BOONE HOSPITAL CENTER

MEDICAL STAFF ORGANIZATION MANUAL

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

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

1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees.

(2) When a Medical Staff or Allied Health Staff member is unavailable or unable to perform an assigned 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. DEPARTMENTS

The Medical Staff will be organized into the following clinical departments:

DEPARTMENT OF ANESTHESIOLOGY

DEPARTMENT OF EMERGENCY MEDICINE

DEPARTMENT OF MEDICINE

- Division of Family Medicine
- Division of Hospital-Based Medicine
- Division of Internal Medicine
- Division of Neurology

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

DEPARTMENT OF ORTHOPAEDIC SURGERY

DEPARTMENT OF PATHOLOGY

DEPARTMENT OF PEDIATRICS

DEPARTMENT OF RADIOLOGY

DEPARTMENT OF SURGERY

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS, DEPARTMENT CHIEFS, AND VICE CHIEFS

(1) The functions and responsibilities of departments, department chiefs, and vice chiefs are set forth in Article 4 of the Medical Staff Bylaws.

(2) The Department of Medicine will function with two departments co-chiefs and vice chiefs. One department co-chief will be a hospital-based internist, either a hospitalist or an intensivist.

(3) All references in the Bylaws, Credentials Policy, Organization Manual, and other Medical Staff policies, procedures, and rules and regulations to "department chief" shall be interpreted to include the applicable Department of Medicine co-chief(s).

2.C. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

(1) Clinical departments will be created and may be consolidated or dissolved by the Medical Executive Committee 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 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 Chief Medical Officer and by the rest of the Medical Staff leadership 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 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 the Bylaws and related policies;

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

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

(d) no qualified individual is willing to serve as department chief; or

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

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

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

(3) In addition to the stated composition of any committee, the Chief of Staff, in consultation with the Chief Medical Officer, may appoint one or more members of the Allied Health Staff to serve as a member of a given committee.

(4) This Article details the standing members of each Medical Staff committee. In addition to the standing members, other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Staff committee meeting (as guests, without vote) in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. Such individuals are an integral part of the credentialing, quality assurance, and peer review process and are bound by the same confidentiality requirements as the standing members of such committees.

(5) In accordance with Article 5 of the Medical Staff Bylaws, the Medical Executive Committee may establish additional committees or special task forces.

3.B. MEETINGS, REPORTS, AND RECOMMENDATIONS

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

3.C. CANCER COMMITTEE

3.C.1. Composition:

(a) Required Cancer Committee members include at least one physician representing each of the diagnostic and treatment services, coordinators, and representatives from administrative, clinical and supportive services. Assessment of the scope of

services offered will determine the need for additional Cancer Committee members based on the major cancer sites seen by the program.

(b) The Chief of Staff will have the authority to appoint other individuals to serve on the committee and is expected to select representatives from both the community and the hospital. The Chief of Staff will appoint the other individuals as needed to comply with the accreditation requirements of the American College of Surgeons ("ACoS") and the Commission on Cancer ("CoC") program.

(c) Appointments for required members must occur at the first meeting of a calendar year at least once during the accreditation cycle. The appointments are documented in the minutes. If a committee member cannot continue to serve on the Cancer Committee, a new member must be appointed at the next meeting and documented in the minutes.

(d) Required Physician Members:

(1) Cancer Committee Chair: Physician of any specialty may be selected according to facility rules and/or bylaws; can also represent one of the required physician specialties;

(2) Cancer Liaison Physician ("CLP"): Can represent one of the required physician specialties and/or the Quality Improvement Coordinator. CLP also serves as the Cancer Committee Chair alternate;

(3) Diagnostic Radiologist;

(4) Pathologist;

(5) Surgeon: Can be a general surgeon involved in cancer care or a surgical specialist involved in cancer care;

(6) Medical Oncologist; and

(7) Radiation Oncologist.

(e) Required Non-Physician Members:

(1) Cancer Program Administrator: Responsible for administrative oversight and has budget authority for the Cancer Program;

(2) Oncology Nurse;

(3) Social Worker (licensed social worker, OSW-C preferred);

(4) Certified Cancer Registrar ("CTR");

(f) Required Coordinator Members:

(1) Cancer Conference Coordinator: Responsible for overseeing multidisciplinary cancer conference;

(2) Quality Improvement Coordinator: Responsible for overseeing quality improvement initiatives;

(3) Cancer Registry Quality Coordinator: Responsible for overseeing cancer registry quality control and Cancer Registry staff credentials;

(4) Clinical Research Coordinator: Responsible for overseeing clinic research accrual;

(5) Psychosocial Service Coordinator: Responsible for overseeing psychosocial distress screening; and

(6) Survivorship Program Coordinator: Responsible for overseeing the survivorship program.

One individual may serve in a maximum of two coordinators roles and represent one of the required physician or non-physician specialties.

A Certified Cancer Registrar may only serve as Cancer Conference Coordinator and/or Cancer Registry Quality Coordinator.

(g) Cancer Committee Members strongly recommended but not required:

(1) Specialty physicians representing the five major cancer sites at Boone Health;

(2) Palliative Care Professional;

(3) Genetics Professional;

(4) Registered Dietitian Nutritionist;

(5) Rehabilitation Services Professional;

(6) Pastoral Care Representative;

(7) American Cancer Society Representative; and

(8) Marketing/Community Health Professionals.

3.C.2. Duties:

The Cancer Committee will perform the following:

(a) monitor Cancer Committee meeting frequency and attendance of the members;

(b) promote and coordinate a multidisciplinary approach encompassing physician and non-physician professionals for the care of cancer patients;

(c) monitor and evaluate multidisciplinary cancer case conference(s) activity and findings to evaluate patient management. All required elements will be documented in the minutes each calendar year;

(d) monitor and document physician credentials for all physicians involved in the evaluation and management of cancer patients. The multidisciplinary team includes radiologist, pathologists, surgeons, radiation oncologists, and medical oncologists;

(e) review, monitor and evaluate policies that ensures oncology nursing competency each year per hospital policy;

(f) monitor and review the policy and procedures to annually evaluate the quality of cancer registry data and activity including procedures to monitor and evaluate each required control component. Assist with physician quality review of cancer registry data timeliness, accuracy and patient follow-up;

(g) monitor required data submission of cancer registry data to State, ACoS, CoC, National Cancer Data Base, and Rapid Cancer Reporting System (RCRS);

(h) monitor the Cancer Program's expected Estimated Performance rates for accountability and quality improvement measures selected by the CoC;

(i) under the guidance of the CLP, the Quality Improvement Coordinator and the Cancer Committee, the Cancer Program must conduct at least one cancer-specific quality improvement initiative each year;

(j) establish, monitor and document in minutes, one Cancer Program goal appropriate and relevant to the Boone Health Cancer Program and patient population;

(k) identify at least one patient, system, or provider-based barrier to accessing health and/or psychosocial care facing cancer patients and implement a plan to address the barrier;

(l) holds at least one cancer prevention event a year focused on decreasing the number of diagnoses of cancer;

(m) review and monitor clinical research information and annual enrollment in clinical research studies in accordance with CoC guidelines, and;

(n) ensure Cancer Program participates in required CoC Cancer Special Studies.

3.C.3. Meetings and Reports:

Each required Cancer Committee member or the member's designated alternate must attend at least 75% of the Cancer Committee meetings held each calendar year. The Cancer Committee must meet at least once each calendar quarter. Quarters are defined as: January 1-March 31; April 1-June 30; July 1-September 30, and; October 1-December 31.

3.D. CARDIOPULMONARY CARE COMMITTEE

3.D.1. Composition:

(a) The Cardiopulmonary Care Committee will consist of at least three members of the Medical Staff, including one representative from the Department of Surgery, one representative from the Department of Anesthesia, and one representative from the Department of Medicine or Pediatrics. One of the Medical Staff members should be board certified in critical care.

(b) The Committee will include one representative of the Hospital Administration.

(c) The Cardiopulmonary Care Committee may be chaired by either a representative of the Hospital or of the Medical Staff.

3.D.2. Duties:

The Cardiopulmonary Care Committee will:

(a) monitor and make recommendations regarding the provision of care to cardiopulmonary patients;

(b) formulate and maintain policies to facilitate the delivery of quality care in the areas of coronary care, respiratory therapy, and cardiopulmonary resuscitation; and

(c) make recommendations to the Medical Executive Committee regarding emergency and standing orders related to cardiopulmonary resuscitation and rapid response.

3.E. CONTINUING MEDICAL EDUCATION COMMITTEE

3.E.1. Composition:

The Continuing Medical Education Committee will consist of at least two representatives of the Medical Staff.

3.E.2. Duties:

The Continuing Medical Education Committee will:

(a) evaluate the effectiveness of educational programs;

(b) evaluate and make recommendations regarding the need for professional library services;

(c) act upon recommendations for continuing education from the Medical Executive Committee, departments, or other committees;

(d) maintain a permanent record of education activities and submit reports to the Medical Executive Committee concerning such activities, as requested; and

(e) organize programs for general Staff meetings and department meetings, as requested.

3.F. CREDENTIALS COMMITTEE

3.F.1. Composition:

(a) The Chairperson of the Credentials Committee, in consultation with the Chief of Staff, will appoint at least five members of the Active Staff to serve on the Credentials Committee. Members will be selected based on their interest or experience in credentialing matters. The Immediate Past Chief of Staff, or another Past Chief of Staff, will also serve as a member of the Credentials Committee.

(b) A Past Chief of Staff will serve as Chairperson of the Credentials Committee. The Immediate Past Chief of Staff will serve as a member of the Credentials Committee and/or as the Chairperson

(c) Members of the committee will be appointed for an initial three-year term and will be replaced on a rotating basis to promote continuity. Members may be reappointed for subsequent terms.

(d) The Chairperson of the Credentials Committee may appoint a representative(s) from the Allied Health Staff to serve as non-voting member(s) of the committee on an as-needed basis, to review applications of or matters relating to Allied Health Staff members.

(e) The Chief Medical Officer and Chief Nursing Officer will serve as nonvoting members of the Credentials Committee.

3.F.2. Duties:

The Credentials Committee will:

(a) review the credentials of all applicants seeking Medical Staff or Allied Health Staff appointment, reappointment, and/or clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) review, as may be requested by the Medical Executive Committee or other appropriate committee, available information regarding the current clinical competence of individuals currently appointed to the Medical Staff or the Allied Health Staff and, as a result of such review, make a written report of its findings and recommendations;

(c) review initial competency evaluation for members; and

(d) recommend to the Medical Executive Committee appropriate threshold eligibility criteria for clinical privileges, including clinical privileges or new procedures and clinical privileges that cross specialty lines.

3.F.3. Meetings and Reports:

The Credentials Committee will meet at least ten times per year and will make regular reports to the Medical Executive Committee on the status of pending applications (including any reasons for delay in processing an application or request). Meetings of the Credentials Committee will only be open to members of the committee, the Chief of Staff, the President, and any other persons that the Chairperson of the Credentials Committee has authorized to be present.

3.G. INFECTION PREVENTION COMMITTEE

3.G.1. Composition:

(a) The Infection Prevention Committee will consist of physician representatives from each of the following clinical areas:

(1) Internal Medicine;

(2) Obstetrics and Gynecology;

(3) Neonatology or Pediatrics; and

(4) Surgery.

(b) There will be a representative from Patient Care and from Pathology on the Infection Prevention Committee.

(c) The Chairperson of the Infection Prevention Committee will have the discretion to add additional individuals to the committee, including members from the Allied Health Staff, to serve as a member(s) of the committee.

3.G.2. Duties:

The Infection Prevention Committee will perform the following duties:

(a) conduct ongoing surveillance of institution infection potentials;

(b) identify and analyze the incidence and cause of infections;

(c) promote preventive and corrective programs to minimize infection hazards;

(d) review infection control practices in the Hospital as requested by the Medical Executive Committee;

(e) review and approve policies and procedures pertaining to infection prevention;

(f) make recommendations to the Hospital administration and Medical Executive Committee relating to infection control concerns raised by the Chief of Staff, the Medical Executive Committee, the departments, or other Staff and Hospital committees; and

(g) recommend appropriate control measures or institute any reasonable study when a situation appears to present a health risk to patients or Hospital personnel.

3.G.3. Meetings and Reports:

The Infection Prevention Committee will meet quarterly and as necessary to perform its duties. The Infection Prevention Committee will maintain a permanent record of activities relating to infection prevention and will report statistics of hospital-acquired infection to the Medical Executive Committee.

3.H. LEADERSHIP COUNCIL

3.H.1. Composition:

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

(1) the Chief of Staff;

(2) the Vice Chief of Staff;

(3) the Secretary-Treasurer; and

(4) the Chief Medical Officer.

(b) At the discretion of the Chief of Staff and the Chief Medical Officer, the duties of the Leadership Council may be carried out by any complement of Leadership Council members, who will report back to the full Leadership Council at its next meeting.

(c) Other Medical Staff members or Hospital personnel may be invited to attend a particular Leadership Council meeting to assist the Leadership Council in its discussions and deliberations. Any such individual will attend as a guest, without vote, but will be considered an integral part of the peer review process and will be bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.H.2. Duties:

The Leadership Council may perform the following functions:

(a) review and address issues regarding the clinical practice of members as part of the peer review process and as set forth in the PPE Policy;

(b) serve as the primary body responsible for addressing concerns about the professional conduct of members by engaging in collegial intervention and other progressive steps as set forth in the Code of Conduct Policy;

(c) meet, as necessary, to consider and address any situation that may require immediate action involving a member of the Medical Staff or Allied Health Staff; and

(d) perform any additional functions as may be requested by the Medical Executive Committee and the Board.

3.H.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 Professional Practice Evaluation Committee and to the Medical Executive Committee.

3.I. MANAGED CARE CREDENTIALS COMMITTEE

The purpose, composition and terms, and duties of the Managed Care Credentials Committee are in Appendix C, Section C-15, of the Credentials Policy.

3.J. MEDICAL EXECUTIVE COMMITTEE

The composition, duties and meeting requirements of the Medical Executive Committee are set forth in Section 5.B of the Medical Staff Bylaws.

3.K. MEDICAL RECORD COMMITTEE

3.K.1. Composition:

(a) The Medical Record Committee will consist of at least three physician representatives from different clinical specialties. Consideration will be given to appointing a hospitalist to serve as a member of the Medical Record Committee.

(b) There will be non-physician representatives from Health Information Management/Medical Records and Patient Care.

(c) A physician will be appointed to serve as Chairperson of the Medical Record Committee.

3.K.2. Duties:

The Medical Record Committee will perform the following duties:

(a) review medical records to evaluate whether they are accurate, adequate, clinically pertinent, and timely;

(b) interface with the IT Committee;

(c) evaluate medical records to assess whether they meet the standards of the Medical Staff and the Joint Commission;

(d) serve as a liaison with the administration and with other medical records professionals;

(e) review and approve the Hospital's Abbreviation List on an annual basis; and

(f) review and approve other applicable medical record policies.

3.K.3. Meetings and Reports:

The Medical Record Committee will meet at least quarterly to accomplish its duties. It will maintain a permanent record of its activities and will submit reports to the Medical Executive Committee.

3.L. NOMINATING COMMITTEE

3.L.1. Composition:

(a) The Nominating Committee will consist of the Chief of Staff, the Vice Chief of Staff, and the immediate past Chief of Staff.

(b) The Chief of Staff will serve as Chairperson of the Nominating Committee.

(c) The President and Chief Medical Officer will serve as *ex officio* members of the Nominating Committee.

3.L.2. Duties:

(a) The Nominating Committee will convene not less than 45 days prior to the annual meeting of the Medical Staff and prepare a slate of qualified nominee(s) for the office of Secretary-Treasurer. In selecting a candidate(s) for this office, the Nominating Committee will consider the qualifications for the office set forth in the Bylaws. The Nominating Committee may also consult with members of the Medical Staff and Hospital administration concerning the qualifications and acceptability of prospective nominees.

(b) The Nominating Committee will timely submit its recommended slate so that notice of the nominees can be provided to the Medical Staff at least 30 days prior to the election.

(c) If an additional nomination is submitted, by written petition signed by at least 10% of the voting members of the Medical Staff, the Nominating Committee will evaluate the proposed candidate to ensure that he or she meets the qualifications for the office as set forth in the Medical Staff Bylaws.

(d) When there is a vacancy in a department chief position, or a new department is created, the applicable department will submit one or more candidates for department chief to the Nominating Committee. Additional nominations may be submitted by ballot. If no candidates are submitted to the Nominating Committee, it will select qualified nominee(s) for the department chief position. The Nominating Committee will review the proposed candidates to determine that they meet the qualifications set forth in the Bylaws.

3.M. PHARMACY AND THERAPEUTICS COMMITTEE

3.M.1. Composition:

(a) The Pharmacy and Therapeutics Committee will consist of at least three members of the Medical Staff. One of the physicians will serve as Chairperson of the Pharmacy and Therapeutics Committee.

(b) The committee will also include representatives from Administration, Nursing, Patient Care, and Pharmacy.

3.M.2. Duties:

The Pharmacy and Therapeutics Committee will perform the following duties:

(a) establish policies, procedures and responsibilities for managing, requesting and dispensing formulary and non-formulary drug products and devices at the Hospital;

(b) strive to prevent unnecessary duplication in the stocking of drugs;

(c) review and approve devices and technologies;

(d) make recommendations concerning drugs to be stocked on the nursing unit floors;

(e) make recommendations concerning appropriate antibiotic utilization policies;

(f) define and review significant untoward drug reactions and medical events;

(g) maintain and periodically review the Hospital formulary; and

(h) serve as an advisor to the Medical Staff and pharmacy on drug products and devices at the Hospital.

3.M.3. Meetings and Reports:

The Pharmacy and Therapeutics Committee will maintain a permanent record of activities relating to the pharmacy and therapeutics function. As requested, it will submit reports and recommendations to the Medical Executive Committee.

3.N. PHYSICIAN INFORMATION TECHNOLOGY COMMITTEE

3.N.1. Composition:

(a) The Physician Information Technology (IT) Committee will consist of the Chief Medical Officer and at least two other members of the Active Staff, one of whom will serve as Chairperson.

(b) The Physician IT Committee will include representatives from Administration and Nursing.

3.N.2. Duties:

The Physician IT Committee will perform the following functions:

(a) receive recommendations from Hospital staff that affect members of the Medical Staff and Allied Health Staff regarding the design of the Hospital information system;

(b) help with implementation of information technology projects, including but not limited to the EMR, that affect members of the Medical Staff and Allied Health Staff;

(c) review hospital standing order protocols;

(d) investigate existing workflow of clinical care issues related to the Medical Staff and Allied Health Staff using clinical IT systems;

(e) identify opportunities to improve the utilization of the Hospital's information systems through education or improvement of existing applications and technologies;

(f) provide guidance and recommendations to maintain information systems and clinical content relevant to the Medical Staff and Allied Health Staff;

(g) assist with accomplishing strategic and tactical goals related to information technology in support of organizational objectives;

(h) make recommendations regarding hardware and software to be utilized by members of the Medical Staff and Allied Health Staff; and

(i) perform such additional duties as will be delegated to it by the Medical Executive Committee.

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

The Physician IT Committee will meet as often as necessary to accomplish its functions, but at least quarterly, and will maintain a permanent record of its findings, proceedings, and actions. The Physician IT Committee will make a timely report after each meeting to the Medical Executive Committee.

3.O. PRACTITIONER HEALTH COMMITTEE

3.O.1. Composition:

(a) The Practitioner Health Committee will consist of the immediate past Chief of Staff, the Chief Medical Officer (unless designated otherwise by the President), and

two other members of the Medical Staff appointed for their experience in addressing health issues.

(b) Whenever the health of a member of the Medical Staff or Allied Health Staff is under review, the chief of his or her department will also join the committee on an ad hoc basis. The Immediate Past Chief of Staff will serve as the Chairperson of the Practitioner Health Committee.

3.O.2. Duties:

The Practitioner Health Committee will perform the following duties:

(a) assume responsibility for the supervision and management of practitioner health issues, as requested;

(b) review the performance of any individual who is referred to the committee and assess whether the individual would benefit from or require treatment, rehabilitation, or other assistance;

(c) assist in the diagnosis, treatment, and rehabilitation of practitioners who may be impaired;

(d) develop a process for referrals to the committee (including a self-referral process);

(e) maintain confidentiality of practitioners reviewed by the committee, unless limited by law, ethical considerations, or concerns about patient safety; and

(f) arrange educational programs for the Medical Staff and the Allied Health Staff on practitioner health issues, including preventive measures designed to promote well-being.

3.O.3. Meetings and Reports:

The Practitioner Health Committee will meet as necessary to perform its duties. At its discretion, it may report to the Medical Executive Committee if it determines that, despite the committee's efforts, a practitioner is potentially unable to safely perform his or her privileges.

3.P. PROFESSIONAL PRACTICE EVALUATION COMMITTEE

3.P.1. Composition:

(a) The Professional Practice Evaluation Committee will consist of the following:

(1) at least eight Medical Staff members who will be: (i) broadly representative of the clinical specialties on the Medical Staff; (ii) experienced or interested

in credentialing, privileging, peer review, or other Medical Staff affairs; and (iii) supportive of evidence-based medicine protocols; and

(2) the Chief Medical Officer.

(b) The Chief Medical Officer may appoint administrative staff as needed who will serve *ex officio*, without vote.

(c) The Chairperson of the Professional Practice Evaluation Committee will be appointed by the Chief of Staff and must be approved by the Medical Executive Committee.

(d) Before any Professional Practice Evaluation Committee member begins serving, the member must understand the expectations and requirements of the position and affirmatively accept them. Members will participate, as required, in periodic training on professional practice evaluation, with the nature of the training to be identified by the Leadership Council or the Professional Practice Evaluation Committee.

(e) To the extent possible, Professional Practice Evaluation Committee members will serve staggered, three-year terms, so that the Committee includes experienced members. Appointed members may be reappointed for additional terms.

(f) If additional expertise is required, the Professional Practice Evaluation Committee may request that a practitioner with the necessary expertise attend Professional Practice Evaluation Committee meetings while the matter is under consideration. The practitioner may assist the Professional Practice Evaluation Committee in its deliberations and the appropriate interventions. The practitioner will be present only for the relevant agenda items. Any such practitioner will attend as a guest, without vote, but will be an integral part of the professional practice evaluation process and will be bound by the same confidentiality requirements as the standing members of the committee.

3.P.2. Duties:

The Professional Practice Evaluation Committee will perform the following duties:

(a) oversee the implementation of the Professional Practice Evaluation Policy ("PPE Policy"), providing training and support to the various components of the process;

(b) review and approve ongoing professional practice evaluation quality data elements that are identified by specialties;

(c) review and approve the specialty-specific quality indicators identified by the specialties that will trigger the professional practice evaluation/peer review process;

(d) review, approve, and assist in the development of patient care protocols and guidelines that are recommended by specialties or others;

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

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

(g) develop, when appropriate, performance improvement plans for practitioners, as described in the PPE Policy;

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

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

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

3.P.3. Meetings and Reports:

The Professional Practice Evaluation Committee will meet at least ten times per year and will promptly report its findings to the Medical Executive Committee.

ARTICLE 4

AMENDMENTS AND ADOPTION

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

(b) The amendment process for this Manual is set forth in the Medical Staff Bylaws.

Adopted by the MEC: August 2, 2021

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