MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF NEW HANOVER REGIONAL MEDICAL CENTER

MEDICAL STAFF ORGANIZATION MANUAL

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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 Glossary document.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Manual is to be carried out by a member of the Administrative Team, 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 Medical Center 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 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, DIVISIONS, AND SERVICE LINES

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) Any department that was established prior to the adoption date of this Manual will be grandfathered. After the adoption of this Manual, the following factors will be considered in determining whether a new clinical department should be created:

(a) there exists ten or more 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 the Department Chair; or

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

2.B. LIST OF CLINICAL DEPARTMENTS AND DIVISIONS

The following clinical departments and divisions are established:

(1) Department of Anesthesiology

(2) Department of Cardiac Services

(3) Department of Dental, Oral and Maxillofacial Surgery

(4) Department of Emergency Medicine

(5) Department of Family Medicine

(6) Department of General Surgery

(7) Department of Medicine

- Allergy
- Critical Care
- Dermatology
- Endocrinology
- Gastroenterology & Endoscopy
- Geriatric
- Hematology/Oncology
- Infectious Disease
- Internal Medicine
- Nephrology
- Pulmonology
- Physical Medicine & Rehabilitation
- Rheumatology

(8) Department of Neurosciences

- Neurology
- Neurosurgery

(9) Department of Obstetrics and Gynecology

(10) Department of Oncology

(11) Department of Ophthalmology

(12) Department of Orthopedics

- Orthopedics
- Podiatry

(13) Department of Otolaryngology

(14) Department of Pathology

(15) Department of Pediatrics

(16) Department of Psychiatry

(17) Department of Radiology

(18) Department of Specialty Surgery

- Urology
- Plastic & Reconstructive Surgery

(19) Department of Vascular Surgery

2.C. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS, DIVISIONS, AND SERVICE LINES

The functions and responsibilities of departments and Department Chairs, divisions and Division Chiefs, and Service Lines and Service Line Directors are set forth in Article 4 of 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 Medical Center 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 Medical Center 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 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 Medical Center 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 a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated in this Manual.

(2) The committee outlined in this Manual may refer to the Medical Staff President, Credentials Committee, CPE, Leadership Council, or MEC for its consideration, any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of Medical Center or Medical Staff Bylaws or policies, or unacceptable conduct on the part of any appointee which is related to the functions of the committee.

3.D. ADVANCED PRACTICE PROFESSIONALS COMMITTEE ("APP COMMITTEE")

3.D.1. Composition:

(a) The Advanced Practice Professionals Committee ("APP Committee") is a subcommittee of the Credentials Committee that consists of Practitioners appointed by the Leadership Council, one of whom will be appointed as Chair.

(b) The following individuals shall serve as non-voting *ex officio* members to facilitate the APP Committee's activities:

(1) the Medical Staff President;

(2) the VPMA; and

(3) the CNO and/or designees.

(c) Other appropriate individuals (e.g., representatives of Medical Staff Services, EPP Specialists, other Practitioners, other Medical Center personnel, Employer representative, etc.) may be invited to attend a particular APP Committee meeting (as guests, without vote) in order to assist the Committee in its discussions and deliberations regarding an issue on its agenda.

3.D.2. Duties:

The APP Committee will perform functions as may be set forth in applicable policy or as requested by the CPE, the MEC, or the Board.

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

The APP Committee will meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The APP Committee will submit reports of its activities to the Credentials Committee, CPE, and MEC as necessary.

3.E. BYLAWS COMMITTEE

3.E.1. Composition:

The Bylaws Committee will consist of at least five Medical Staff members. A representative from the Administrative Team will also serve on the committee, *ex officio*, without vote.

3.E.2. Duties:

The Bylaws Committee will:

(a) review the Bylaws of the Medical Staff and other associated documents at least annually and recommend amendments, as appropriate, to the MEC. This review will also include, but not be limited to, the Medical Staff Organizational Manual, Rules and Regulations, and appointment and reappointment application forms; and

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

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

The Bylaws Committee will meet as often as necessary to fulfill its duties, but at least annually, will maintain a permanent record of its findings, proceedings and actions, and will make a written report of its recommendations after each meeting to the MEC and the CEO.

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

3.F.1. Composition:

(a) The CPE will consist of between seven and 12 voting members as follows:

(1) Secretary-Treasurer of the Medical Staff;

(2) an experienced past Medical Staff Leader;

(3) at-large Medical Staff members who are:

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

(ii) interested or experienced in credentialing, privileging, EPP/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 not also serving on the MEC; and

(4) the Advanced Practice Professional who serves as Chair of the APP Committee.

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

(1) Chief Clinical Officer;

(2) VPMA; and

(3) EPP Specialists representative(s).

(c) At-large members of the CPE will be appointed as follows: Departments will recommend to the Leadership Council Practitioners to serve as Clinical Specialty Reviewers for the department. From among those Practitioners, the Leadership Council will recommend to the MEC the individuals to be appointed as at-large members of the CPE. The MEC will appoint at-large CPE members after consideration of such recommendations. Following consultation with the Leadership Council, the MEC may appoint additional at-large members as needed to represent a service line or other interdisciplinary area of practice.

(d) The MEC will appoint one voting member of the CPE to serve as its chair, after considering the recommendation of the Leadership Council.

(e) To the fullest extent possible, CPE members will serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.

(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 the evaluation of professional practice, 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 Medical Center 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 will be present only for the relevant agenda item and will be excused for all others. Such individuals are an integral part of the evaluation of professional practice 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 VPMA 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 clarifications 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.F.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 will perform the following specific functions:

(a) oversee the implementation of the Evaluation of Professional Practice Policy (Peer Review) ("EPP 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 EPP 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 that are identified by individual departments and sections, and adopt Medical Staff-wide data elements;

(d) review, approve, and periodically update the specialty-specific quality indicators identified by the departments that will trigger the evaluation of professional practice/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 EPP Policy;

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

(h) obtain and review monthly reports from the Patient Safety Oversight Committee ("PSOC") to ensure that system issues that have been identified as part of the evaluation of professional practice activities and referred to the PSOC are successfully resolved;

(i) work with Department Chairs to disseminate educational lessons learned from the review of cases pursuant to the EPP Policy, either through educational sessions in the department 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.F.3. Meetings, Reports, and Recommendations:

The CPE will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The CPE will 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 EPP 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.G. CREDENTIALS COMMITTEE

3.G.1. Composition:

(a) The Credentials Committee will consist of at least five members of the Medical Staff, including the Immediate Past Medical Staff President and Medical Staff Vice President, with preference given to individuals who are serving as a Division Chief, have served in Medical Staff leadership positions (e.g., past Medical Staff Presidents and Department Chairs) and/or who have a particular interest in the credentialing functions.

(b) One member of the Board, as selected by the Medical Staff President and Board Chair, will serve as an *ex officio* member, without vote.

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

3.G.2. Duties:

The Credentials Committee will carry out the functions described in the Medical Staff and APP Credentials Policy, including reviewing applicants seeking Appointment, Reappointment, and Clinical Privileges.

3.H. CRITICAL CARE/VITALINK COMMITTEE

3.H.1. Composition:

The Critical Care/Vitalink Committee will consist of Physicians who represent the interests of each of the critical or intensive care units of the Medical Center and the intermediate care or transition units. The Critical Care/Vitalink Medical Director and Medical Director of the Intensivist Service will be permanent members of the committee. Representatives of Medical Center management, ancillary support services, and of the nursing service may serve, *ex officio*, without vote.

3.H.2. Duties:

The Critical Care/Vitalink Committee will:

(a) monitor and evaluate the quality and appropriateness of care in the intensive and progressive care units of the Medical Center;

(b) assess the utilization patterns of these units as well as the medical necessity for admission, continued stay, and readiness for transfer of patients from these units;

(c) establish and maintain criteria for use of intensive units; encourage compliance with criteria for admission; and

(d) provide direction and oversight to clinical affairs of the units, including equipment needs.

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

The Critical Care/Vitalink Committee will meet at least once every other month and will maintain written records which reflect the results of its evaluations of quality management and utilization programs. The committee will report on a regular basis its actions or recommendations to the MEC and, as necessary, to the CPE. Additionally, the committee may forward a report of its findings, proceedings, and actions, as appropriate, to the CEO.

3.I. ENDOSCOPY COMMITTEE

3.I.1. Composition:

The Endoscopy Committee will consist of at least five Physicians from various disciplines who represent the interests of the endoscopists, who perform endoscopic procedures, as well as Physicians who represent the patient. Representatives of Medical Center management, ancillary support services, and of the nursing service may serve *ex officio,* without vote, and may be assigned by the CEO.

3.I.2. Duties:

The Endoscopy Committee will:

(a) monitor and evaluate the quality and appropriateness of care in the endoscopy suite and in other patient care units where the specialized endoscopic service procedures are performed (i.e., bronchoscopic, gastrointestinal procedures);

(b) establish and maintain criteria for use of the facility and indications for its procedures; and

(c) provide direction and oversight to clinical affairs of the endoscopy service, including recommendations as to equipment, technical and facility needs.

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

The Endoscopy Committee will meet at least once every other month and will maintain written records which reflect the results of its evaluations of quality management and utilization programs. The committee will report on a regular basis its actions or recommendations to the MEC and, as necessary, to the CPE. Additionally, the committee may forward a report of its findings, proceedings, and actions, as appropriate, to the CEO.

3.J. INFECTION, PREVENTION, AND CONTROL COMMITTEE

3.J.1. Composition:

The Infection, Prevention, and Control Committee will consist of Physician representation from each clinical Department, as appointed by their respective Department Chair. All infectious disease clinicians are encouraged to attend. The Medical Center epidemiologist will serve as Chair. A representative from nursing service and Medical Center management will also serve, *ex officio*, without vote. Medical Center representation will also include the infection preventionists who serve, *ex officio*, without vote.

3.J.2. Duties:

The Infection, Prevention, and Control Committee will:

(a) oversee and guide the Medical Center's infection prevention and control program to include:

(1) surveillance of rates, risks, and trends in healthcare associated infections;

(2) making recommendations which are considered necessary to minimize the potential for healthcare associated infection hazards as they relate to our patients, visitors, and employees; and

(3) addressing other issues which are epidemiologically important to the Medical Center;

(b) monitor infection prevention and control techniques and procedures throughout the Medical Center with recommendations and/or actions as necessary; and

(c) develop educational programs for Practitioners with regard to healthcare associated infections and prevention thereof.

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

The Infection, Prevention, and Control Committee will meet at least quarterly, and more often as necessary. The Committee will maintain a permanent record of its findings, proceedings and actions, and will make a written or oral report periodically to the MEC, the CPE, and to the CEO, as necessary.

3.K. INFORMATION TECHNOLOGY COMMITTEE

3.K.1. Composition:

The Information Technology Committee will consist of at least six Medical Staff members. Representatives from the Information Services Department, Pharmacy, Medical Center management and ancillary services will also serve, *ex officio*, without vote.

3.K.2. Duties:

The Information Technology Committee will:

(a) annually review the current status of information technology at the Medical Center;

(b) recommend additions and changes to information technology that will improve patient care;

(c) review and evaluate recommendations for information technology projects, etc., from the Medical Staff; and

(d) collaborate with other departments (e.g., Information Services, Education) to facilitate education of the Medical Staff regarding information technology.

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

The Information Technology Committee will meet as often as necessary to accomplish its duties, but at least annually, will maintain a permanent record of its findings, proceedings and actions, and will provide an oral or written report to the MEC and/or the CEO, as necessary

3.L. LEADERSHIP COUNCIL

3.L.1. Composition:

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

(1) Medical Staff President, who will serve as Chair;

(2) Medical Staff Vice President;

(3) Secretary-Treasurer of the Medical Staff;

(4) Chair, Committee for Professional Enhancement ("CPE");

(5) Chair, Credentials Committee; and

(6) Immediate Past Medical Staff President.

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

(1) Chief Clinical Officer; and

(2) VPMA.

(c) Other appropriate individuals (e.g., Medical Staff members, Advanced Practice Professionals, Chief Nursing Officer, other Medical Center 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 will be present only for the relevant agenda item and will be excused for all others. Also, one or more EPP Specialists may be invited to attend Leadership Council meetings to support the committee's activities. All individuals who attend a meeting 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 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.L.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) 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 EPP Policy;

(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 Medical Center;

(f) help to identify and recommend to the departments qualified individuals to serve as Department Chairs, to be elected by the relevant departments;

(g) help to identify and recommend to the Department Chairs qualified individuals to serve as Division Chiefs, to be presented to and selected by the relevant Department Chairs;

(h) appoint the Chair of the Nominating Committee;

(i) appoint the Chairs and members of all Medical Staff committees, except for the MEC, the members of the Nominating Committee other than the Chair, the CPE, or as otherwise provided in applicable Medical Staff policy;

(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 pursuant to the EPP Policy, the MEC, or the Board.

3.L.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 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.M. MEDICAL RECORDS REVIEW COMMITTEE

3.M.1. Composition:

The Medical Records Review Committee will consist of at least five Medical Staff members and the CEO or a designee. Each member will serve for two years with staggered terms and may serve a maximum of two consecutive terms. The CEO may also assign representatives from medical records, nursing or other Medical Center departments to the committee to assist it in its function. The director of the Medical Records Department will be an *ex officio* member of the committee.

3.M.2. Duties:

The Medical Records Review Committee will:

(a) determine that each medical record, or a representative sample of records, is reviewed for quality of documentation, timeliness of completion and clinical pertinence of the record contents;

(b) determine that each medical record, or a representative sample, is completed with respect to a diagnosis, diagnostic test results, therapies as rendered, in-hospital progress of the patient and the condition of patient at time of discharge;

(c) receive regular reports of summary information with regard to the timely completion of all medical records; and

(d) receive recommendations from the medical records director and take action as necessary relative to hospital chart forms.

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

(a) The Medical Records Review Committee will meet at least quarterly and will maintain written records which reflect the results of all evaluations performed by the committee members and the actions taken by the committee.

(b) The committee will report on a regular basis its actions or recommendations to the MEC of the Medical Staff and, as necessary, to the Credentials Committee. Additionally, the committee may forward a report of its findings, proceedings, and actions, as appropriate, to the CPE of the Medical Staff and to the CEO.

3.N. ONCOLOGY ADVISORY COMMITTEE

3.N.1. Composition:

The Oncology Advisory Committee will be a standing committee and must consist of a multidisciplinary Physician membership that includes at least one board certified Physician

in each of the following disciplines: surgery, medical oncology, radiation oncology, diagnostic radiology, pathology. The membership must also include Physicians from those disciplines representing the top five cancer sites seen at the Medical Center. Other members of the committee must include the American College of Surgeons Cancer Liaison Physician, the Cancer Registrar, and one representative from the Medical Center management, Oncology Nursing, Social Services and Quality Assurance to serve, *ex officio*, without vote. The Medical Staff President will appoint the Chair. The Chair will appoint one member of the committee to assume direction of, and to maintain liaison between, the Cancer Registry, the Medical Staff, and other Medical Center departments.

3.N.2. Duties:

The Oncology Advisory Committee will designate a Physician to provide medical direction for the cancer program and may be the Chair assuming the following responsibilities: access, use, and maintenance of appropriate certification, accreditation, and membership of individuals involved in the care of cancer patients; establish and monitor medical, scientific, and ethical standards; and effective and cost-efficient use of resources in the areas of budgeting, long-range planning, needs assessment, and grant applications. The Oncology Advisory Committee will plan, initiate, and assess all cancer-related activities in the Medical Center with the following responsibilities, including, but not limited to:

(a) develop and evaluate annual goals and objectives for clinical, educational and programmatic activities related to cancer;

(b) promote a coordinated, multidisciplinary approach to cancer patient management;

(c) ensure that educational and consultative cancer conferences cover all major sites and related issues;

(d) ensure that an active supportive care system is in place for patients, families and staff;

(e) monitor quality management and improvement through completion of studies that focus on quality, access to care and outcomes on an annual basis that must include, but will not be limited to:

- establishment of a quality management plan that identifies the roles and responsibilities of the Oncology Advisory Committee, the Committee Chair, cancer registrar and the ACOS liaison physician,

- establishing the quality improvement priorities of the cancer program, the responsibility for defining quality measures for topics considered high-priority opportunities for improvement and to monitor compliance with treatment guidelines, evaluating the results of measurement activities to determine the current performance levels, assess the need for interventions and identify opportunities for refining existing processes, and

- ensuring that all quality management activities will be documented and reported to relevant caregivers and leadership groups;

(f) promote clinical research;

(g) supervise the cancer registry and ensure accurate and timely abstracting, staging and follow-up; perform quality control of registry data and encourage data usage and regular reporting;

(h) publish and distribute an annual report of cancer program activity by November 1 of the following year; and

(i) develop a public education plan that includes annual review and revision and should include the following:

- program scope, goals, objectives,
- method for selecting activities,
- description of programs and services offered, and
- outcome evaluation of programs and services.

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

The Oncology Advisory Committee must meet at least quarterly, but as often as necessary to transact its business with a schedule that meets the needs of the Medical Staff and will maintain a permanent record of its findings, proceedings, and actions. The committee will provide a written or oral report to the MEC and the CEO as necessary.

3.O. OPERATING ROOM COMMITTEE

3.O.1. Composition:

The Operating Room Committee will consist of representatives from the Departments of Anesthesiology, Cardiac Services, General Surgery, Obstetrics and Gynecology, Orthopedics, Otolaryngology, Specialty Surgery, and Dental, Oral and Maxillofacial Surgery. These representatives will be appointed by their respective Department Chair. There will be one representative for every ten members of the respective department with the exception of the Department of Cardiac Services which will be represented by one cardiothoracic surgeon. The Medical Staff President will appoint either the Department Chair of Surgery or General Surgery to be the Chair of the committee. Additional members *ex officio,* without vote, will include representatives from nursing services and Medical Center management.

3.O.2. Duties:

The Operating Room Committee will:

(a) review and evaluate the appropriateness and quality of patient care in the operating room suites;

(b) review the appropriateness of utilization of the operating room suite and facilities;

(c) regularly review and recommend policies and procedures concerning the quality of surgical care and the efficient and smooth functioning of the operating room suites;

(d) review and evaluate reports from other committees, departments and patient care units concerning the quality of surgical and recovery care provided to patients and other professional matters;

(e) collaborate with the operating room supervisor and the nursing staff concerning the evaluation of new products, equipment and procedures, and make recommendations relative to improvements or modifications in operating room equipment, instruments, supplies and supportive procedures necessary to properly maintain the operating room; and

(f) recommend continuing education programs for the Medical Staff and nursing service relative to the functioning of the operating room.

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

The Operating Room Committee will meet as often as necessary to accomplish its duties, but at least every other month, will maintain a permanent record of its findings, proceedings and actions, and will provide an oral or written report to the MEC, appropriate Department Chairs, CPE, or the CEO as necessary.

3.P. PHARMACY AND THERAPEUTICS COMMITTEE

3.P.1. Composition:

The Pharmacy and Therapeutics Committee will consist of physician representation from each clinical department as appointed by their respective Department Chair. A representative(s) from nursing service and Medical Center management as appointed by the CEO to serve, *ex officio*, without vote. Medical Center representation will also include the pharmacy director and nurse epidemiologist, who serve *ex officio,* without vote.

3.P.2. Duties:

The Pharmacy and Therapeutics Committee will:

(a) review drug usages by analyses of data with regard to individual and/or collective prescribing patterns;

(b) develop and recommend to the Medical Center management procedures which relate to medication practices, as, for example, selection, distribution, handling, and administration of drugs as well as hazardous and investigational drug protocols;

(c) review all significant untoward drug reactions and the administration of known/suspected problem-prone medication, with actions as appropriate;

(d) maintain a formulary or product selection list based on efficacy, safety, and cost considerations; and

(e) develop educational programs for professional staff with regard to drugs and drug practices.

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

The Pharmacy and Therapeutics Committee will meet as often as necessary to transact its business, but at least every other month, will maintain a permanent record of its findings, proceedings and actions, and will make a written or oral report periodically to the MEC, the CPE, and to the CEO as necessary.

3.Q. RADIATION SAFETY COMMITTEE

3.Q.1. Composition:

The Radiation Safety Committee will consist of Medical Staff members who include an oncologist, pathologist, radiation therapist, cardiologist, surgeon, interventional neurologist and radiologist with special interest in nuclear medicine. The Radiation Safety Officer and one representative each from nursing service and Medical Center management who is neither an authorized user nor a Radiation Safety Officer to serve, *ex officio*, without vote.

3.Q.2. Duties:

The Radiation Safety Committee will:

(a) monitor and make recommendations concerning the safe handling of radioactive isotopes utilized within the Medical Center pursuant to the standards set forth in the applicable policy and regulatory manual;

(b) maintain a policy manual in keeping with guidelines and recommendations of appropriate state and federal governmental agencies including DNV Healthcare Accreditation;

(c) appoint, approve and authorize the Radiation Safety Officer as designee for Radiation Safety throughout the Medical Center;

(d) review all proposals for research, diagnostic, and therapeutic uses of radioisotopes and unsealed radionuclides;

(e) develop regulations for the use, transport, storage and disposal of radioactive materials used in nuclear medicine procedures;

(f) review quality control procedures to guide personnel in the standardized performance of diagnostic studies and therapeutic processes in order to maintain the identity, strength and integrity of all radiopharmaceutical agents;

(g) establish regulations to guide nursing and other health care practitioners who are in contact with patients receiving therapeutic amounts of unsealed radionuclides;

(h) maintain a file of special rules and regulations wherever radioactive materials are used or dispensed;

(i) review the training and experience of proposed authorized users, the Radiation Safety Officer, the radiopharmacist and teletherapy physicists to determine that their qualifications are sufficient to enable the individuals to perform their duties safely;

(j) prescribe special conditions that will be required during the use of radioactive materials, such as requirements for bioassays, physical examinations of users, and special monitoring procedures;

(k) establish an ongoing educational and safety program for all persons whose duties may require them to work in or to frequent areas where radioactive materials and/or radiation producing materials are used;

(l) review quarterly summary reports prepared by the Radiation Safety Officer concerning the occupational radiation exposure records of all personnel, with particular attention to those individuals or groups whose occupational exposure appears excessive;

(m) review, at least annually, summary reports of the entire Radiation Safety Program to determine that all activities are being conducted safely, in accordance with NRC and state regulations, and the conditions of license;

(n) recommend remedial action to correct any deficiencies identified in the Radiation Safety Program;

(o) establish a table of investigational levels for individual occupational radiation exposures based upon NRC regulations; and

(p) provide technical advice to the Radiation Safety Officer on matters pertaining to radiation safety.

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

The Radiation Safety Committee will meet as often as necessary to conduct its business, but at least two times a year, will maintain a permanent record of its findings, proceedings and actions, and will make a written report after each meeting to the MEC and the CEO.

3.R. STRATEGIC PLANNING AND EQUIPMENT PLANNING COMMITTEE

3.R.1. Composition:

The Strategic Planning and Equipment Planning Committee will consist of one Active Staff representative from each clinical department, appointed by the Department Chair, and a physician affiliated with the AHEC residency programs, appointed by the Medical Staff President, who will each serve three to five year staggered terms. The Medical Staff President and a representative from Medical Center management will serve on the committee *ex officio*, without vote.

3.R.2. Duties:

The Strategic Planning and Equipment Planning Committee will:

(a) Strategic Planning Duties:

(1) develop and maintain a list of projects deemed to be important to the Medical Staff;

(2) review and evaluate recommendations for projects, etc. from the Medical Staff;

(3) consider proposals based on a consistent review system;

(4) seek consensus from the MEC on Medical Staff priorities;

(5) collaborate with senior administration to determine the cost and benefit of expenditures with consideration of long-range plans; and

(6) serve as a conduit to the Board of Trustees for Medical Staff strategic planning.

(b) Equipment Planning and Evaluation Duties:

(1) consider for approval all requests for capital equipment for each clinical department;

(2) develop a long-range plan for the orderly acquisition of equipment for the provision of future clinical services;

(3) coordinate the planning and procurement of equipment with Medical Center management;

(4) review utilization patterns concerning medical and surgical equipment and make recommendations to clinical Department Chairs and/or the MEC as appropriate; and

(5) participate, in concert with the corporate bylaws and the Medical Center's long-range plan, regarding the procurement of equipment to be used in the care and treatment of patients at the Medical Center.

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

The Strategic Planning and Equipment Planning Committee will meet as often as necessary to accomplish its duties, but at least quarterly, will maintain a permanent record of its findings, proceedings and actions, and will make a report after each meeting to the MEC, appropriate Department Chairs, and the CEO as necessary.

3.S. TRAUMA SERVICES COMMITTEE

3.S.1. Composition:

The Trauma Services Committee will consist of a multidisciplinary group of physicians actively involved in the care of trauma patients. Essential to the committee is membership by one or more representatives from the fields of general surgery, orthopedic surgery, trauma surgery, emergency medicine and neurosurgery, all of whom are appointed by the Medical Staff President. Representatives from anesthesiology and radiology are ad hoc members and are appointed as needed by their respective Department Chair. The Medical Director of the Trauma Service must serve as a voting member. The following serve as permanent non-voting members – CEO (or designee), Site Administrator, CFH (or designee), Trauma Services Director, Trauma Coordinator, Trauma Register, ED Director, Surgical Services Director, Clinical Outcomes Director, Performance Improvement Coordinator, Orthopedic Case Manager and Assistant Chief, Vitalink and Transport. Other specialists may be appointed at the discretion of the Medical Staff President.

Representatives from Medical Center management, ancillary support services, and the nursing service may serve *ex officio*, without vote, and may be assigned by the CEO.

3.S.2. Duties:

The Trauma Services Committee will:

(a) oversee Trauma Services and the Trauma Performance Improvement Program;

(b) prioritize improvement initiatives relating to clinical outcomes of trauma patients;

(c) review and discuss performance data and trends;

(d) make recommendations and take actions to improve processes and care;

(e) make recommendations to address issues that are important to trauma services that will be brought back with actions from other groups/disciplines;

(f) conduct mortality/morbidity review; and

(g) conduct functions outlined in the EPP Policy.

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

The Trauma Services Committee will meet monthly and/or at the discretion of the Chair of the committee and will maintain minutes to reflect such activity. The committee will report its actions or recommendations to the MEC on a regular basis and, as necessary, to the CPE and Medical Staff departments. Additionally, the committee may forward a report of its findings, proceedings and actions, as appropriate, to the CEO.

3.T. UTILIZATION MANAGEMENT COMMITTEE

3.T.1. Composition:

The Utilization Management Committee will consist of the following members: Medical Staff Leaders, hospital service line leaders, and Physicians that represent the interests of the Medical Center related to the appropriateness of resource utilization. These representatives will be appointed by the Medical Staff President who also names two co-Chairs. The Medical Director of Clinical Resource Services will be a permanent member of the Utilization Management Committee. Representatives from Medical Center management, ancillary support services, and from the nursing service may serve *ex officio*, without vote, and may be assigned by the CEO.

3.T.2. Duties:

The Utilization Management Committee will perform the following functions:

(a) monitor and evaluate the appropriateness of resource utilization;

(b) assess utilization patterns;

(c) assist in the establishment and maintenance of criteria for use within the Medical Center;

(d) ensure compliance with approved criteria;

(e) provide direction and oversight to clinical affairs; and

(f) perform such other functions as described in the Policy on Review of Concerns Related to Utilization.

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

The Utilization Management Committee will meet at least every other month and will maintain written records which reflect the results of its evaluation of resource utilization. The committee will report on a regular basis its actions or recommendation to the CPE.

ARTICLE 4

AMENDMENTS

This Manual may be amended pursuant to Article 8 of the Medical Staff Bylaws.

ARTICLE 5

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 Medical Center policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: December 14, 2020

Approved by the Board: December 15, 2020