MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS MEMORIAL HEALTH

SPRINGFIELD MEMORIAL HOSPITAL

MEDICAL STAFF ORGANIZATION MANUAL

Adopted by the Medical Executive Committee: July 23, 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 Medical Staff Credentials Policy document.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Manual is to be carried out by a member of Administrative Leadership, 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 and related policies. 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 assigned a function under this Manual 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. 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 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 shall 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 a Department Chair; 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:

Anesthesiology
Cardiovascular Medicine
Cardiothoracic Surgery
Emergency Medicine
Family Medicine
General Surgery
Internal Medicine
Laboratory Medicine
Neurology
Neurosurgery
Obstetrics-Gynecology
Ophthalmology
Oral and Maxillofacial Surgery
Orthopedics
Otolaryngology and Head and Neck Surgery
Pediatrics
Plastic Surgery
Podiatry
Psychiatry
Radiation Oncology
Radiology
Rehabilitation Medicine
Urology
Vascular 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 Medical Staff members or Hospital personnel may be invited to attend a committee 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 committee's functioning and are bound by the same confidentiality requirements as the standing members of the committee, as applicable.

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

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 the five most recent and available Past-Presidents of the Medical Staff. If there are fewer than five Past-Presidents of the Medical Staff available or willing to serve, then the Leadership Council may appoint other individuals to ensure there are five members on the Committee, with a preference for those with Medical Staff leadership experience (e.g., past Department Chairs or Committee Chairs). The most recent Past-President shall act as chair.

3.D.2. Duties:

The Bylaws Committee shall be charged with reviewing the Medical Staff Bylaws, Medical Staff Rules and Regulations, and related Medical Staff policies at least every three years or more often as requested by the President, as well as reviewing all suggested amendments to the same. The committee shall develop suggested amendments to the same in order to enhance the administration of the Medical Staff or to maintain consistency with the bylaws of the Hospital or the mandates of federal or state regulatory authorities or of accreditation entities.

3.E. CANCER COMMITTEE

3.E.1. Composition:

The Cancer Committee shall consist of eight representatives of the Medical Staff from all major departments involved in the care of cancer patients, one representative from the Tumor Registry, and one representative from the Nursing Service (Oncology Unit).

3.E.2. Duties:

The duties of the Cancer Committee shall be to:

(a) oversee a functioning Tumor Registry approved by the American College of Surgeons or other accrediting agency, the primary function of which will be to provide follow-ups to cancer patients seen at the Hospital;

(b) organize and support an ongoing multi-disciplinary educational program related to cancer diagnosis, therapies, and treatment; and

(c) provide a system for evaluation of quality of care rendered to cancer patients treated in the Hospital.

3.F. CLINICAL PERFORMANCE COMMITTEE

3.F.1. Composition:

The Clinical Performance Committee shall consist of at least nine Active Staff physicians representing various clinical departments, the CMO and the Chief Quality Officer.

3.F.2. Duties:

The duties of the Clinical Performance Committee shall be to:

(a) conduct systematic evaluations of the quality and appropriateness of inpatient and outpatient medical care rendered within the Hospital. This evaluation will be based on scientific/evidence-based knowledge and the appropriate standard of care;

(b) develop a written plan providing patient care based on scientific/evidence-based knowledge and the appropriate standard of care; and

(c) coordinate scientific/evidence-based practice changes and improvements throughout all areas and clinical departments.

3.G. COMMITTEE FOR PROFESSIONAL ENHANCEMENT ("CPE")

3.G.1. Composition:

(a) The CPE shall consist of the following voting members:

(1) Immediate Past President of the Medical Staff;

(2) another experienced past Medical Staff Leader;

(3) additional Medical Staff members who are:

(i) broadly representative of the clinical specialties on the Medical Staff;

(ii) interested or experienced in credentialing, privileging, PPE/peer review, or other Medical Staff affairs;

(iii) supportive of evidence-based medicine protocols; and

(iv) consistent with the non-disciplinary nature of the CPE, generally do not also serve on the MEC.

In appointing these individuals, the Leadership Council will give preference to Practitioners who have been selected to either serve as an individual Clinical Specialty Reviewer or to chair a committee that functions as a Clinical Specialty Reviewer, as described in the Professional Practice Evaluation Policy (Peer Review); and

(4) an Advanced Practice Professional.

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

(1) CMO; and

(2) one or more PPE Specialists.

(c) The Leadership Council shall appoint the CPE members and shall designate one voting member as CPE Chair.

(d) If the Immediate Past Medical Staff President is unwilling or unable to serve, the Leadership Council shall appoint another former Medical Staff Leader who is experienced in credentialing, privileging, PPE/peer review, or Medical Staff matters.

(e) To the fullest extent possible, CPE members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may serve two consecutive terms (regardless of the length of the term). They must then take one year off before serving up to two additional terms. This cycle may be repeated indefinitely.

(f) Before any CPE member begins serving, the member must review the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on professional practice evaluation, with the nature of the training to be identified by the Leadership Council or CPE.

(g) Other appropriate individuals (e.g., Clinical Specialty Reviewers and other Medical Staff members, Advanced Practice Professionals, Chief Nursing Officer, other Hospital personnel, Employer representative, etc.) may be invited to attend a particular CPE meeting (as guests, without vote) in order to assist the CPE 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 CPE.

(h) Between meetings of the CPE, the CPE Chair, in conjunction with the CMO or another CPE member, may take steps as necessary to implement and operationalize the decisions of the CPE. By way of example and not limitation, this may include providing clarification to a Practitioner regarding the CPE's decisions or expectations, reviewing and approving communications with the Practitioner, responding to questions posed by an internal or external reviewer, and similar matters.

3.G.2. Duties:

The CPE 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 CPE 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 CPE shall 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 Ongoing Professional Practice Evaluation ("OPPE") data elements for individual departments, sections or specialties, and adopt Medical Staff-wide data elements;

(d) review, approve, and periodically update the specialty-specific quality indicators identified by the departments or specialties that will trigger the professional practice evaluation/peer review process;

(e) 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;

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

(g) develop, when appropriate, Voluntary Enhancement Plans for Practitioners, as described in the PPE Policy;

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

(i) work with Department Chairs or other Medical Staff Leaders to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through peer learning sessions or through some other mechanism; and

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

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

The CPE shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The CPE shall submit reports of its activities to the MEC and the Board on a regular basis. The CPE'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 generally not include the details of any reviews or findings regarding specific Practitioners.

3.H. CREDENTIALS COMMITTEE

3.H.1. Composition:

(a) The Credentials Committee shall consist of at least five members of the 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 and at least one Advanced Practice Professional with experience on the APPC.

(b) To the fullest extent possible, Credentials Committee members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms. Service on this committee shall be considered the primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere.

(c) The CMO and Medical Staff Services support staff representatives shall serve as *ex officio* members, without vote, to facilitate the Credentials Committee's activities.

3.H.2. Duties:

The Credentials Committee shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants seeking Medical Staff appointment and clinical privileges as well as all applicants seeking to practice as Advanced Practice Professionals and Licensed Independent Practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make reports of its findings and recommendations;

(b) review applications and all information available regarding the reappointment of Medical Staff members and Advanced Practice Professionals and Licensed Independent Practitioners; and

(c) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.1 pertaining to the development and ongoing review of privilege delineations, 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.I. INFECTION CONTROL COMMITTEE

3.I.1. Composition:

The Infection Control Committee shall consist of at least seven physicians from the Medical Staff and an infection control nurse, a Nursing Services representative and a Pharmacy representative of the Hospital. The chair of the committee shall be an infectious disease specialist, and one of the seven physicians must include a bacteriologist from the Department of Laboratory Medicine.

3.I.2. Duties:

The committee shall be responsible for the surveillance of nosocomial infections, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities, including:

(a) operating rooms, recovery rooms, and special care units;

(b) sterilization procedures by heat, chemicals or otherwise;

(c) isolation procedures;

(d) prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;

(e) testing of Hospital personnel for carrier status;

(f) disposal of infectious material; and

(g) other situations as requested by the MEC.

3.I.3. Scope of Authority:

The committee shall recommend disciplinary action based on records and reports of actual or potential nosocomial infections to any patients or Hospital personnel. The authority of the committee, through its chair, to institute any appropriate control measures or studies shall be defined in writing and approved by the CEO and the MEC.

3.J. LEADERSHIP COUNCIL

3.J.1. Composition:

(a) The Leadership Council shall consist of the following:

- Medical Staff President (who shall serve as Chair);

- Immediate Past Medical Staff President (who shall serve for the first year of his/her term in office);

- Chair of the Committee for Professional Enhancement;

- Medical Staff President-Elect (who shall serve for the second year of his/her term in office);

- President and Chief Executive Officer; and

- Chief Medical Officer.

(b) One or more PPE Specialists designated by the Leadership Council shall attend Leadership Council meetings to support the activities of the committee.

(c) Other appropriate individuals (e.g., Medical Staff members, Advanced Practice Professionals, Chief Nursing Officer, other Hospital personnel, Employer representative, etc.) 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.

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

3.J.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 shall perform the following specific 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) meet, as necessary, to consider and address any situation involving a Practitioner that may require immediate action;

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

(f) identify and nominate a slate of qualified individuals to serve as the Medical Staff Officers and any at-large members of the MEC, to be presented to and elected by the Medical Staff;

(g) identify and nominate qualified individuals to serve as department chairs, to be presented to and elected by the relevant departments;

(h) identify qualified individuals to serve as Section Chiefs, to be presented to and selected by the relevant Department Chairs;

(i) appoint the chairs and members of all Medical Staff committees, except for the MEC;

(j) cultivate a physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future; and

(k) perform any additional functions as may be requested by the CPE, 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 CPE, the MEC, and others as described in the Policies noted above. The Leadership Council's reports to the MEC will provide summary and aggregate information regarding the committee's activities. These reports will generally not include the details of any reviews or findings regarding specific Practitioners.

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:

The Operating Room Committee shall consist of the Administrator, Perioperative Services, a representative from Hospital Administration, and chairs from all departments that utilize the Operating Room.

3.L.2. Duties:

The committee shall be responsible for all medical activities relating to the use of the surgical suite.

3.M. SURGICAL CASE AND PROCEDURE REVIEW COMMITTEE

3.M.1. Composition:

The Surgical Case and Procedure Review Committee shall consist of one pathologist from the Department of Laboratory Medicine and one representative from each of the departments of General Surgery, Internal Medicine, Obstetrics-Gynecology, Orthopedics, Radiology, Vascular Surgery, Urology, Cardiothoracic Surgery and the Quality Resources Peer Review Coordinator.

3.M.2. Duties:

The committee shall review surgical cases and other procedures related to non-tissue surgical procedures, removal of normal tissue, and inconsistencies between pre-operative and post-operative diagnosis. It shall also conduct prospective and retrospective studies as necessary to evaluate the appropriateness of surgical and other procedures.

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

The Surgical Case and Procedure Review Committee shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The Surgical Case and Procedure Review Committee shall submit reports of its activities to the relevant Department Chair and the CPE as a part of the professional practice evaluation process.

3.N. TRANSFUSION COMMITTEE

3.N.1. Composition:

The Transfusion Committee shall consist of four members from the Active Staff and the Director of the Blood Transfusion service.

3.N.2. Duties:

The duties of the committee shall be to develop policies and procedures to evaluate the appropriate usage of blood and blood products in the Hospital, evaluate all transfusion reactions, and evaluate, on a quarterly basis, transfusions for the purpose of determining whether the use of blood and blood products is appropriate.

3.O. UTILIZATION MANAGEMENT COMMITTEE

3.O.1. Composition:

The Utilization Management Committee shall consist of three members from the Active Staff, the Vice President, Ambulatory Networks and Clinical Integration, Utilization Management and Clinical Documentation Improvement Physician Advisors, and members of Hospital administration as necessary.

3.O.2. Duties:

The duties of the Utilization Management Committee shall be to:

(a) establish and implement a program of concurrent review of admission and continued stay for any patient admitted to the Hospital, in accordance with applicable statutes, regulations, and standards;

(b) oversee timely and appropriate discharge planning;

(c) assist in the ongoing assessment of screening criteria, standards, and review methods;

(d) recommend changes in hospital procedures or Medical Staff practice where indicated by review findings;

(e) prepare and arrange educational programs as needed to address deficiencies noted by analysis or review findings;

(f) establish teams to participate in retrospective and concurrent reviews of patient medical records to identify trends of over-utilization, under-utilization, and inefficient scheduling of services;

(g) oversee the implementation of the Hospital's Utilization Management Plan;

(h) refer concerns and patterns of utilization issues that continue despite the Utilization Management Committee's efforts to the CPE and oversee and assist with any Voluntary Enhancement Plan that may be developed by the CPE; and

(i) refer a practitioner's refusal to cooperate with the Utilization Management process to the Leadership Council for review in accordance with the Professionalism Policy.

ARTICLE 4

MEMORIAL HEALTH COMMITTEES

4.A. GENERAL

(1) The committees outlined in this Article are integrated committees of each individual Memorial Health Hospital Medical Staff.

(2) Each Memorial Health Hospital Medical Staff, through its Medical Staff President, shall designate one or more Medical Staff representatives as members of the committees. The Memorial Health President and Chief Executive Officer (or designee) will appoint all Memorial Health administrative representatives and shall designate a chair or chairs for each committee.

(3) All Memorial Health Committees shall meet as often as necessary to perform their duties. The committees shall report to each Memorial Health Hospital MEC at least annually.

(4) Minutes of all meetings of a Memorial Health Committee shall be maintained and shall contain information that is specific to each Memorial Health Hospital. Such minutes shall be made available so that they are accessible on site at each hospital.

(5) Because of the system-wide nature of these committees, each committee may establish additional rules concerning the conduct of meetings and their activities that may supplement or vary from other rules contained herein that are applicable to Medical Staff committees generally.

4.B. ADVANCED PRACTICE PROFESSIONALS COMMITTEE ("APPC")

4.B.1. Composition:

(a) The Advanced Practice Professionals Committee ("APPC") shall consist of Advanced Practice Professionals representing the range of areas in which APPs function within Memorial Health. The APPC may also obtain assistance, on an ad hoc basis, from the other representatives from the Medical Staffs, Nursing Staffs, and administration within Memorial Health.

(b) The System CMO and System CNO will serve as *ex officio* members of the committee, without vote.

4.B.2. Duties:

The APPC shall serve as an advisory/policy body to the Medical Staffs within Memorial Health. Its duties include, but are not limited to, the following:

(a) recommend standard policies, procedures, and guidelines pertaining to the practice of Advanced Practice Professionals within Memorial Health, including OPPE and FPPE measures/processes;

(b) develop recommendations for each type of Advanced Practice Professionals permitted to practice within Memorial Health, including, as appropriate:

(1) any specific education, experience and/or training qualifications that they must possess beyond those set forth in the Credentials Policy;

(2) detailed delineation of privileges forms, including eligibility criteria;

(3) any specific conditions that apply to their functioning within a hospital setting; and

(4) any supervision/collaboration requirements, if applicable;

(c) as may be requested, provide the Credentials Committee (or MEC if there is no Credentials Committee) with recommendations concerning an individual Advanced Practice Professional's application for clinical privileges;

(d) in accordance with relevant policies, provide education and improvement assistance to individual Advanced Practice Professionals who have been granted clinical privileges within Memorial Health;

(e) evaluate and make recommendations regarding the need for the services that could be provided by types of Advanced Practice Professionals that are not currently permitted to practice within Memorial Health; and

(f) perform any additional functions as may be set forth in applicable policy or as requested by a Credentials Committee, CPE, MEC, or Board within Memorial Health.

4.B.3. Meetings, Reports, and Recommendations:

The APPC shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions.

4.C. HEALTH INFORMATION MANAGEMENT COMMITTEE

4.C.1. Composition:

The Health Information Management Committee shall consist of at least one member from each Memorial Health Medical Staff, along with representatives from Memorial Health administration.

4.C.2. Duties:

The Health Information Management Committee shall perform the following functions:

(a) help assure that medical records are maintained in compliance with all applicable regulations, accreditation standards, and professional practice standards;

(b) monitor the conduct of audits regarding timeliness, completeness, and appropriateness of medical record documentation, and help assure that audit findings are reviewed and that follow-up recommendations are made as needed;

(c) track safety and quality data separately for each facility and assure that records are maintained on site at each hospital;

(d) make recommendations to the appropriate hospital Medical Staffs for action with respect to Medical Staff members who fail to conform to policies, including policies pertaining to timeliness and completeness of medical records;

(e) evaluate and make recommendations as appropriate regarding policies, rules and regulations relating to medical records; and

(f) engage in strategic planning for management of health information, including electronic medical record systems.

4.C.3. Meetings, Reports, and Recommendations:

The Health Information Management Committee shall meet as necessary to accomplish its functions, but at least four times per year.

4.D. PHARMACY AND THERAPEUTICS COMMITTEE

4.D.1. Composition:

The Pharmacy and Therapeutics Committee shall consist of at least one member from each Memorial Health Medical Staff, the Director of Pharmacy at each Memorial Health Hospital, at least one representative from the nursing staff at each Memorial Health Hospital, and representatives from Memorial Health administration.

4.D.2. Duties:

The Pharmacy and Therapeutics Committee shall perform the following functions:

(a) monitor and evaluate the prophylactic, therapeutic and empiric use of drugs in an effort to assure that drugs are provided appropriately, safely and effectively;

(b) assist the Directors of Pharmacy in the formulation of policies and procedures relating to the selection, distribution, handling, and use and administration of drugs and diagnostic testing materials;

(c) assist the Directors of Pharmacy in the development and periodic review of a formulary or drug list for use in each Memorial Health Hospital;

(d) assist in the formulation, revision, and enforcement of policies and procedures governing the safe administration of drugs;

(e) establish guidelines and recommendations for the clinical review and statistical/prevalence study of antibiotic and other drug usage throughout Memorial Health;

(f) recommend standards regarding the use and control of investigational drugs and concerning research in the use of recognized drugs;

(g) review clinical data concerning new drugs or preparations requested for use in Memorial Health;

(h) make recommendations regarding drugs to be stocked on the nursing unit floors and by other services;

(i) establish procedures which will prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients; and

(j) make recommendations concerning drugs for which automatic stop orders are necessary.

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

The Pharmacy and Therapeutics Committee shall meet as necessary to accomplish its functions, but at least quarterly.

ARTICLE 5

AMENDMENTS

This Manual may be amended in accordance within the process outlined in Section 9.B of 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.

Adopted by the Medical Staff: September 7, 2022

Approved by the Board: September 14, 2022