DEPARTMENT

12.5-1 General

Each Department shall:

(a) Recommend privileges, based upon specific criteria, to be granted within the department to practitioners who have applied for appointment to the Staff; review the professional performance of all practitioners with clinical privileges in the department or section in making recommendations to the Credentials Committee concerning their Staff classification, reappointment, and delineation of clinical privileges;

(b) Recommend privileges, based upon specific criteria, to be granted to Allied Health Professionals; review the professional performance of Allied Health Professionals;

(c) Establish, implement and monitor its members' adherence to clinical standards, policies, procedures, and practices relevant to the various clinical disciplines under its jurisdiction, including establishing procedures for new procedures and/or protocols related to standards of care in the department subject to the approval of the Executive Committee and the Board of Managers;

(d) Establish, implement and monitor its members' adherence to clinical standards, policies, procedures and practices relevant to the various clinical disciplines under its jurisdiction, including establishing types of privileges in the department subject to the approval of the Executive Committee and the Board of Managers;

(e) Provide an interspecialty and interdepartmental forum for matters of clinical concern and for resolving clinical issues arising out of the interface between its member's activities and the activities of other patient care and administrative services;

(f) Develop consistency in the patient care data, standards, policies, procedures and practices within the department and across any of its constituent sections;

(g) Provide a forum for its members to contribute their professional views to the formulation of the departmental, Staff, and University Health System policies and plans;

(h) Receive and review quality assurance and utilization data pertinent to the department and make recommendations or take action as appropriate; and
Serve as the most immediate peer group for providing clinical support, teaching, continuing education and sharing new knowledge relevant to the practice of department members.

12.6 RESPONSIBILITY OF DEPARTMENT CHAIRMAN

12.6-1 General

Each Chairman shall:

(a) Assume responsibility for all professional, administrative and clinically related activities within his department;

(b) Be a member of the Executive Committee;

(c) Give guidance on the overall medical policies of the University Health System and make specific recommendations and suggestions regarding his department in order to assure quality patient care;

(d) Review the professional performance of all practitioners with clinical privileges in the department and report regularly to the Executive Committee; take corrective action as deemed appropriate and consistent with these Bylaws;

(e) Develop and implement policies and procedures that guide and support the provision of care, treatment and services and facilitate the enforcement of the Staff Bylaws, Rules and Regulations and policies within his department;

(f) Implement actions taken by the Executive Committee of the Staff;

(g) Transmit his department's recommendations concerning the Staff classification, the reappointment, and the delineation of clinical privileges for all practitioners in his department;

(h) Facilitate the teaching, education and research programs in his department;

(i) Participate in the administration of the department through cooperation with Patient Care Services and University Health System management in matters affecting patient care to include implementation of special regulations, standing orders and techniques;

(j) Assist in the preparation of the annual budget pertaining to his department as may be requested by the Chief Executive Officer;
(k) Counsel or advise individual members of the department when there are questions of clinical performance, disregard for reasonable departmental rules, lack of respect for co-workers, possibility of physical or mental impairment, or practicing outside the limits of clinical privileges that have been granted;

(l) Analyze information including but not limited to applications for membership and privileges of individuals who are members or who are to be assigned to the department;

(m) Evaluate causes and respond to untoward incidents involving members of the department;

(n) Orientation and continuing education of all persons in the department of service;

(o) Assess and recommend to relevant University Health System administration off-site sources for needed patient care, treatment and services not provided by the department of the organization;

(p) Recommend space and other resources needed by the department or service;

(q) Recommend sufficient number of qualified and competent practitioners to provide care, treatment and services; and

(r) Determine the qualifications and competence and review the professional performance of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.

12.6-2 Quality Improvement

Each Chairman shall:

(a) Be responsible for the Quality Improvement Program in his Department;

(b) Analyze patient care information resulting from University Health System Quality Improvement activities; and

(c) Timely provide documentation of actions taken in response to Quality/Peer review.
12.7 DEPARTMENT MEETINGS

12.7-1

In those departments with divisions, division meetings will be held as needed. A special meeting of any department may be called by the Chairman or the Chief of Staff.

12.7-2 Quorum

The members of the Active Staff in attendance at Department meetings, but not less than two (2), shall constitute a quorum.

12.7-3 Manner of Action

The action of a majority of members present at a meeting in which a quorum is present shall be the action of a Department.

12.8 CLINICAL CASE REVIEW

12.8-1

An individual whose patient’s clinical course of treatment is scheduled for case discussion as part of regular quality assessment and review at a department, division, or committee meeting will be notified in writing and invited to present the case. Any member who fails to attend such meeting without good cause, may be subject to automatic suspension as set forth in Article VIII or to such other corrective action as deemed necessary by the Executive Committee and Board of Managers.

12.8-2

Whenever a clinical educational program is prompted by findings of review, evaluation and monitoring activities, the individual whose pattern of performance prompted the program will be notified of the time, date and place of the program. Attendance is mandatory. Failure to attend unless excused by the Executive Committee upon a showing of good cause may result in automatic suspension as set forth in Article VIII or to such other corrective action as deemed necessary by the Executive Committee and Board of Managers.
ARTICLE XIII
MEETINGS OF MEDICAL DENTAL STAFF

13.1 SPECIAL MEETINGS

13.1-1

The Chief of Staff or Executive Committee may call a special meeting of the Staff at any time.

13.1-2

Written notice stating the place, day, and hour of a special meeting by the Staff shall be delivered, either personally or by mail, to every member of the Active and Provisional Staff no less than five, nor more than ten days prior to the date of such meeting, by or at the direction of the Chief of Staff. If mailed, the notice of the meeting shall be considered delivered when deposited, postage prepaid, in the United States mail, addressed to each staff member at the address that appears in the records of the University Health System. The attendance of a member of the Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except as stated in the notice calling the meeting.

13.1-3

The agenda of a special meetings shall consist of:

(a) Reading of the notice calling the meeting;

(b) Transaction of the business for which the meeting was called; and

(c) Adjournment.

13.2 QUORUM AND VOTING

13.2-1

For meetings of the Staff a quorum shall be declared by the Chief of Staff. The presence of or voting by mail of at least twenty percent (20%) of the Active and Provisional Staff shall constitute a quorum for purposes of amendment of the Bylaws.
For purposes of voting by the Active and Provisional Staff, the Executive Committee may conduct the vote by mail. The Executive Committee shall develop a procedure to ensure the validity of the vote.

13.3 RULES OF ORDER

13.3-1

The rules contained in Sturgis Rules of Order shall govern the Staff in all cases to which they are applicable and in which they are not inconsistent with the Bylaws or the special rules of order of the Staff.

ARTICLE XIV
COMMITTEES

14.1 COMMITTEE STRUCTURE

14.1-1 Organization

There shall be committees of the Staff which serve to organize and centralize activities of the Staff. All Staff Committees report to the Executive Committee. Whenever a Staff Committee’s duties and functions include activities related to the evaluation of medical and health care services, including but not limited to, the evaluation of the qualifications and professional conduct of practitioners, limited healthcare practitioners and allied health professionals and/or of the quality of patient care provided by these individuals or others, these activities are strictly confidential and privileged as provided by state and federal law.

The Staff may designate one or more committees with the authority provided by the Executive Committee to act upon matters pertaining to the administration of the Staff. Staff committees consist of members of the Active, Affiliate, House Staff and Provisional Staff. All Chairman/Vice-Chairman must be members of the Active or Provisional Staff at the time of nomination and election and must remain Active or Provisional Staff members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The Chief of Staff appoints members of the committees with the approval of the Executive Committee. Ex-officio members of committees shall be eligible to vote on all committee matters, unless otherwise provided. The Chief Executive Officer, or his representative, may attend all
official meetings of the Staff Committees as an ex-officio member without vote. Members of Administration, Patient Care Services or other departments of the University Health System may be assigned by the Chief of Staff in consultation with the Chief Executive Officer as consulting members to a committee to serve as a resource to Staff.

14.1-2 Appointment of Members and Responsibilities of Committee

(a) Appointments to the Committees shall be made by the Chief of Staff from recommendations made by the Chairman of each department or the appropriate University Health System vice president for ex-officio positions. Service shall commence on the first day of January for a term of three years. At the discretion of the Chief of Staff, a member may be nominated for additional terms. At the discretion of the Chief of Staff and the Chief Executive Officer, an ex-officio member may be nominated for additional terms. Consulting members may be added at the discretion of the Chairman with the advice and consent of the Chief of Staff and may serve for an unlimited period. If a committee member is unable to attend a meeting, another member of the same department or function may substitute with the same privileges held by the absent committee member.

(b) At the first called meeting of the committee each year, the membership of the committee shall elect a Chairman, Vice-Chairman, and Secretary except where the positions are designated by the Bylaws.

(c) All committees shall maintain a permanent record of their proceedings and actions. All committees shall keep minutes with attendance of its meetings, copies of which shall be forwarded to the Staff office for confidential filing and distribution. The minutes shall also serve as reports to the Executive Committee. In addition, the Committee shall prepare a brief annual report for presentation to the Executive Committee, Board of Managers and the Staff.

14.1-3 Officers

(a) Chairman
The chairman shall be responsible for the conduct of the business of the committee as well as the presentation of the reports of the committee to which it is responsible. Reports shall be in the form of written minutes.

(b) Vice-Chairman
In the absence of the Chairman, the Vice-Chairman shall assume the duties and have the authority of the Chairman.

(c) Secretary
Shall keep accurate and complete minutes of all Committee meetings and perform such other duties as ordinarily pertain to this office.

14.1-4 Notice of Meetings

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Written or verbal notice stating the place, day, and hour of any special or regular meetings, not held pursuant to resolution, shall be given to each member of the Committee no less than 24 hours before the time of such meetings.

14.1-5 Attendance

Any member of the Active or Provisional Staff who is compelled to be absent from a Committee meeting of which he is a member shall submit in writing, to the Committee Chairman, the reason for such absence.

14.1-6 Special Meetings

A special meeting of any Committee may be called by the Committee Chairman or the Chief of Staff.

14.1-7 Minutes

Minutes of all regular and special meetings of a Committee shall be prepared so as to include a record of attendance, the business transacted, and the vote taken on each matter. A record that includes the resultant conclusions, recommendations, and actions taken at each meeting will be maintained. The minutes shall be signed by the presiding officer and copies thereof shall be promptly submitted to the attendees for approval and, after such approval is obtained, forwarded to the University Health System Staff office for confidential filing.

14.1-8 Quorum

The members of the Active and Provisional Staff in attendance at a Committee meeting, but not less than two (2) appointees, shall constitute a quorum.

14.1-9 Manner of Action

The action of a majority of members present at a meeting in which a quorum is present shall be the action of a Committee or Department.
14.2 BIOETHICS COMMITTEE

14.2-1 Composition

The Bioethics Committee shall consist of representatives from the Departments of Medicine, Psychiatry, Surgery, Pediatrics, Obstetrics and Gynecology, Hospital Dentistry, Anesthesiology/Pain Management, and Family and Community Medicine as well as a representative from Palliative Care. Ex-officio members shall include, but not be limited to, representation from Patient Care Services, Administration, Social Work, Spiritual Care, Legal Services, Center for Medical Humanities and Ethics and a community representative. The Director, Ethics Services, shall be permanent secretary of this committee.

14.2-2 Duties

(a) The Bioethics Committee of the University Health System shall serve, on request, as a consulting group to the members of the Staff and University Health System staffs to assist in clarifying patient care treatment options affected by conflicting ethical, moral, biomedical, social, legal or religious considerations. In addition, the committee shall serve as a resource in educating the staffs and lay community regarding patient rights, including the right to informed consent, to refuse treatment and to issue advance directives;

(b) A request for a Bioethics consult may be initiated by a health care professional, patient or patient’s relatives. The attending physician shall be notified in a timely fashion whenever a clinical ethics consultation is initiated; and

(c) The extent of the review shall be appropriate to the case and a summary of the Committee’s deliberations, however, will be conducted in strict confidence under its nondisclosure privilege as allowed by state and federal law. The Committee’s suggestions shall be advisory in nature to facilitate, not supplant, the decision-making authority of the attending physician. Ethical issues in biomedical research are outside the purview of this Committee.

14.2-3 Meetings

Every other month and on call.

14.2-4 Reporting

Annually to the Executive Committee and Chief of Staff.
14.3 BLOOD AND TISSUE UTILIZATION REVIEW COMMITTEE

14.3-1 Composition

The Blood and Tissue Utilization Review Committee shall consist of representatives from the Departments of Pathology, Anesthesiology, Obstetrics and Gynecology, Surgery, Orthopaedics, Otolaryngology-Head & Neck Surgery, Pediatrics and Medicine (including a representative from the Division of Hematology or Oncology). Ex-Officio members shall include the Medical Director of Transfusion Medicine and one representative each from Administration and Patient Care Services. The permanent secretary of this committee shall be the Medical Director of Transfusion Medicine.

14.3-2 Duties

(a) Review all current policies and practices relating to the administration of blood, blood products and tissue;

(b) Review all cases in which patients were administered transfusions, including the use of whole blood and blood components and the use of blood and tissue by the several clinical services;

(c) Recommend policies, procedures, and necessary action to assure that the supply of blood, blood products and tissues is at all times adequate to meet the needs of the institution; and

(d) When the blood and tissue usage review consistently supports the justification and appropriateness of blood and tissue use, the review of an adequate sample of cases is acceptable.

14.3-3 Meetings

Monthly and on call.

14.3-4 Reporting

Monthly to the Quality/Risk Management Committee.
14.4 BY LAWS COMMITTEE

14.4-1 Composition

The Bylaws Committee shall consist of the Immediate Past-Chief of Staff, and two other senior members of the Staff. The Chief Executive Officer, or designee, and a representative from Legal Services shall serve as ex-officio members. The Staff Office shall serve as permanent secretary of this Committee.

14.4-2 Duties

(a) To review the Staff Bylaws and Rules and Regulations on an annual basis or upon the request of the Executive Committee to ensure their compliance with the philosophy of the University Health System, the standards of relevant accreditation organizations (e.g. The Joint Commission) and appropriate federal and state statutes and regulations;

(b) To present any Bylaws change(s) to the voting Staff through the Executive Committee and to the Board of Managers for final approval;

(c) To present such changes, accepted by the Executive Committee, to the Voting Staff for its consideration and subsequently to the Board of Managers for approval. If approved, to assure that these are included in future copies of the Bylaws; and

(d) To assure that policies established by departments or sections, accepted by the Executive Committee, be appended to future copies of the Bylaws and Rules and Regulations.

14.4-3 Meetings

Annually and on call.

14.4-4 Reporting

Annually and as needed to the Executive Committee.
14.5 CANCER COMMITTEE

14.5-1 Composition

The Cancer Committee shall consist of representatives from the Departments of Surgery, Radiology, Pathology, Medicine (Oncology), Radiation Oncology, Pain Service, Palliative Care, Cancer Liaison, Orthopaedics, University Hospital Administration (Cancer Program Administrator), Patient Care Services (Oncology), Social Work, Tumor Registry, Risk Management, and Research.

14.5-2 Duties

Coordinate and enhance the diagnosis and treatment of cancer, specifically acting in a supervisory capacity in maintaining the organization and function of the University Health System cancer program in accordance with the current recommendations of the American College of Surgeons. A register shall be maintained to provide statistical reports on site, stage, method of diagnosis, treatment and results.

The Cancer Committee is concerned with the entire spectrum of care for the cancer patients. Specifically, the Committee shall:

(a) Insure that patients have access to consultative services in all disciplines;

(b) Monitor educational programs, conferences, and clinical activities to be sure they cover the entire spectrum of cancer;

(c) Audit patient care and supervise the cancer data for quality control of abstracting, staging, and reporting; and

(d) Actively supervise the cancer data base for quality control of abstracting, staging, and reporting.

14.5-3 Meetings

Monthly and on call.

14.5-4 Reporting

Annually and as needed to the Executive Committee.
14.6 CREDENTIALS COMMITTEE

14.6-1 Composition:

The Credentials Committee shall consist of representatives from all clinical departments. The Chief Executive Officer, or designee, Chief Nursing Officer, Chief Medical Officer, a representative from the Risk Management department and a representative from the House Staff shall serve as ex-officio members. The Staff Office shall serve as permanent secretary of this committee.

14.6-2 Duties

(a) Review the credentials of all applicants and to make recommendations to the Executive Committee for membership and delineation of clinical privileges as recommended by the Department Chairman;

(b) Review credentials of all applicants and to make recommendations to the Executive Committee for delineation of clinical privileges for Allied Health Professionals as recommended by the Department Chairman;

(c) To investigate any breach of ethics that is reported to it by Medical Records Committee, departmental and University Health System Quality/Risk Management Committees;

(d) Review information to include reports that are referred by the Executive Committee, Chief of Staff, a Department Chairman or Chief Executive Officer regarding the competence of Staff members, and as a result of such review, to make recommendations for the granting or removal of privileges to the Executive Committee;

(e) Review pertinent information on current competence and clinical abilities of each individual recommended by the Department Chairman for reappointment and renewal of privileges and to recommend to the Executive Committee for reappointment;

(f) Review and recommend for approval changes in forms utilized in the credentialing process; and

(g) Maintain a record of its proceedings and activities, and submit monthly reports and recommendations to the Executive Committee.

14.6-3 Meetings

Monthly and on call.
14.6-4 Reporting

Monthly to the Executive Committee.

14.7 DRUG UTILIZATION EVALUATION COMMITTEE

14.7-1 Composition

The Drug Utilization Evaluation Committee shall consist of representatives from all clinical departments. Ex-officio members shall include two representatives from Pharmacy Services, one representative each from Administration, Patient Care Services, and House Staff. The Director of Pharmacy Services for University Health System shall be the permanent secretary for the Committee.

14.6-2 Duties

(a) Responsible for the development and surveillance of all drug utilization policies and practices within University Health System;

(b) Assist in the formulation of broad professional policies regarding the evaluation, appraisal, and use relating to drugs in University Health System; and

(c) Serve as an advisory group to the Staff and the Pharmacy Department on matters pertaining to the choice of available drugs.

14.7-3 Meetings

Monthly and on call.

14.7-4 Reporting

Monthly to the Pharmacy and Therapeutics Committee and Quality/Risk Management Committee.
14.8 EXECUTIVE COMMITTEE

14.8-1 Composition

The Executive Committee shall consist of the Officers of the Staff, the Immediate Past-Chief of Staff, Chairman from each Clinical Department, Chief Executive Officer/President of Community Medicine Associates and four Members-at-Large elected from the membership of the Active or Provisional Staff. The President of The University of Texas Health Science Center at San Antonio, the Deans of the Medical and Dental Schools, the Chief Executive Officer and Chairman of the Board of Managers, shall serve as ex-officio members, without vote. Consulting members shall include, but not be limited to, Chief Executive Officer of University Hospital, Chief Medical Officer, Chief Nursing Officer, appropriate CMA Medical Leadership, Designated Institutional Official for Graduate Medical Education, directors of Clinical Centers, and the President of the House Staff Council. Other members of the Administrative Staff may attend the meetings at the invitation of the Chief of Staff. The Chief of Staff shall serve as Chairman. In his absence, the Vice-President or the Immediate Past-President of the Staff shall serve, in that order. The Staff Office shall provide administrative support and services to this committee.

14.8-2 Removal of Member

A member of the Executive Committee may be removed from the Committee as follows:

(a) Upon two-thirds majority vote of the Executive Committee, a special meeting may be called to consider or act upon the removal of any member. A member may be removed from the Committee for failure to fulfill his responsibilities while on Committee, physical or mental infirmity to a degree that renders him incapable of fulfilling the duties of the Committee or conduct detrimental to the interests of University Health System and/or Staff.

(b) Removal of a member during his term of Committee membership may be initiated by a two-thirds majority vote of Committee members, but no such removal shall be effective unless, and until, it has been ratified by the Board of Managers.

14.8-3 Duties

(a) Represent and act on behalf of the Staff subject to such limitations as may be imposed by these Bylaws;

(b) Coordinate the activities and general policies of the various departments;
(c) Receive and act upon committee reports;

(d) Implement policies of the Staff;

(e) Provide liaison between the Staff and the Chief Executive Officer and the Board of Managers;

(f) Recommend action to the Chief Executive Officer on matters of medico-administrative nature, and make recommendations on University Health System management matters to the Board of Managers through the Chief Executive Officer;

(g) Fulfill the Staff accountability to the Board of Managers for the medical care rendered to patients;

(h) Review the credentials and privileges of all applicants and to recommend to the Board of Managers appointment to the Staff, assignments to departments and delineation of clinical privileges;

(i) Review periodically all information available regarding the performance and clinical competence of Staff members and other practitioners with clinical privileges, and as a result of such reviews, to make recommendations for reappointment and renewal or changes in clinical privileges;

(j) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Staff including the initiation of and/or participation in Staff corrective or review measures when warranted;

(k) Ensure that the Staff is kept abreast of the accreditation program and informed of the accreditation status of University Health System;

(l) At its next regular meeting, following the receipt of a report required under section 3.1-1, review such report and make a recommendation to the Board of Managers for appropriate action, including investigation, limiting privileges or suspension of privileges;

(m) Enhance patient care through ongoing objective assessment of important aspects of patient care and the correction of identified needs or concerns;

(n) Fulfills the responsibility and duties as delineated in the Quality Improvement Plan approved by the Executive Committee of the Staff and the Board of Managers;

(o) Review and approve amendments to these Bylaws;
(p) Recommends the clinical services to be provided by telemedicine;

(q) Ensures that the Staff communicates about the safety and quality of patient care and the educational needs and performance of the House Staff; and

(r) The Medical-Dental Staff Executive Committee acts on behalf of the organized medical staff between medical staff meetings.

14.8-4 Meetings

The Committee will meet as often as necessary to expeditiously conduct its business, but at least 10 times per year.

14.8-5 Reporting

Monthly to the Board of Managers.

14.9 INFECTION CONTROL COMMITTEE

14.9-1 Composition

The Infection Control Committee shall consist of representatives from all clinical departments and University Health System Epidemiologist. Ex-officio members shall include University Health System Epidemiologist, Infection Control and Prevention Director, and University Health System Microbiologist. The Infection Control and Prevention Director shall be the permanent secretary of this Committee.

14.9-2 Duties

(a) Responsible for the surveillance of potential infections;

(b) Investigate and make recommendations for the control and prevention of infections within University Health System facilities and to evaluate and disseminate information concerning the proper use of antibiotics;

(c) Review the analysis of actual infections;

(d) Promotion of a preventative and corrective program designed to minimize infection hazards; and
(e) The supervision of infection control in all phases of the University Health System activities including:

1. Operating rooms, delivery rooms, recovery rooms, special care units;
2. Sterilization procedures by heat, chemicals or otherwise;
3. Isolation procedures;
4. Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment; and
5. Disposal of infectious material.

(f) Consultation with Employee Health, Safety, and Engineering.

14.9-3 Meetings

(a) Monthly and on call.

(b) Should a hazardous condition arise during the interval between the regular meetings of the Committee, a special meeting shall be called by the Chairman upon the request of any member of the Staff. The results of such special meetings shall be communicated to the Chief of Staff in writing and to the Quality/Risk Management Committee at its next meeting.

(c) Should the hazardous condition be of such nature as to require immediate action, this need shall be referred to the Chief of Staff and the Chief Executive Officer who shall institute appropriate action to safeguard patients.

14.9-4 Reporting

Monthly to the Quality/Risk Management Committee.

14.10 INVASIVE PROCEDURE REVIEW COMMITTEE

14.10-1 Composition

The Invasive Procedure Review Committee shall consist of representatives from the Department of Pathology, Obstetrics & Gynecology, Surgery, Medicine, Hospital Dentistry, Orthopaedics, Ophthalmology, Otolaryngology-Head & Neck Surgery, Radiology, Urology, Radiation Oncology, Medicine (Oncology) and Anesthesiology. Ex-officio members shall include Medical Director of Surgical Pathology, Senior Director of Quality Improvement and Accreditation Services, and one representative
14.10-2 Duties

(a) Conduct a review of operative and other invasive procedures that are defined as High Risk that do not meet approved criteria to assure that the procedure/surgery performed is appropriate and of high quality;

(b) Monthly reports and recommendations shall be submitted to the appropriate clinical departments and the Quality/Risk Management Committee; and

(c) All major discrepancies between pre-operative and post-operative (including pathology) diagnoses are stressed.

14.10-3 Meetings

Quarterly.

14.10-4 Reporting

Monthly to the Quality/Risk Management Committee.

14.11 MEDICAL RECORDS COMMITTEE

14.11-1 Composition

The Medical Records Committee shall consist of representatives from each of the Clinical Departments. Ex-officio members shall include one representative from Patient Care Services, Medical Records, and House Staff. The Senior Director of Health Information Services shall be the permanent secretary for the committee.

14.11-2 Duties

(a) Responsible for assuring that all medical records meet the highest standards of patient care, usefulness, and historical validity;

(b) Responsible for assuring that all of the medical records reflect realistic documentation of medical events, properly describe the condition and progress of the patient, and the results of therapy provided;
(c) Responsible for overseeing record review process of discharged patients to determine the promptness, clinical pertinence, adequacy and completeness of the record. Receives reports and makes recommendations to improve overall patient care;

(d) Report to the Executive Committee any persistent or habitual delinquency in completion of records and recommend such action as it deems appropriate; and

(e) Approve new and revised medical record forms and make recommendations relative to any changes in the format of the record, as well as to its proper filing, indexing, storage, and availability.

14.11-3 Meetings

Monthly and on call.

14.11-4 Reporting

Monthly to the Executive Committee.

14.12 NOMINATING COMMITTEE

14.12-1 Composition

Shall be Chaired by the Past President, or designee, and includes two (2) members of the Executive Committee appointed by the Chief of Staff who consent to serve. The Staff Office shall serve as permanent secretary of this committee.

14.12-2 Duties

(a) Select at least one nominee for the offices of President, Vice-President, Secretary and two nominees for Member-at-Large in even numbered years; and

(b) Select at least two nominees for member-at-large in odd-numbered years.

14.12-3 Meetings

Annually.

14.12-4 Reporting

Annually and as needed to the Executive Committee.
14.13 OPERATING ROOM COMMITTEE

14.13-1 Composition

The Operating Room Committee shall consist of representatives of all Divisions of Surgery, Departments of Anesthesiology, Cardiothoracic Surgery, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Oral & Maxillofacial Surgery, Orthopaedics, Otolaryngology-Head & Neck Surgery, Pathology Administration and Urology. University Health System administration shall be represented by the Chief Executive Officer of University Hospital and the Chief Medical Officer. The Operating Room shall be represented by the Director of Perioperative Services, Director of Perioperative Supply, the Patient Care Coordinators of the Operating Rooms, Operating Room Scheduling Manager and the Operating Room Operations Manager.

14.13-2 Duties

(a) Respond to any problems or questions presented relating to the Operative and Perioperative areas;

(b) Formulate policy for the proper and orderly function of the operating rooms;

(c) Review and analyze the services rendered in the Operative and Perioperative areas of University Health System facilities;

(d) Recommend to the Chief Executive Officer, through the Executive Committee, any changes in policy or modifications in scheduling deemed necessary to improve the activity of the Operative and Perioperative areas; and

(e) Provide recommendations for the acquisition of new equipment and for modification of staffing to provide for maximum efficiency and to assure optimal facilities are provided for the highest quality of patient care.

14.13-3 Meetings

Monthly and on call.

14.13-4 Reporting

Annually to the Executive Committee.
14.14 PHARMACY AND THERAPEUTICS COMMITTEE

14.14-1 Composition

The Pharmacy and Therapeutics Committee shall consist of representatives from all clinical departments. Ex-officio members shall include two representatives from Pharmacy Services, one representative from Administration, Patient Care Services, and the House Staff. The Director of Pharmacy Services for University Health System shall be the permanent secretary for the Committee.

14.14-2 Duties

(a) To determine policies governing the operation of the Pharmacy and to deal with other matters of a pharmaceutical nature as may arise from time to time;

(b) Develop and review periodically a formulary or drug list for use in University Health System facilities;

(c) Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

(d) Evaluate clinical data concerning new drugs or preparations requested for use in the University Health System facilities;

(e) Establish standards and approve usage and control of non-formulary drugs; and

(f) Consider various changes and additions to the Diet Manual and review the standards for nutritional patient care.

14.14-3 Meetings

Monthly and on call.

14.14-4 Reporting

Monthly to the Quality/Risk Management Committee.
14.15 QUALITY/RISK MANAGEMENT COMMITTEE

14.15-1 Composition

The Quality/Risk Management Committee shall be a standing committee of the Staff composed of one (1) ad hoc non-voting member of the Board of Managers and such members of the Staff, University Health System staff, assistants or other persons or organizations that serve the Committee. Members shall be determined by the Chief of Staff and the Chief Executive Officer. The membership shall be reviewed at least annually. The Risk Management department serves as the permanent secretary for this committee.

14.15-2 Duties

The Quality/Risk Management Committee shall conduct itself as a forum to assess and improve the quality of patient care. It shall develop plans for Clinical Quality Improvement/Performance Improvement and Clinical Risk Management (“the Plans”), in accordance with relevant accreditation organizations’ (e.g. The Joint Commission) standards which encourage the application of principles of continuous quality improvement. The Plans shall be submitted for the approval by the Executive Committee and the Board of Managers. Consistent with the above responsibilities, this Committee shall also be responsible for the following:

(a) To coordinate all quality improvement programs in University Health System on an ongoing basis;

(b) Promote interdisciplinary and collaborative activities using statistical quality control techniques;

(c) Promote comparison of performance and outcome to up to date sources;

(d) Receive, review and collate all information regarding quality assurance at prescribed intervals and transmit progress reports to the Board of Managers via the Executive Committee on a regular basis; and

(1) Initiate intensive assessment when undesirable variation in performance is determined; and

(2) Make recommendations on information regarding internal survey for compliance with the Joint Commission’s standards;

(e) Review the results of patient satisfaction surveys;
(f) Receive and review information measuring staffing effectiveness for possible correlation between operation and clinical indicators and patient complaints;

(g) Development of criteria for identifying specific cases with potential risk in the clinical aspects of patient care and safety, and evaluation of these cases;

(h) Correction of problems in the clinical aspects of patient care and safety identified by risk management activities;

(i) Annually design one program to reduce risk in the clinical aspects of patient care and safety;

(j) Through standing, special and ad hoc committees of the Staff, will identify issues and problems relating to the quality of patient care and the operation of the University Health System;

(k) Oversee the derivation, definition and implementation of solutions to those problems identified;

(l) Conduct medical and professional peer review, including evaluation of the qualifications of practitioners, limited healthcare practitioners and allied health professionals and of patient care rendered by those individuals. Professional Peer Review specifically includes, but is not limited to, the evaluation of:

   (1) Accuracy of diagnosis;

   (2) Quality of care rendered;

   (3) Reports made to a medical peer review committee concerning activities under the committee’s review authority;

   (4) Reports by a medical peer review committee to other committees or to the board as permitted or required by law; and

   (5) Implementation of the duties of a medical peer review committee by its members, agents or employees.

14.15-3 Meetings

   Monthly and on call.
14.15-4 Reporting

Monthly to the Executive Committee and Board of Managers.

14.16 RADIATION SAFETY COMMITTEE

14.16-1 Composition

Shall consist of at least four (4) members of the Staff representing the Departments of Pathology, Radiology, Medicine and Surgery, as appointed by the Chief of Staff. Ex officio members shall include Vice President for Operations, Radiation Safety Officer, and Director of Radiology. The Director of Radiology shall be permanent secretary for the committee.

14.16-2 Duties

(a) Review the usage of radioactive isotopes, radiation emitting diagnostic and therapeutic equipment, and any other radioactive sources within University Health System facilities to assure that radiation exposure to patients and personnel remains within recognized permissible limits; and

(b) Make recommendations to maintain compliance with applicable state and federal regulations pertaining to radioactive materials handling, storage and usage.

14.16-3 Meetings

Quarterly and on call.

14.16-4 Reporting

As needed to the Quality/Risk Management Committee.

14.17 RESEARCH COMMITTEE

14.17-1 Composition

The Research Committee shall include three representatives of the Staff active in clinical research, a representative from Patient Care Services, a representative from Pharmacy Services, the Vice President responsible for research, Vice President, University Hospital
14.17-2 Duties

(a) The Committee shall have oversight responsibility for all research conducted within University Health System facilities;

(b) Monitor the implementation of research protocols and participate in quality improvement activities related to clinical research;

(c) Review abstracts of all IRB and University Health System approved research, as well as, audit and monitor data presented by the Research Department. The Committee will review studies for patient/participant risk and request additional information, recommend changes to the protocol or recommend additional study monitoring. The Committee may also recommend that a study not be considered at the Hospital based on the potential risk to the participants;

(d) Review and act on research conducted without required approval(s) or research not conducted according to the approved protocol;

(e) Promote the development of quality clinical research within University Health System and represent research interests within the Staff; and

(f) Advise the Executive Committee on policy matters involving research.

14.17-3 Meetings

Monthly and on call.

14.17-4 Reporting

Annually to the Executive Committee.

14.18 OTHER COMMITTEES

Other committees shall be appointed by the Chief of Staff as may be required to properly carry out the duties of the Staff. The membership, duties, and frequency of meetings shall be subject to approval of the Executive Committee.
ARTICLE XV
MANAGEMENT TEAMS

15.1 PURPOSE

In order to promote an effective, productive, and efficient work environment, management teams will function within University Health System. The initial review and evaluation for problem identification and resolution will be the management team’s function. The management team, for both inpatient and outpatient activity, is best suited to identify problems and trends and take corrective action, ensuring resolution and documentation of all actions taken. The management team is to provide its quality/risk management activities in written form to its associated clinical department for monthly review.

15.2 ORGANIZATION

15.2-1 Organization

The Staff may designate one or more management teams with the authority provided by the Executive Committee to act upon matters pertaining to the administration of specific patient care areas. All Chairman must be members in good standing of the Active or Provisional Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The Chief of Staff appoints members of the clinical management teams with the approval of the Executive Committee and Chief Executive Officer. Ex-officio members of clinical management teams shall be eligible to vote on all matters unless otherwise provided. Members of Staff, Administration, Patient Care Services or other departments of University Health System may be assigned to a clinical management team to serve as a resource. All clinical management teams shall maintain a permanent record of their proceedings and actions. Whenever a clinical management team’s duties and functions include activities related to the evaluation of medical and health care services, including but not limited to, the evaluation of the qualifications and professional conduct of practitioners, limited healthcare practitioners and allied health professionals and/or the quality of patient care being provided, these activities are strictly confidential and privileged as provided by state and federal law.
15.2-2 Appointment of Members and Responsibilities of Management Teams

(a) Appointments to the Management Teams shall be made by the Chief of Staff from recommendations made by the Chairman of each department or the appropriate University Health System vice president. Service shall commence on the first day of January for a term of three years. Consulting members may be added at the discretion of the Chairman with the advice and consent of the Chief of Staff and Chief Executive Officer. Consulting members may serve for an unlimited period. If a member is unable to attend a meeting, another member of the same department or function may substitute with equivalent privileges held by the absent member.

(b) At the first called meeting of the management team each year, the membership of the management team shall elect a chairman, vice-chairman, and secretary except where the positions are designated by the Bylaws.

(c) All management teams shall keep minutes with attendance of its meetings, copies of which shall be forwarded to the Staff office for confidential filing and distribution. The minutes shall also serve as reports to the Quality/Risk Management Committee. In addition, the management teams shall prepare a brief annual report for presentation to the Staff.

15.3 CLINICAL MANAGEMENT TEAMS

Clinical Management Teams will be established consistent with distinct University Hospital service units or service lines. Each of the management teams will establish and operate an effective Clinical Management Team (CMT). The CMT, for both inpatient and outpatient activity, is best suited to identify problems and trends, take corrective action, ensuring resolution and documentation of all actions taken.

15.3-1 Composition:

The Clinical Management Team will consist of a representative from the Staff, nursing leadership of the service unit or service line, a representative from Quality Improvement and Accreditation Services, the operations/unit manager, and other members as deemed necessary. The permanent chairman of this team will be Medical Director of the service unit or service line.

15.3-2 Duties:

(a) Meet to discuss the daily operation of the unit, quality/risk management issues and other items of business as needed;
(b) To provide its quality/risk management activities in written form to its respective clinical department for monthly review and the department of Quality Improvement and Accreditation Services; and

(c) Initial review and evaluation for problem identification and resolution to assure that information from the service unit or service line is used to detect trends, patterns of performance or potential problems.

15.3-3 Meetings
Monthly.

15.3-4 Reporting
As needed to the Quality/Risk Management Committee regarding Quality/Risk Management Issues.

15.4 MANAGEMENT TEAM MEETINGS

15.4-1 Notice of Meetings
Written or verbal notice stating the place, day, and hour of any special or regular meetings, not held pursuant to resolution, shall be given to each member of the Management Team no less than 48 hours before the time of such meetings.

15.4-2 Special Meetings
A special meeting of any Management Team may be called by the Management Team Chairman or the Chief of Staff.

15.4-3 Minutes
Minutes of all regular and special meetings of a Management Team shall be prepared so as to include a record of attendance, the business transacted, and the vote taken on each matter. A record that includes the resultant conclusions, recommendations, and actions taken at each meeting will be maintained in a confidential manner. The minutes shall be signed by the presiding officer and copies thereof shall be promptly submitted to the attendees for approval and, after such approval is obtained, forwarded to Quality Improvement and Accreditation Services office for confidential filing.
15.4-4 Quorum

The members of the Management Team in attendance at a Management Team meeting, but not less than two (2) appointees, shall constitute a quorum.

15.4-5 Manner of Action

The action of a majority of members present at a meeting in which a quorum is present shall be the action of a Clinical Management Team.

ARTICLE XVI
CONFIDENTIALITY, IMMUNITY, LIABILITY, AND RELEASES

16.1 AUTHORIZATIONS AND CONDITIONS

By applying for Staff membership or privileges, or exercising clinical privileges or providing specified patient care services, an individual:

(a) Authorizes representatives of University Health System Administration and the Staff to solicit, provide and act upon information bearing on his/her professional ability and qualifications;

(b) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative or third party who acts in accordance with the provisions of this Article and or other provisions of the Staff Bylaws, and Rules and Regulations of University Health System; and

(c) Acknowledges that the provisions of this Article are express conditions to his application for and acceptance of Staff membership, or his exercise of clinical privileges or provision of specified patient services at any University Health System facility.

16.2 CONFIDENTIALITY OF INFORMATION

Information with respect to any individual submitted, collected or prepared by any representative of this or any other health care facility or organization or Staff in connection with the quality assurance or credentialing activities at University Health System facilities shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than as required by law or used in any way except as provided pursuant to these Bylaws. Such confidentiality shall also extend to information
of like kind that may be provided by third parties. This information shall not become part of any particular patient's medical record or of records made or maintained in the regular course of the University Health System's business.

16.3 INDEMNITY

To the extent authorized by the TEX. CIV. PRAC. & REM CODE §§ 104.001 et seq., as amended, Staff members may be eligible for indemnification from the State of Texas for actual damages, court costs and attorney's fees incurred as a result of certain acts or omissions performed in the course and scope of carrying out a Staff members' responsibilities.

16.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health related institution's or organization's activities 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) Corrective action;

(d) Hearing and appellate reviews;

(e) Patient care audits;

(f) Utilization review;

(g) Quality assurance;

(h) Other University Health System, Department, Section, or Committee activities related to monitoring and maintaining quality care and appropriate professional conduct; and

(i) Review and evaluation of patient claims and complaints.

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to an individual's professional qualifications,
clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or any other matter relating to competence or professional conduct that might directly or indirectly affect patient care.

16.5 RELEASES

Each practitioner and allied health professional shall, upon request of University Health System, execute general and specific releases in accordance with the provisions, tenor, and import of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

16.6 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE XVII
GENERAL PROVISION

17.1 STAFF RULES AND REGULATIONS

Subject to approval by the Board of Managers, the Executive Committee, on behalf of the Medical-Dental Staff, shall adopt and amend such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. Changes to the Rules and Regulations shall be communicated to the Medical-Dental Staff by the members of the Executive Committee.

17.2 DEPARTMENT AND SECTION POLICIES

Subject to the approval of the Executive Committee and the Board of Managers, each department, section or other clinical unit will formulate its own written policies concerning the conduct of its affairs and the discharge of its responsibilities.
17.3 CONSTRUCTION OF TERMS AND HEADINGS

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

ARTICLE XVIII
AMENDMENTS

These Bylaws may be amended, or repealed by the Staff provided that a notice of such proposed amendment or repeal is sent to all Staff with voting privileges, who then vote to adopt the proposed amendment or repeal. A adoption or amendment of the Medical-Dental Staff Bylaws cannot be delegated. The notice shall include the exact wording of the proposed addition or amendment, if applicable, and a written ballot shall be included providing the member the opportunity to vote. In order to enact a change, the affirmative vote of a majority of the active Staff members who vote on such change. If the vote is by mail, for purposes of quorum and vote, only those ballots received within thirty (30) days of the sending of the notice and ballot shall be counted. Changes adopted by the Staff shall become effective only after approval by the Board of Managers. Changes to these Bylaws may be proposed by any member of the Staff by written request to the Executive Committee. In cases of a documented need for an urgent amendment to rules and regulations of the Medical-Dental Staff which is necessary in order to comply with a law or regulation, the Executive Committee, as delegated to do so by the Staff with voting privileges, may provisionally adopt an urgent amendment without prior notification of the Medical-Dental Staff. The Board of Managers may then provisionally approve an urgent amendment. In such cases, the Medical-Dental Staff will be immediately notified by the Chief of Staff. The Medical-Dental Staff shall have the opportunity for retrospective review of and comment on the provisional amendment for a thirty (30) day period post the action on the provisional amendment.

If, after the thirty (30) day period has elapsed and there is no comment indicating a conflict between the Medical-Dental Staff and the Executive Committee, the provisional amendment stands.

If there is comment indicating conflict over the provisional amendment, the conflict resolution process as provided for in Article XIX is implemented. If, as a result of this process a revised amendment is necessary, it will be presented to the Board of Managers for action.

All provisional and/or revised amendment(s) shall be submitted to the Board of Managers for final action.
ARTICLE XIX
CONFLICT MANAGEMENT

19.1 CONFLICT MANAGEMENT

19.1-1 Criteria for Initiation

A conflict management process will be implemented when a conflict arises between the Medical-Dental Staff and the Executive Committee on issues including, but not limited to, proposals to adopt a revision to or amendment of a rule, regulation, policy or these Bylaws.

19.2 PROCESS

19.2-1

The Executive Committee, in partnership and collaboration with the Medical-Dental Staff, will make every effort to resolve all conflicts informally at the Executive Committee level. These efforts shall include a meeting between the involved parties as early as possible to identify the conflict, gathering information about the conflict, working with all parties to manage and to the extent possible, resolve the conflict, and ultimately protect patient safety and quality of care.

In the event the informal process is unsuccessful in resolving the conflict, the Executive Committee or Chief of Staff shall call a special meeting of the Staff as provided for in Article XIII, Special Meetings.

During the specially called meeting of the Staff, which will be led by the Chief of Staff, attempts will be made to resolve the conflict by those members of the Staff in attendance. Recommendations for resolving the conflict that are made at the specially called meeting will be voted on as provided in these Bylaws and submitted to the Board of Managers for final action when necessary.

[END OF BYLAWS—SIGNATURE PAGE Follows]
Adopted by the Staff on the __________ day of ____________________________, 2015.

_________________________________  ______________________________
President, Medical-Dental Staff   Secretary, Medical-Dental Staff

Approved by the Board of Managers on the 25th day of August, 2015.

__________________________________
Chairman, Board of Managers