HENDRICK MEDICAL CENTER
AND
HENDRICK MEDICAL CENTER SOUTH

MEDICAL STAFF ORGANIZATION MANUAL

Effective 04/03/2025

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ARTICLE I

GENERAL

1.A. DEFINITIONS

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

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Manual is to be carried out by a member of Administrative Leadership, 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 must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws Documents. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

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

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Manual, technical or minor deviations from the procedures set forth within this Manual will not invalidate any review or action taken.

ARTICLE 2

CLINICAL DEPARTMENTS

2.A. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

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

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

(a) there exists a 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 this Manual and 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 CEO that there is a clinical and administrative need for a new department; and

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

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

(a) there is no longer an adequate number of members of the Medical Staff in the clinical department to enable it to accomplish the functions set forth in this Manual or in the bylaws;

(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.

2.B. LIST OF CLINICAL DEPARTMENTS

The following clinical departments are established:

- Department of Medicine
- Department of Surgery

2.C. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS

The functions and responsibilities of departments and Department Chairs are set forth in the Medical Staff Bylaws.

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 individuals (e.g., other Medical Staff members, Advanced Practice Providers, Hospital personnel, legal counsel, employer representatives, etc.) 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. These individuals will be present only for the relevant agenda item and will be excused for all others. 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 on 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

(1) Unless otherwise indicated, each committee described in this Manual will meet as necessary to accomplish its functions, and will maintain a permanent record of its findings, proceedings, and actions. Each committee will make reports to the MEC and to other committees and individuals as may be indicated in this Manual.

(2) Between meetings of a committee, the Chair, in conjunction with the CMO or another committee member, may take steps as necessary to implement and operationalize the decisions of the committee. By way of example and not limitation, this may include providing clarifications to a Practitioner regarding a committee's decisions or expectations, reviewing and approving communications with the Practitioner, and similar matters.

3.D. ADVANCED PRACTICE PROVIDERS COMMITTEE

3.D.1. Composition:

The Advanced Practice Providers Committee ("APP Committee") will consist of members of the Active Medical Staff, Advanced Practice Providers Staff, and hospital personnel appointed by the Leadership Council.

3.D.2. Duties:

The APP Committee will perform the following functions:

(a) review the files of APP applicants and make recommendations to the Credentials Committee about membership, privileges, and job descriptions;

(b) review periodically all available information regarding the competency of APP Staff members, and, as a result of such review, make recommendations to the Credentials Committee about reappointment;

(c) review all available information regarding FPPE and OPPE, and, as a result of such review, make recommendations to the Credentials Committee;

(d) recommend action on any information received regarding the qualifications of applicants to or members of the APP Staff at any time;

(e) establish criteria and procedures for evaluations of members of the APP Staff; and

(f) undertake specific tasks as may be appropriately referred to it by the Credentials Committee.

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

The Committee will meet as necessary, maintain a permanent record of its proceedings, and report to the Credentials Committee.

3.E. BYLAWS COMMITTEE

3.E.1. Composition:

The Bylaws Committee shall consist of members of the Active or Honorary Medical Staff, appointed by the Leadership Council. The membership may serve for more than one term.

3.E.2. Duties:

The Bylaws Committee will perform the following functions:

(a) monitor the appropriateness and conduct ongoing review of the Bylaws, Rules and Regulations, policies, and procedures of the Medical Staff and submit recommendations to the Medical Executive Committee ("MEC") and Hospital Administration when changes are indicated;

(b) review the Medical Staff Bylaws, Rules and Regulations, and policies at least triennially to reflect current practice and regulatory requirements; and

(c) perform other related duties which may be directed by the MEC.

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

The Committee will meet as necessary, maintain a permanent record of its proceedings, and report to the MEC.

3.F. CARDIOLOGY GOVERNANCE COMMITTEE

3.F.1. Composition:

The Cardiology Governance Committee shall consist of the Medical Directors and dyad leaders from all Cardiology sub-section committees that includes: Cardiovascular Surgery, Invasive Cardiology, Non-Invasive Cardiology, Electrophysiology, Ambulatory Services, Hendrick Medical Center South, and Hendrick Medical Center Brownwood sub-section. The Executive Medical Director for the Cardiology Governance Committee chairs the Committee providing structure and direction.

3.F.2. Duties:

The Cardiology Governance Committee will perform the following functions:

(a) develop, establish, and oversee appropriate policies related to the care and treatment of cardiology patients;

(b) monitor, review and report quality data;

(c) oversee and manage the efficiencies of each area of cardiology;

(d) review the written policies and procedures for cardiovascular services and recommend changes when needed in order to maintain standards of care;

(e) provide guidance and direction for strategy and growth;

(f) make recommendations and oversee financial aspects and alignment within the system;

(g) assist in developing operational throughput with all aspects of patient care;

(h) recommend changes and regularly update privilege forms for all Cardiology and Cardiovascular practitioners;

(i) perform other related duties as directed by the Cardiology Executive Medical Director, the Performance Improvement Committee, and/or the MEC.

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

The Cardiology Governance Committee meets monthly, or as deemed necessary by the chair of the committee. Minutes of the committee meetings will be prepared and retained. They will include, at a minimum, a record of the attendance of members and actions taken on significant matters. The meeting minutes and review of warranted actions will be forwarded to the Performance Improvement Committee, which reports to the MEC.

3.G. CREDENTIALS COMMITTEE

3.G.1. Composition:

The Credentials Committee will be composed of at least six Members of the Active or Honorary Medical Staff. An administrator will be assigned by the President of the Medical Center to the Credentials Committee and may attend meetings as a non-voting member.

3.G.2. Duties:

The Credentials Committee will perform the following functions:

(a) review the Department Chair's recommendations on applicants for Medical Staff appointment, reappointment, and clinical privileges, make investigations of and interview such applicants as may be necessary, and make a written report of its findings and recommendations to the MEC;

(b) review the credentials files of applicants who request to practice at the Hospital as Advanced Practice Providers (APPs), to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations;

(c) review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as APPs, and, as a result of such review, make a written report of its findings and recommendations to the MEC;

(d) review periodically all available information regarding competency (FPPE/OPPE) of Medical Staff Members and APPs, and, as a result of such review, make recommendations to the MEC. The MEC has delegated the authority for approval of FPPE indicators and review to the Credentials Committee;

(e) establish criteria and procedures for privileging and evaluations of Medical Staff members and APPs;

(f) review and take appropriate action to develop privileges or core privilege checklists, research medical literature and develop "best practices" regarding new and emerging technology and the privileges, credentialing criteria, and/or proctoring necessary to support the same;

(g) supervise the maintenance of confidential quality files on Medical Staff members and APPs;

(h) review the policies related to the Credentials Committee at least every three years; and

(i) such other duties as outlined in the Medical Staff Bylaws or requested by the MEC.

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

The Credentials Committee will meet at least bi-monthly or more often as needed to accomplish its duties, will maintain a permanent record of its proceedings and actions, and will report its recommendations to the MEC.

Each Member of the Credentials Committee will attend at least fifty percent (50%) of the meetings held each calendar year. Members not meeting the attendance requirement may be removed and replaced by the Leadership Council.

3.H. CRITICAL CARE COMMITTEE

3.H.1. Composition:

The Critical Care Committee shall consist of members of the Active Staff, appointed by the Leadership Council and approved by the MEC. Other voting members include the Chief Nursing Officer and three members of nursing leadership assigned by the Leadership Council.

3.H.2. Duties:

The Critical Care Committee will perform the following functions:

(a) determine barriers that limit access to the Critical Care Unit, Intermediate Care Unit, and Telemetry;

(b) develop, implement, and oversee policies and procedures that guide right level of care decisions;

(c) define, implement, and monitor admission, discharge, and transfer criteria;

(d) establish criteria and procedures for evaluation of evidence-based practice implementation for Medical Staff and other personnel prescribed in the Bylaws, Rules and Regulations;

(e) evaluate outcomes and recommend opportunities for improvement;

(f) recommend action on any information regarding variability in regards to evidence-based practice guidelines;

(g) provide regular reports to the Performance Improvement (PI) Committee;

(h) undertake specific tasks as may be appropriately referred to it by the PI Committee or MEC; and

(i) review critical care-specific hospital/nursing policies on a periodic basis.

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

The Committee will meet as necessary but at least quarterly, maintain a permanent record of its proceedings, and report to the PI Committee.

3.I. LEADERSHIP COUNCIL

3.I.1. Composition:

(a) The Leadership Council will consist of the following voting members:

(1) Chief of Staff, who will serve as Chair;

(2) Vice Chief of Staff;

(3) Chair, Professional Review Committee; and

(4) Chair, Credentials Committee.

(b) The following individuals will serve as non-voting members to facilitate the Leadership Council's activities:

(1) CMO; and

(2) a representative(s) from Medical Staff Services.

3.I.2. Duties:

The Leadership Council is a non-disciplinary body, whose primary charge is to attempt to resolve the performance issues referred to it in a constructive and successful manner. The Leadership Council makes recommendations to colleagues when appropriate but does not have the authority to require any particular action. Only the MEC, acting in accordance with the Medical Staff Bylaws documents, possesses disciplinary authority. The Leadership Council will perform the following specific functions:

(a) serve as a resource for Department Chairs and other Medical Staff Leaders who are working with colleagues to improve clinical or professionalism performance or manage health issues that may impact the safety and quality of care;

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

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

(d) review and address any issues that may be referred to it regarding Practitioners' clinical practice, as outlined in the Professional Practice Evaluation Policy (Peer Review);

(e) meet, as necessary, to consider and address any situation involving a Practitioner that may require immediate action or the development of interim safeguards while a matter is being reviewed in accordance with one of the above Policies or the Medical Staff Bylaws documents;

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

(g) perform any additional functions as may be described in the Medical Staff Bylaws or as requested by the MEC or the Board.

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

The Leadership Council will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The Leadership Council will report to the PRC, the MEC, the Board, and others as described in the Policies noted above. The Leadership Council's reports to the MEC and the Board will provide summary and aggregate information regarding the committee's activities. These reports will not include the details of any reviews or findings regarding specific Practitioners unless the Leadership Council determines such information is necessary for the MEC to address a matter.

3.J. MEDICAL ADVISORY COMMITTEE

3.J.1. Composition:

(a) The Medical Advisory Committee ("MAC") shall consist of the following voting members on the Medical Staff at the South Campus of Hendrick Medical Center, with all representatives to be appointed by the Leadership Council:

(1) the Chair of the MAC;

(2) the Vice Chair of the MAC;

(3) a representative of the HMC South Campus Department of Surgery;

(4) a representative of the HMC South Campus Department of Medicine;

(5) a representative of the Performance Improvement Committee;

(6) a representative of the Performance Review Committee; and

(7) a representative of the Credentials Committee.

(b) Hospital Administration shall assign one or more administrators or representatives to attend meetings of the MAC as a non-voting member(s).

(c) Those members of the Medical Staff who are appointed by the Leadership Council of HMC to serve on the MAC shall serve two-year terms. There shall be no limit on the number of terms an appointed member may serve, but an appointed member may not serve more than three consecutive terms.

3.J.2. Duties:

The MAC will perform the following functions:

(a) act as liaison between the MEC and members of the HMC Medical Staff who practice primarily at the South campus of HMC;

(b) report the results of all meetings of the MAC to the MEC, by and through MAC members who are appointed as members of the MEC;

(c) review the policies related to the MAC at least every three years; and

(d) such other duties as may be determined by the MEC.

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

The MAC shall meet at least every other month, or at the call of the MEC, Chief of Staff, or Chair of MAC. The meetings themselves shall, if possible, be at least five business days prior to regularly scheduled MEC meetings. The MAC shall maintain a confidential record of its proceedings, and shall make a report to the MEC at each regularly scheduled MEC meeting, or at such other times as may be required by the MEC. Each Member of the MAC shall attend at least fifty percent (50%) of the meetings held each calendar year. A minimum of half the voting members of the MAC must be present to vote on anything before the MAC. Actions of the MAC shall require the vote of a majority of those present for a vote.

3.K. MEDICAL EXECUTIVE COMMITTEE

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

3.L. OPERATING ROOM COMMITTEE

3.L.1. Composition:

(a) The Operating Room Committee will consist of at least five members of the Active Medical Staff in the Department of Surgery who represent a cross section of the surgical specialties, one of whom must be an anesthesiologist.

(b) The Department of Surgery Chief chairs the OR Committee of their primary campus and may designate a chair for the OR Committee at the other campus. The Chair of the OR Committee at each campus assigns the membership rather than the Leadership Council. If the Department of Surgery Chief is not a surgeon or an anesthesiologist, the Leadership Council will assign a surgeon or an anesthesiologist as Chair.

(c) The Nurse Manager of the Operating Room and the Director of Surgical Services will be included as non-voting members.

3.L.2. Duties:

The Operating Room Committee will perform the following functions:

(a) develop, establish, and oversee appropriate policies related to the function of surgical services;

(b) monitor the effectiveness and efficiency of surgical services;

(c) oversee and manage the allocation of the block schedule to improve utilization and provide increased access for surgeons to schedule cases;

(d) review the written policies and procedures for surgical services as needed and recommend changes in procedures as necessary;

(e) provide input for the review and evaluation of the quality and appropriateness of services provided in the surgical services area;

(f) provide guidance and direction to the surgical services staff in the solution of problems;

(g) make recommendations and oversee the equitable distribution of resources within the operative areas; and

(h) perform other related duties as directed by the Department of Surgery, the Performance Improvement Committee or the MEC.

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

The OR Committee meets monthly, bimonthly, or as deemed necessary by the OR Committee Chair, maintains a permanent record of its proceedings and actions, and reports to the MEC.

3.M. PERFORMANCE IMPROVEMENT COMMITTEE

3.M.1. Composition:

(a) The Performance Improvement Committee ("PI Committee") will consist of the following voting members:

(1) Vice Chief of Staff will serve as Chair;

(2) Department Chairs (Senior Department Chair will serve as Vice Chair);

(3) seven At-Large members from the Active Medical Staff. One of the seven At-Large members must be on Medical Staff at the South Campus of Hendrick Medical Center; and

(4) three hospital representatives, as assigned by the Leadership Council.

(b) The Performance Improvement Department, with the assistance of the Medical Staff Services Department, will be responsible for collection of all appropriate information for the PI Committee and will act as agents of the PI Committee.

(c) Physician liaisons are appointed by the Leadership Council and assigned to the PI Committee. They are not required to attend meetings of the PI Committee and are

not voting members unless assigned as a member, but provide a valuable service on behalf of their specific functions:

(1) Blood Usage;

(2) Infection Prevention;

(3) Medical Records;

(4) Surgical Case Review; and

(5) Utilization Management.

A physician liaison for continuing medical education (CME) is appointed by the Leadership Council but does not report to the PI Committee. The PI Committee refers topics for potential CME presentations to the hospital's CME Committee as deemed appropriate.

3.M.2. Duties:

The PI Committee will perform the following functions:

(a) coordinate the systematic and ongoing review of the appropriateness and quality of blood usage, drug usage, surgery and invasive procedures, timeliness of completion of medical records, physician-related infection data and utilization management;

(b) prioritize and monitor the Medical Staff data gathering and analysis components of the Hospital's performance improvement program and coordination of the Medical Staff's activities in this area with those of the other professional and support services in the Hospital;

(c) OPPE – serves as a liaison with the Credentials and PR Committees, MEC, and the Medical Staff and plays a key role in OPPE by:

(1) overseeing data gathering by the Medical Staff Office, Performance Improvement Department and Risk Management Department;

(2) regularly evaluating Medical Staff Members' performance in the six areas established by the ACGME and recommending to the MEC target areas of performance and variances therefrom;

(3) meeting on a regular basis with Medical Staff Members whose performance deviates from established targets in the area of rates and rules; and

(4) referring to the PR Committee Medical Staff Members or AHPs deemed in need of FPPE;

(d) identify indicators used for FPPE/OPPE that are approved by the Medical Executive Committee (MEC). Review may be delegated by the MEC to the Credentials or PI Committee as appropriate;

(e) supervise the conduct of specific programs and procedures for assessing, maintaining and improving the quality and efficiency of the Medical Staff provided in the Hospital. Adopt and modify such programs and procedures, subject to the approval of the MEC and the Board of Trustees of the Hospital. This may include developing criteria and identifying data needs for the various activities;

(f) identify patterns of performance within or outside the acceptable range, by receiving and evaluating explanations for patterns significantly different from the norm, and by reporting these findings and explanations;

(g) coordinate the Medical Staff's performance improvement activities with those of other health care disciplines;

(h) participate in evaluating the overall quality review program for its comprehensiveness, integration, effectiveness and cost efficiency; and

(i) review and report to the MEC on a continuous basis other general indicators of the quality of care and of clinical performance, including unexpected patient care management events and adverse event data.

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

The PI Committee meets as necessary but at least quarterly, maintains a permanent record of its proceedings, and reports to the MEC.

3.N. PHARMACY & THERAPUETICS COMMITTEE

3.N.1. Composition:

(a) Voting members of the Pharmacy & Therapeutics Committee ("P&T Committee") are the Director of Pharmacy/Chief pharmacist from each Hendrick Medical Center campus or designee and at least three members of the Active Medical Staff from major clinical specialties appointed by the Leadership Council. Honorary Medical Staff members may also serve as voting members.

(b) Non-voting members include representatives from Nursing Service and from Hospital Administration. One faculty or administrative member from the Texas Tech School of Pharmacy may, at the discretion of the Leadership Council, be appointed to serve.

3.N.2. Duties:

The P&T Committee participates in formulating Medical Staff policies regarding the evaluation, selection, distribution, handling, use, and administration of drugs and devices in the Hospital, and is responsible for reviewing all other Medical Staff matters relating to the use of drugs and devices in the Hospital. The P&T Committee makes recommendations to the PI Committee regarding quality issues identified in the review process.

(a) The P&T Committee periodically reviews and evaluates:

(1) drug therapy practices and drug utilization, including review of the appropriateness of empirical and therapeutic use of drugs;

(2) appropriateness, safety, and effectiveness of the prophylactic, empirical, and therapeutic use of antibiotics in the Hospital;

(3) protocols and order sets of the Medical Staff, involving medications.

(i) Best Practice Committee (a hospital committee) and Pharmacy review new and revised order sets and perform routine review of already established order sets and report to the P&T Committee;

(ii) Recommendations from Best Practice Committee and Pharmacy are forwarded to the Physician Advisory Committee (a hospital committee) which has the authority to approve protocols and order sets not involving medications;

(iii) The P&T Committee has the authority to approve protocols and order sets involving medications; and

(4) recommendations from Antimicrobial Stewardship.

(b) The P&T Committee:

(1) serves as an advisory group to the Medical Staff and Pharmacy on matters pertaining to the choice of available drugs;

(2) serves as an advisory group for the Hospital's Institutional Review Board in establishing standards for the use and control of investigational drugs and of research in the use of recognized drugs;

(3) serves as a continuing liaison between the Medical Staff and the dietetic services of the Hospital, providing review and evaluation of the quality and appropriateness of nutritional care provided by dietetic services;

(4) reviews and approves protocols developed by and for the Medical Staff.

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

The P&T Committee meets monthly or at least quarterly as needed to perform its duties. A permanent record of its proceedings is maintained and reported to the PI Committee.

3.O. PHYSICIAN HEALTH & REHABILITATION COMMITTEE

3.O.1. Composition:

The Physician Health & Rehabilitation ("PH&R") Committee will consist of the PI Vice Chair and other members of the Active or Honorary Staff, as appointed by the Leadership Council . The Chair of the PH&R Committee will be the Vice Chair of the Credentials Committee.

3.O.2. Duties:

The PH&R Committee will:

(a) provide education about practitioner health issues;

(b) address prevention of physical, mental, behavioral, or emotional issues, and

(c) consult with the Leadership Council under the Practitioner Health Policy in order to facilitate the confidential diagnosis, treatment, and rehabilitation of practitioners with health issues. This includes:

(1) referring practitioners to the appropriate resource for diagnosis and treatment for the condition or concern or to other organizations (e.g., the Texas Physician Health Program);

(2) assisting the Leadership Council with the evaluation of the credibility of a complaint, concern, or allegation indicating a practitioner may be experiencing a health issue;

(3) at the request of the Leadership Council, monitoring practitioners who are affected by a health issue;

(4) reporting, if necessary, to the MEC instances where there may be lack of quality care; and

(5) assisting practitioners who are affected by a health issue in retaining or regaining optimal performance.

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

The PH&R Committee will meet as necessary, maintain a permanent record of its proceedings, and make periodic reports to the Credentials Committee.

3.P. PROFESSIONAL REVIEW COMMITTEE

3.P.1. Composition:

(a) The Professional Review Committee ("PRC") will consist of the following voting members:

(1) the Vice Chair of the Department of Medicine;

(2) the Vice Chair of the Department of Surgery;

(3) three At-Large members of the Department of Medicine, appointed by the Leadership Council;

(4) three At-Large members of the Department of Surgery, appointed by the Leadership Council; and

(5) one At-Large member from the South Campus of Hendrick Medical Center, appointed by the Leadership Council.

(b) The following individuals will serve as non-voting members to facilitate the PRC's activities:

(1) CMO; and

(2) a representative(s) from Medical Staff Services.

(c) The PRC is chaired by the senior Department Vice Chair. The Department Vice Chair who is in his/her first year, will be the Committee Vice Chair. In the event that no Department Vice Chair has tenure, the Leadership Council will appoint from the Department Vice Chairs the positions of Committee Chair and Committee Vice Chair, subject to ratification by the MEC.

3.P.2. Duties:

The PRC is a non-disciplinary body, whose primary charge is to attempt to resolve the clinical performance issues referred to it in a constructive and successful manner. The PRC makes recommendations to colleagues when appropriate, but does not have the authority to require any particular action. Only the MEC, acting in accordance with the Medical Staff Bylaws documents, possesses disciplinary authority. The PRC will perform the following specific functions:

(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 the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;

(d) identify 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 and perform such other functions as outlined in the PPE Policy;

(f) monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;

(g) work with Medical Staff Leaders to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy; and

(h) perform any additional functions as may be set forth in applicable policy or as requested by the MEC or the Board.

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

The PRC will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The PRC will submit reports of its activities to the MEC and the Board on a regular basis. The PRC's reports will provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty; types and numbers of dispositions for the cases; listing of education initiatives based on reviews; listing of system issues identified). These reports will not include the details of any reviews or findings regarding specific Practitioners unless the PRC determines such information is necessary for the MEC to address a matter.

3.Q. TRAUMA SERVICES COMMITTEE

3.Q.1. Composition:

(a) The Trauma Services Committee shall consist of the following voting members: Trauma Medical Director; Active Staff General Surgeons; Administrator; Trauma Coordinator; Neurosurgeon; Orthopedic Surgeon; Emergency Medicine physician; Anesthesiologist; Pathologist; Radiologist; and Pediatrician.

(b) With the exception of the Trauma Medical Director, Medical Staff Members shall be appointed by the Leadership Council from Members of the Active Staff. The Trauma Services Medical Director shall act as Chair. In the event a general surgeon is not the Trauma Medical Director, a general surgeon on the Active Medical Staff shall serve as co-chair. All general surgeons on the Active Staff may be assigned to the Committee.

3.Q.2. Duties:

The Trauma Services Committee will perform the following functions:

(a) ensure all American College of Surgeons, Joint Commission, Texas Department of State Health Services, and Regional Advisory Council requirements for a Level III Trauma Center are met;

(b) ensure practice parameters established by the Trauma Services, Trauma Medical Director, and Administrative staff are met;

(c) define the roles, responsibilities, and accountabilities of the performance improvement process for Trauma Service performance; and

(d) review all charts of all patients identified by the screening process of the Trauma Service and/or any referrals from other Departments/Services.

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

The Committee will meet as necessary, maintain a permanent record of its proceedings, and report to the PI Committee.

ARTICLE 4

MEDICAL STAFF PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff, through its Medical Staff Leaders and the committees outlined in Article 3 of this Manual, will be actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

(b) the Hospital's and individual Practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(c) medical assessment and treatment of patients;

(d) use of information about adverse privileging determinations regarding any Practitioner;

(e) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(f) the utilization of blood and blood components, including review of significant transfusion reactions;

(g) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(h) appropriateness of clinical practice patterns;

(i) significant departures from established patterns of clinical practice;

(j) education of patients and families;

(k) coordination of care, treatment and services with other Practitioners and Hospital personnel;

(l) accurate, timely and legible completion of medical records;

(m) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix B of the Medical Staff Bylaws;

(n) the use of developed criteria for autopsies;

(o) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(p) nosocomial infections and the potential for infection;

(q) unnecessary procedures or treatment; and

(r) appropriate resource utilization.

ARTICLE 5

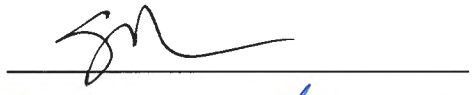
AMENDMENTS

This Manual will be amended in accordance with the amendment process outlined in the Medical Staff Bylaws.

ARTICLE 6

ADOPTION

This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Medical Staff: 

Board of Trustees: