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

COVENANT HEALTH PLAINVIEW MEDICAL STAFF ORGANIZATION MANUAL

Adopted by the Medical Staff: April 11, 2022
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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

The following clinical departments are established:

Medicine
Surgery
OB/Peds
ER/Trauma

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS

The functions and responsibilities of departments and department chairs are set forth in the Medical Staff Bylaws.

2.C. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

(1) Clinical departments 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 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 (this number must be sufficiently large to enable the department to accomplish its functions as set forth in the Bylaws);

(b) the level of clinical activity that will be affected by the new department 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 vote in favor of the creation of a new department;

(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 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;

(c) the department 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

(e) a majority of the voting members of the department 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) 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 be chaired by the Immediate Past Chief of Staff and will consist of the Chief of Staff and Chief Medical Officer in addition to the department chairs. Additional individuals may be invited as needed.

3.D.2. Duties:

The Bylaws Committee shall:

(a) review the Medical Staff Bylaws and policies 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. It shall consist of the Covenant Health Plainview Department Chairs and/or Credentials Chair. *Ex officio* members, without vote, shall include 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) 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;

(c) 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

(d) 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. PEER REVIEW COMMITTEE ("PRC")

3.F.1. Composition:

(a) The PRC shall be comprised of at least three members of the Active Staff nominated by the active members of the medical staff and approved by the Board.

(b) Members shall be appointed to serve initial two-year terms. Following the end of the first term, each member may be eligible for reappointment by the active medical staff with Board approval for a subsequent two-year term. An individual may serve two consecutive terms and then must take a two-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 two years. A commencement date of July 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 (July 1 – June 30). 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 PRC is chaired by the Vice Chief of Staff.

(d) 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.

(e) Other Medical Staff members or Hospital personnel may be invited to attend a particular PRC meeting (as guests, without vote) in order to assist the PRC 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 PRC.

3.F.2. Duties:

The PRC 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) 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;

(e) review cases referred to it by a Department Chair, CMO or MEC;

(f) develop, when appropriate, Performance Improvement Plans for practitioners;

(g) review utilization of blood products;

(h) participate in the evaluation of the Utilization Review Plan;

(i) monitor the discharge-planning program to assure timely discharge planning activities are completed;

(j) 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;

(k) 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;

(l) review mortalities; and

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

3.F.3. Meetings and Reports:

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

3.G. EMERGENCY SERVICES/TRAUMA COMMITTEE

3.H.1. Composition:

(a) The Emergency Services and Trauma Committee shall consist of the ER/Trauma Department Members which include at least 3 active members of the Medical Staff. The Committee will be chaired by the Department Chair.

(b) Other Medical Staff members or Hospital personnel may be invited to attend a particular meeting (as guests, without vote) in order to assist the committee 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.

3.H.2. Duties:

The Emergency Services/Trauma Committee, shall:

(a) monitor, evaluate and improve the care delivered in the Emergency Room;

(b) review the effectiveness of emergency department call coverage;

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

(d) recommend standards of professional performance within the Emergency Room;

(e) evaluate the quality, safety, and appropriateness of emergency patient care and institute appropriate action based on the findings of the review activities;

(f) monitor the clinical quality of specialties under contract ED call coverage;

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

(h) ensure that the trauma care activities in the hospital are an integrated and comprehensive system;

(i) establish clinical indicator screening criteria for the trauma service;

(j) act in such related matters as may be assigned to it by the MEC; and

(k) assess potential EMTALA violations.

3.H. LEADERSHIP COUNCIL

3.H.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; 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.H.2 Duties:

The Leadership Council shall perform the following functions:

(d) review and address concerns about practitioners' professional conduct;

(e) review and address possible health issues that may affect a practitioner's ability to practice safely;

(f) provide input to the Chief of Staff in the appointment of members and chairs of Medical Staff committees;

(g) nominate the Vice Chief of Staff;

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

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

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

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

3.J.2. 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.

3.I. MEDICAL EXECUTIVE COMMITTEE

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

3.J. PHARMACY AND THERAPEUTICS COMMITTEE

3.N.1 Composition:

The Pharmacy and Therapeutics Committee is a joint committee of the Medical Staff and Covenant Health System. It represents the system as a regional committee consisting of representatives from each entity in the system. It also serves as the Pharmacy and Therapeutics Committee of Covenant Medical Center.

The Committee Chair is the Covenant Medical Center Director of Pharmacy. Regional Representation will be determined by the Chief of Staff and Chief Medical Officer of each entity with the nomination of one physician and one pharmacist committee member. Physician members of the committee from Covenant Medical Center will be appointed by the Chief of Staff and the Committee Chair with input from the Leadership Council.

Committee Chair – Voting Member
Physician Regional Representative, CCH – Voting Member Pharmacist
Regional Representative, CCH – Voting Member Physician Regional
Representative, CSH – Voting Member Pharmacist Regional
Representative, CSH – Voting Member Physician Regional
Representative, LVL – Voting Member Pharmacist Regional
Representative, LVL – Voting Member Physician Regional
Representative, PLV – Voting Member Pharmacist Regional
Representative, PLV – Voting Member Physician Regional
9 (nine) Covenant Medical Center Physicians – Voting Members
Medication Safety Nurse Specialist, CMC – Voting Member Pharmacy
Director, CMC – Voting Member
Pharmacy Clinical Manager, CMC – Voting Member Pharmacist
CMC – Voting Member
Medical Director, Regional Antimicrobial Stewardship Program – Non Voting Member
Pharmacist, Regional Antimicrobial Stewardship Program – Non Voting Member

3.N.2 Duties:

The Regional Pharmacy and Therapeutics Committee shall:

(a) be responsible for developing and maintaining surveillance of drug utilization policy and practices;

(b) assist in formulation of the broad professional policies regarding evaluation, appraisal, selection and procurement, storage, and distribution, use, safe procedures, and all other matters relating to drugs in the Hospital;

(c) advise the Medical Staff and Hospital pharmacy departments on matters pertaining to the choice of available drugs,

(d) develop and review periodically formulary or drug lists for use in the Hospital formulary;

(e) evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

(f) review all matters related to significant adverse drug reactions;

(g) oversee the Antibiotic Stewardship Program;

(h) maintain pertinent records of all activities related to the Pharmacy and Therapeutics Committee and shall submit any necessary reports and recommendations to the MEC concerning drug utilization policies and procedures within the Hospital;

(i) participate in emergency preparedness planning as it pertains to Pharmacy and Therapeutics;

(j) perform class reviews based on the same criteria medications are added or removed from the formulary (class reviews can be a result of the addition, removal, or therapeutic substitution policies; the Chair will solicit expert opinions from physician specialists and/or the department chair or section chief who have relevant opinions and expertise about the medication(s) in question);

(k) perform such other duties assigned by the Chief of Staff or the MEC when necessary; and

(l) provide appropriate representation at Providence/St. Joseph System Pharmacy & Therapeutics system committee.

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 Staffmember 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:

Approved by the Board: