MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF COVENANT HEALTH

COVENANT MEDICAL CENTER MEDICAL STAFF ORGANIZATION MANUAL

Adopted by the Medical Staff: November 28, 2017
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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Credentials Policy.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Manual is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee is bound by all the terms, conditions and requirements of this Manual. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Manual.

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

ARTICLE 2

CLINICAL DEPARTMENTS

2.A. LIST OF DEPARTMENTS AND SECTIONS

The following clinical departments and sections are established:

- Medicine
  - Cardiology
  - Gastroenterology
  - Internal Medicine
  - Nephrology
  - Pathology
  - Psychiatry
  - Radiology
- Surgery
  - Anesthesiology
    - Pain Management
  - Dental
  - Emergency Medicine
  - Neurosurgery
  - Obstetrics and Gynecology
  - Ophthalmology
  - Orthopedic Surgery
  - Otorhinolaryngology
  - Surgery (general, plastic, and transplant)
    - Hand Surgery
  - Thoracic and Cardiovascular Surgery
  - Trauma
  - Urology

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND SECTIONS

The functions and responsibilities of departments, sections, department chairs, and section chiefs are set forth in Article 4 of the Medical Staff Bylaws.

2.C. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS AND SECTIONS

(1) Clinical departments and sections shall be created and may be consolidated or dissolved by the MEC upon approval by the Board as set forth below.

(2) The following factors shall be considered in determining whether a clinical department or section should be created:

(a) there exists an adequate number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department or section (this number must be sufficiently large to enable the department or section to accomplish its functions as set forth in the Bylaws);

(b) the level of clinical activity that will be affected by the new department or section is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;

(c) a majority of the voting members of the proposed department or section vote in favor of the creation of a new department or section;

(d) it has been determined by the Medical Staff leadership and the CMO that there is a clinical and administrative need for a new department or section; and

(e) the voting Medical Staff members of the proposed department or section have offered a reasonable proposal for how the new department or section will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) The following factors shall be considered in determining whether the dissolution of a clinical department or section is warranted:

(a) there is no longer an adequate number of active members of the Medical Staff in the clinical department or section to enable it to accomplish the functions set forth in the Bylaws and related policies;

(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department or section;

(c) the department or section fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as chair of the department or chief of the section; or

(e) a majority of the voting members of the department or section vote for its dissolution.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of the Hospital that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Procedures for the appointment of committee chairs and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

(3) This Article details the standing members of each Medical Staff committee. However, other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Staff committee meeting in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. All such individuals are an integral part of the credentialing, quality assurance, and professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of such committees.

3.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical Staff committee, members must acknowledge and agree to the following:

(1) have the willingness and ability to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent upon the full participation of its members;

(2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;

(3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee's functions may be performed in an informed, efficient, and effective manner;

(4) attend meetings on a regular basis to promote consistency and good group dynamics;

(5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid off-topic or sidebar conversations;

(6) voice disagreement in a respectful manner that encourages consensus-building;

(7) understand and strive for "consensus" decision-making, thereby avoiding the majority vote whenever possible;

(8) speak with one voice as a committee and support the actions and decisions made (even if they were not the individual's first choice);

(9) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

(10) bring any conflicts of interest to the attention of the committee chair, in advance of the committee meeting, when possible;

(11) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the committee chair outside of committee meetings;

(12) participate in the development of an annual committee work plan and ensure that committee plans are in alignment with the strategic goals of the Hospital and Medical Staff; and

(13) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

3.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated in this Manual.

3.D. BYLAWS COMMITTEE

3.D.1. Composition:

The Bylaws Committee shall consist of at least six members of the Medical Staff with experience in Medical Staff issues, including the Chief of Staff, Vice Chief of Staff, and the Immediate Past Chief of Staff.

3.D.2. Duties:

The Bylaws Committee shall:

(a) review the Medical Staff Bylaws, Credentials Policy, Policy on Advance Practice Providers, and the Medical Staff Rules and Regulations at least every three years and make recommendations for appropriate amendments and revisions; and

(b) receive and consider all recommendations for changes to these documents made by any committee or department of the Medical Staff, any individual appointed to the Medical Staff, and/or senior administration.

3.E. CENTRALIZED CREDENTIALS COMMITTEE

3.E.1. Composition:

The Centralized Credentials Committee is a joint committee responsible for both Covenant Medical Center and Covenant Children's Hospital. It shall consist of at least six members of the CMC Medical Staff, with preference given to individuals who have served in Medical Staff leadership positions and/or who have a particular interest in the credentialing functions, plus the CCH Chief of Staff and a member of the CCH Medical Staff appointed by the CCH Chief of Staff. *Ex officio* members, without vote, shall include the Vice President of Medical Affairs and the CMO. An attorney who represents the Medical Staff shall also be an *ex officio* member, without vote.

3.E.2. Duties:

The Centralized Credentials Committee shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) in accordance with the Policy on Advance Practice Providers, review the credentials of all applicants seeking to practice as Category I and Category II practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(c) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Advance Practice Providers and, as a result of such review, make a written report of its findings and recommendations;

(d) review and approve specialty-specific data elements for ongoing professional practice evaluation and specialty-specific triggers for focused professional practice evaluation that are identified by each department; and

(e) review and make recommendations regarding privilege criteria for existing and new procedures within the Hospital, including specifically as set forth in Section 4.A.3 ("Clinical Privileges for New Procedures") and Section 4.A.4 ("Clinical Privileges That Cross Specialty Lines") of the Credentials Policy.

3.F. COMMITTEE ON PROFESSIONAL ENHANCEMENT ("CoPE")

3.F.1. Composition:

(a) The CoPE shall be comprised of at least nine members of the Active Staff nominated by the Leadership Council and approved by the Board.

(b) Members shall be appointed to serve initial three-year terms. To the fullest extent possible, CoPE members shall serve staggered, three-year terms, so that the committee always includes experienced members. Following the end of the first term, each member may be eligible for reappointment by the Leadership Council with Board approval for a subsequent three-year term. An individual may serve two consecutive terms and then must take a one-year hiatus from membership. Following this hiatus, the individual is eligible for reappointment according to the terms above. All appointments/reappointments will be based on a term of three years. A commencement date of January 1 of the current calendar year will be applied to all terms, regardless of actual date of appointment. Terms are based on a calendar year (January 1 – December 31). If attrition or premature termination of current term occurs, leaving insufficient membership, the Chief of Staff may make adjustments to the membership term/rotation scheduled. The members may vote on all matters coming before the Committee except that a member presenting a review may not vote on that matter.

(c) The following additional members shall also serve as voting members of the CoPE: CMC Vice Chief of Staff, CCH Vice Chief of Staff, CMC Department of Surgery Chair, CMC Department of Medicine Chair, Centralized Credentials Committee Chair, Director of Trauma Services, and the Chair of the Emergency Care Committee.

(d) The CoPE is chaired by the CMC Immediate Past Chief of Staff.

(e) Grounds for removal/replacement of a physician reviewer include, but shall not be limited to:

(1) failure to regularly participate in peer reviews and meetings;

(2) breach in confidentiality (must keep confidential any records, documents, information or names of anonymous reviewers other than oneself); and

(3) a pattern of inadequate performance in reviews.

(f) Other Medical Staff members or Hospital personnel may be invited to attend a particular CoPE meeting (as guests, without vote) in order to assist the CoPE in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the CoPE.

3.F.2. Duties:

The CoPE shall:

(a) oversee the implementation of the Professional Practice Evaluation Policy (Peer Review) ("PPE Policy") and ensure that all components of the process receive appropriate training and support;

(b) review reports showing the number of cases being reviewed through the PPE Policy, by department or specialty, in order to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;

(c) review, approve, and periodically update ongoing professional practice evaluation ("OPPE") quality data elements that are identified by departments and sections, and adopt Medical Staff-wide data elements;

(d) review, approve and coordinate the periodic update of the specialty-specific quality indicators that will trigger the professional practice evaluation/peer review process;

(e) identify those variances from rules, regulations, policies, or protocols which do not require physician review, but for which an Informational Letter may be sent to the practitioner involved in the case;

(f) review cases referred to it as outlined in the PPE Policy;

(g) develop, when appropriate, Performance Improvement Plans for practitioners, as described in the PPE Policy;

(h) receive reports of system or process concerns that have been referred to the appropriate Hospital department or to the Quality Support Staff, and keep those

system or process issues on its agenda until notification is received that the issue has been successfully resolved;

(i) work with department chairs to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through education sessions in the department or through some other mechanism;

(j) periodically review the effectiveness of the PPE Policy and recommend revisions or modifications as may be necessary; and

(k) perform any additional functions as may be requested by the Leadership Council, the MEC, or the Board.

3.F.3. Meetings and Reports:

The CoPE shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The CoPE shall submit reports of its activities to the MEC and the Board on a regular basis.

3.G. CONTINUING MEDICAL EDUCATION COMMITTEE

3.G.1. Composition:

The Continuing Medical Education Committee shall consist of at least six members of the Medical Staff. The chair and the other members shall be appointed by the Leadership Council. The chair shall serve a two-year term and the members shall serve staggered four-year terms.

3.G.2. Duties:

(a) The Continuing Medical Education Chair shall resolve conflicts of interest for committee members and activity directors.

(b) The Continuing Medical Education Committee shall:

(1) review educational requests, determine the educational needs of the Medical Staff and develop programs to address those requests and needs;

(2) approve, oversee and review Hospital-provided educational activities;

(3) confirm that educational programs are free of commercial bias and conflicts of interest;

(4) ensure that education programs comply with the Hospital's values, policies and procedures;

(5) provide recommendations and feedback to activity directors;

(6) determine appropriate speaker honorarium; and

(7) provide quarterly reports to the Quality Review Committee.

3.H. EMERGENCY DEPARTMENT CALL COVERAGE AND TRANSFER REVIEW COMMITTEE

3.H.1. Composition:

(a) The Emergency Department Call Coverage and Transfer Review Committee shall consist of the department chairs and Chiefs of Staff of both Covenant Medical Center and Covenant Children's Hospital; at least five members of the CMC Active Medical Staff; the Medical Director(s) for the Emergency Departments(s); the Medical Director for Trauma Services; and representatives of the Hospital staff and administration with responsibilities involving the emergency transfer of patients and/or acceptance of such transfers.

(b) The physician members of the committee will be appointed by the Covenant Medical Center Chief of Staff, in consultation with administration, and will include members from each specialty participating in the call program.

(c) The members of the CMC Active Medical Staff will serve staggered terms to provide continuity. One half of the appointees will be in Group A and one half in Group B. The initial term for Group A will be one year and all subsequent terms for both groups will be two years. Committee members may be reappointed and serve consecutive terms. Service on this committee is not compensated. In the event a committee member cannot attend a meeting, the section may provide an alternate with the approval of the Chief of Staff.

3.H.2. Duties:

The Emergency Department Call Coverage and Transfer Review Committee, which has oversight for both Covenant Medical Center and Covenant Children's Hospital, shall:

(a) serve as a joint committee of the Medical Staff and administration responsible for the oversight and implementation of strategies, policies, and procedures regarding emergency department non-trauma call coverage and transfer issues affecting Covenant Health System and its Medical Staffs for the provision of medical care to the unassigned patients of our region;

(b) recommend to the MEC and CEC all policies and procedures governing the Medical Staff and operations relating to the effectiveness of emergency department call coverage;

(c) recommend to administration and the Board of Directors regarding compensation methodology and budgets for physician call compensation as a group and within individual specialties. Committee oversight encompasses Covenant Medical Center and Covenant Children's Hospital;

(d) review all transfers and receipt of transfers of emergency patients;

(e) assess all questionable unaccepted transfers with Lubbock and regional facilities for effective and appropriate physician response and initiate inquiry and appropriate action related to questionable Hospital or physician issues;

(f) review transfer reports to monitor compliance with Medical Staff and Hospital policies and procedures and applicable law and recommend corrective measures or reporting, as indicated, in accordance with these applicable policies and procedures and/or governing law;

(g) determine sanctions or penalties for noncompliance with these policies or for repeated inappropriate refusal of transfer by a member of the call rotation;

(h) assist in obtaining call coverage for any specialty unable to provide coverage due to physician shortage or insufficient response;

(i) provide input into compensation methodology, contracts, and budgets to ensure call coverage continuity;

(j) provide physician leadership and intervention for contract resolution within specific specialties;

(k) monitor the clinical quality of positions and specialties under contract ED call coverage;

(l) review and make recommendations as needed regarding those physicians who exhibit continuing patterns of an unacceptable quality, responsiveness, or behavior;

(m) assist with decisions regarding staffing needs for ED call coverage rotation; and

(n) assess potential EMTALA violations by regional facilities and assist with CHS response to such infractions.

3.I. GRADUATE MEDICAL EDUCATION COMMITTEE

3.I.1. Composition:

The Graduate Medical Education Committee shall consist of the Medical Director for Education and Research, the TTUHSC Residency Directors and Covenant Health

Medical Directors from specialties with current affiliation agreements, the Chief of Staff and/or CMO, Covenant Medical Center, and the Chief of Staff and/or CMO, Covenant Children's Hospital.

3.I.2. Duties:

The Graduate Medical Education Committee shall:

(a) meet to discuss and communicate regularly about the safety and quality of patient care provided by interns, residents, and fellows and their related educational and supervisory needs;

(b) periodically communicate with the Quality and Patient Safety Committee of the Board of Directors about the educational needs and performance of interns, residents, and fellows; and

(c) submit a comprehensive report to the QRC and the MEC on the educational needs and performance of interns, residents, and fellows on an annual basis.

3.J. LEADERSHIP COUNCIL

3.J.1. Composition:

(a) The Leadership Council shall be comprised of the following voting members:

(1) Chief of Staff, who shall serve as Chair of the Committee;

(2) Vice Chief of Staff;

(3) Immediate Past Chief of Staff (who also serves as Chair of the Committee on Professional Enhancement ("CoPE")); and

(4) CMO.

(b) Medical Staff/Quality Support staff representatives shall serve as *ex officio* members, without vote, to facilitate the Leadership Council's activities.

(c) Other Medical Staff members or Hospital personnel may be invited to attend a particular Leadership Council meeting (as guests, without vote) in order to assist the Leadership Council in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the Leadership Council review process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.J.2. Duties:

The Leadership Council shall perform the following functions:

(a) review and address concerns about practitioners' professional conduct as outlined in the Medical Staff Professionalism Policy;

(b) review and address possible health issues that may affect a practitioner's ability to practice safely as outlined in the Practitioner Health Policy;

(c) review and address issues regarding practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy (Peer Review);

(d) advise the Chief of Staff on the appointment of the members of the CoPE;

(e) identify candidates for Medical Staff Officers and provide input to the Chief of Staff in the appointment of members and chairs of Medical Staff committees;

(f) meet, as necessary, to consider and address any situation involving a practitioner that may require immediate action;

(g) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;

(h) process requests for reinstatement from leaves of absence and automatic relinquishments received from members of the Medical Staff and Advance Practice Providers; and

(i) perform any additional functions as may be requested by the CoPE, the MEC, or the Board.

3.J.3. Meetings, Reports, and Recommendations:

The Leadership Council shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The Leadership Council shall report to the CoPE, the MEC, and others as described in the Policies noted above.

3.K. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the MEC are set forth in Section 5.D of the Medical Staff Bylaws.

3.L. PHYSICIAN HEALTH AND WELLNESS COMMITTEE

3.L.1. Composition:

The Physician Health and Wellness Committee shall be comprised of a maximum of six members of the Medical Staff.

3.L.2. Duties:

The Physician Health and Wellness Committee shall:

(a) provide education about practitioner health and address prevention of physical, psychiatric, or emotional illnesses;

(b) facilitate and encourage self-referrals as well as confidential impairment referrals by other medical or Hospital staff (reporting may be directly to the Chief of Staff or to a member of this committee);

(c) facilitate the confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition;

(d) develop, implement, and annually review policies for the evaluation and monitoring of potentially impaired Medical Staff members and Advance Practice Providers, to include, without limitation, testing and monitoring for use of illicit drugs, non-therapeutic mind altering substances, and alcohol;

(e) receive regular reports of status, treatment, and prognosis of physicians from the facility or practitioner responsible for evaluation and rehabilitation of the physician;

(f) evaluate, provide a course of action, and provide monitoring as needed for any member of the Medical Staff or Advance Practice Provider who experiences or suffers from any impairment or other significant health issue with the potential to affect the individual's ability to provide services to the patients of this Hospital;

(g) advise Medical Staff leadership of instances in which a physician is unwilling to accept assistance or is non-compliant in the treatment program and recommend appropriate action;

(h) assist impaired practitioners in the process of rehabilitation while protecting the welfare of patients; and

(i) present a report on its activities annually to the MEC.

3.M. QUALITY REVIEW COMMITTEE

3.M.1. Composition:

The Quality Review Committee shall be comprised of at least 12 members of the Medical Staff who shall be appointed taking into consideration the plan for improving organization performance. The Immediate Past Chief of Staff shall serve as the Chair. The Vice President of Medical Affairs and the CMO shall be *ex officio* members of the committee, without vote.

3.M.2. Duties:

The Quality Review Committee shall:

(a) be responsible for oversight of the following activities and review functions, which may be delegated by the Committee to appointed subcommittees:

(1) Blood Usage/Pathology Review

(2) Infection Control

(3) Intensive Care Units

(4) Laser Safety

(5) Medical Records

(6) Pharmacy & Therapeutics

(7) Committee on Professional Enhancement

(8) Radioisotope and Radiation Safety

(9) Transplant

(10) Risk Management

(11) Utilization Review

(12) Sentinel Event and RCA Review;

(b) provide oversight of all Medical Staff Quality Improvement activities;

(c) receive and assess Quality Improvement reports from combined Hospital/Medical Staff committees;

(d) assess and assign Medical Staff members to cross-functional teams;

(e) coordinate and prioritize Quality Improvement efforts between all Medical Staff departments, sections, and combined Hospital/Medical Staff committees to minimize duplication of efforts;

(f) participate in identifying and recommending processes, functions, and dimensions of performance that warrant cross-functional efforts for improvement;

(g) report improvement activities to the MEC, as appropriate;

(h) analyze utilization review and risk management activities;

(i) communicate and recommend to the MEC optimum utilization of Hospital resources and facilities commensurate with quality patient care and safety;

(j) charter cross-functional Medical Staff teams to address process issues;

(k) annually evaluate quality, utilization, and risk management programs for effectiveness, and revise as appropriate;

(l) provide oversight of reviews by Peer Review Organization (PRO) and third-party payers when criteria are not met;

(m) take appropriate action when improvement opportunities are identified, assess the action taken for effectiveness, and evaluate results;

(n) define purpose and objective of committee;

(o) provide oversight for optimum utilization of Hospital resources and facilities commensurate with quality patient care and safety; and

(p) provide oversight for departments in acting and evaluating the effectiveness of such actions when improvement opportunities are identified.

ARTICLE 4

AMENDMENTS

(a) This Manual may be amended by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists.

(b) Notice of all proposed amendments shall be provided to each Active Staff member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place, and any Active Staff member may submit written comments on the amendments to the MEC.

(c) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein, and henceforth all department and committee activities of the Medical Staff and of each individual serving as a member of a department or staff committee shall be undertaken pursuant to the requirements of this Manual.

Adopted by the Medical Staff: November 28, 2017

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