

JOINT POLICIES AND PROCEDURES

OF THE

MEDICAL STAFF OF MEMORIAL REGIONAL HOSPITAL,

MEMORIAL REGIONAL HOSPITAL SOUTH, AND

JOE DIMAGGIO CHILDREN’S HOSPITAL

AND

THE MEDICAL STAFF OF MEMORIAL HOSPITAL PEMBROKE

AND

THE MEDICAL STAFF OF MEMORIAL HOSPITAL MIRAMAR

AND

THE MEDICAL STAFF OF MEMORIAL HOSPITAL WEST

OF THE

SOUTH BROWARD HOSPITAL DISTRICT

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MEMORIAL HEALTHCARE SYSTEM

HOLLYWOOD, FLORIDA

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MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

CREDENTIALING POLICIES AND PROCEDURES

TITLE: Credentialing policy and procedure for new/initial appointments to the Medical Staffs of Memorial Healthcare System.

PURPOSE: To define the steps for uniformly processing each application for Medical Staff appointment and clinical privileges.

OBJECTIVES:

1. To assist in fulfilling the responsibility of each Hospital in assuring that the patients afforded care at each Hospital will have such care rendered by individuals appropriately qualified to do so.
2. To assure that each eligible applicant is afforded equal opportunity to be appointed to the Medical Staff.
3. To assure that adequate information pertaining to education, training, and current competence is reviewed by the appropriate individuals and committees prior to rendering a final recommendation to the Board.

INITIAL APPOINTMENT PROCEDURES

REQUEST FOR APPLICATION/APPLICATION PACKET

1. Upon request for application, an electronic packet will be launched to the provider that includes an application, delineation of privileges form, and other related documents.

Applicants requesting privileges in a department which is an incorporated group and is under contract with the Hospital or System, (i.e., Radiology, Anesthesia, Emergency Medicine) shall be referred to that group for application submission

RECEIPT & REVIEW OF APPLICATION PACKET FROM APPLICANT

If the applicant does not meet the minimum requirements for membership to one or more of the Hospitals (i.e. lack of board certification, residence or primary office, or lack of hospital affiliation), he or she will be so notified.

The Credentials Coordinator will review application for completion and submittal of all required documentation. If upon review the application is deemed incomplete, the applicant shall be notified via email or written letter of missing information. The Credentials Coordinator may also revert the application to practitioner and request completion.

PROCESSING OF APPLICATION/VERIFICATION OF CREDENTIALS

1. The credentials coordinator will verify the following:
 - Medical Education *
 - E.C.F.M.G., if foreign medical graduate *
 - Post Graduate Training (Internship, Residency, Fellowship)
 - Professional Practice History, if applicable
 - Teaching Appointments
 - Membership on other Hospital Staffs
 - Personal References
 - Insurance Carriers, past and present
 - Applicant's health status
 - Status in the U.S. either copy of H1B Visa or Permanent Residency [Green] Card. If naturalized US citizen, a copy of the photo page of the US passport.
 - Status of Discharge from the Military (DD Form 214)

2. The following sources will also be queried/verified:
 - AMA and/or AOA Physician Profiles
 - National Practitioner Data Bank (NPDB)
 - Board certification status
 - Florida Board of Medicine for verification of licensure
 - DEA Registration, and query to the NTIS
 - Medicare and Medicaid Sanctions, via query to Excluded Parties Listing or OIG
 - Background check

A copy of the delineation of privileges form completed by the applicant must be forwarded to the applicable reference source for verification of adequate training/competence for those privileges being requested.

Each individual practitioner who applies for Medical Staff membership and/or privileges has the burden of providing evidence that demonstrates, in the sole discretion of the Hospital, that he or she meets the Hospital's established criteria for membership and privileges. This applies at the time of initial appointment, reappointment, application for clinical privileges, employment, or at any time during a practitioner's affiliation with the institution. The Hospital has the sole discretion for determining what is an adequate response. If, during the process of initial application, the applicant fails to adequately respond within thirty (30) days to a request for information or assistance, the Medical Staff will exhaust the application. The result of the withdrawal is termination of the application process. This termination will not be considered an adverse action

nor will it be reported to any external agency for action and therefore will not entitle the applicant to any hearing or appellate review procedures under the Medical Staff Bylaws.

REVIEW OF COMPLETED APPLICATION

Upon completion of the applicant's file (i.e., all documentation in support of the application has been received, including without limitation, the information as specified in the Medical Staff Bylaws), the file will be reviewed for completeness by the Credentials Coordinator. If the practitioner is making application to multiple Hospitals within the Memorial Healthcare System, each Hospital where membership/privileges are being sought shall receive an electronic copy of the credentials file. Medical Staff Services will be responsible for obtaining departmental review and recommendation for appointment and approval of clinical privileges.

PRESENTATION TO THE CREDENTIALS COMMITTEE, MEDICAL EXECUTIVE COMMITTEE AND BOARD

1. A recommendation is made by the Department Chief and the Credentials Committee. Each Department in which the practitioner seeks clinical privileges shall provide the Executive Committee, or Advisory Council in the case of Memorial Regional Hospital Division or Joe DiMaggio Children's Hospital Division, with specific written recommendations for delineating the applicant's clinical privileges.
2. The written recommendations of both the Department and the Credentials Committee are reported to the Executive Committee, or Advisory Council in the case of Memorial Regional Hospital Division or Joe DiMaggio Children's Hospital Division, of each Hospital at which practitioner is making application, within ninety (90) days, for review at its next regularly scheduled meeting. The recommendation of an Advisory Council shall be forwarded to the Executive Committee of Memorial Regional Hospital.
3. At its next regular meeting after receipt of the application together with the Credentials Committee's report and Department report(s), the Executive Committee of each Hospital where the applicant seeks appointment, shall determine whether to recommend to the Board that the practitioner be appointed as a member of the Medical Staff, rejected for staff membership or that the application be deferred for further consideration.
 - If the Executive Committee recommends deferment for further consideration, a subsequent recommendation must be made within thirty (30) days for appointment for staff membership. Deferments beyond sixty (60) days from the date the Executive Committee first reviews the applications shall not be permitted without the consent of the applicant.
 - When the Executive Committee's recommendation is favorable for the practitioner, the Chief of Staff shall promptly forward the recommendation, together with all supporting documentation to the Board for final action.

- When the Executive Committee’s recommendation is not favorable for the practitioner, he or she shall be entitled to a reconsideration, hearing, and appellate review in accordance with the procedures outlined in the Medical Staff Bylaws.
4. When the Board’s decision is favorable, the Memorial Healthcare System shall send appropriate notices to the practitioner. Notification of unfavorable recommendations will be sent in accordance with the Medical Staff Bylaws.

VERIFICATION OF EXPIRABLES

All professional licenses, registrations and certificates are verified, at a minimum, at the time of a practitioner’s initial appointment, reappointment, and upon the request for additional privileges.

VERIFICATION/TERMINATION

Should Medical Affairs identify that a professional license has expired, that practitioner’s membership and/or privileges at all System Hospitals shall be automatically terminated in accordance with the Medical Staff Bylaws.

Should Medical Affairs identify that a DEA registration certificate has expired, the practitioner is notified that he or she no longer holds prescribing privileges in the Memorial Healthcare System. The Directors of Medical Staff at each Hospital are notified via email that said practitioner no longer holds prescribing privileges.

Upon verification of renewal of expired licenses/certificates, a practitioner may be reinstated to the Medical Staff to their last known staff status.

ALLIED HEALTH PROFESSIONALS

The Board has determined the categories of individuals eligible for clinical privileges as an Allied Health Professional (“AHP”) defined as in these Bylaws and as determined appropriate by the Medical Staff. These categories include:

- Anesthesia Assistant
- Advanced Practice Registered Nurse
- Certified Clinical Perfusionist
- Certified Neuro Intraoperative Monitorist
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialist
- “House Physician”*
- Physician Assistant
- Registered Nurse First Assist
- Surgical Assistant

* *“House Physician” is defined as a physician who is an unlicensed, foreign medical graduate.*

TEMPORARY PRIVILEGES

As outlined in the Medical Staff Bylaws, Temporary Privileges may be granted under the following two circumstances:

- Type 1: Pendency of an application, i.e. when an Applicant for new privileges with a complete application that causes no concerns is awaiting review and approval by the Executive Committee and/or the Board of Commissioners. Applicant for new privileges includes an individual applying for clinical privileges for the first time, or an individual currently holding clinical privileges who is requesting one or more additional privileges; or
- Type 2: To fulfill an important patient care, treatment, or service need

This policy applies to Licensed Independent Practitioners and Allied Health Professionals applying for Temporary Privileges at one or more Memorial Healthcare System hospitals, and the staff responsible for processing, evaluating and granting/denying these requests. Temporary Privileges are granted only to appropriately credentialed practitioners for a limited period of time, not to exceed 120 days, as set forth in the Medical Staff Bylaws.

PROCEDURE:

A. Verifications

1. For applicants who are requesting Type 1 Temporary Privileges (during pendency of an application’s approval by the Executive Committee and/or the Board of Commissioners)

The full credentialing process shall be completed, as set forth in the Medical Staff Bylaws and all associated credentialing policies. To consider the grant of such Temporary Privileges, there must be a complete application, as defined in the Medical Staff Bylaws, which shall include, but not limited to:

- A completed credentialing application;
 - A completed delineation of privileges request;
 - All verifications required by the Medical Staff credentialing and privileging policies;
 - Verification of current clinical competence for the privileges requested;
 - Confirmation that is clean application, as defined in the Medical Staff Bylaws;
 - A positive recommendation from the applicable Department Chief; and
 - A positive recommendation from the Chair of the Credentials Committee
2. For applicants who are requesting Type 2 Temporary Privileges (those requested to fulfill an important patient care, treatment and/or service need)

The credentials office shall obtain at a minimum, the following elements:

- Verification of current licensure;

- Verification of current professional liability insurance that meets or exceeds the minimum limits set by the Memorial Healthcare System;
- A completed delineation of privileges request or a full description of the care, treatment and/or service that the applicant wishes to provide;
- Attestation from the Department Chief (or designee) of the applicant's current clinical competence to exercise the privileges requested; and
- Documentation of the justification for the granting of Type 2 Temporary Privileges

The credentials office shall obtain the following additional information either prior to the grant of Temporary Privileges or, if time does not permit, as soon as possible thereafter:

- For applicants who intend to prescribe controlled substances, verification of the Practitioner's DEA registration;
- Query of the NPDB
- Query of the OIG/Excluded Parties and other routine sanction queries
- Review and recording of the AMA or AOA Profile; and
- Verification of Board Certification via direct query or AMA/AOA Profile

If these additional items are provided after the grant of temporary privileges due to the urgency of the need, the authorized approvers may consider this information to determine whether to authorize continuation, modification or termination of such Temporary Privileges.

B. Disqualification

The following shall disqualify an applicant from requesting or being granted Temporary Privileges:

- Previous successful or current in-process challenge to license or registration in any state or jurisdiction;
- Involuntary termination of Medical or Allied Health Staff membership at any organization;
- Involuntary limitation, reduction, denial, or loss of clinical privileges at any organization;
- Previous or pending corrective action taken at any Memorial Healthcare System Hospital; or
- Any red flags deemed to be of significance by the Department, or in the case of requests for Type 1 Temporary Privileges, the Credentials Committee.

C. Recommendation & Approval

Temporary Privileges are granted only on the documented recommendation of the Chief of Staff (or designee). Temporary Privileges are granted only by the Hospital Administrator (or designee).

D. Termination

A Practitioner shall not be entitled to due process or procedural rights afforded by the Medical Staff Bylaws if a request for Temporary Privileges is denied, or if any portion of,

or all of the Temporary Privileges are terminated or suspended for any reason.

EMERGENCY AND DISASTER PRIVILEGES

When the Emergency Management Plan has been activated and the immediate needs of the patients cannot be met, the Hospital may implement a modified credentialing and privileging process for eligible volunteer practitioners. The following procedure will be followed:

1. The Command Center will determine on a case-by-case basis in accordance with the needs of the Hospital and its patients whether volunteer practitioners are required.
2. Privileges to assist during the emergency/disaster will be granted by the Incident Commander (Administrator, or his or her designee) upon the recommendation of the System Chief Medical Officer, Hospital or Hospital Division Chief Medical Officer, or their designee, on a case-by-case basis. These privileges terminate automatically when the emergency situation no longer exists, or as determined by the Incident Commander.
3. Any practitioner who is not a member of the Medical Staff or AHP Staff and who provides patient care must be granted privileges prior to providing patient care, even in an emergency or disaster situation. Volunteer practitioners will be required to report to the designated location and provide the following:
 - a. A valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
 - (1) Current picture hospital ID card that clearly identifies professional designation;
 - (2) Primary source verification of licensure;
 - (3) Identification indicating that the individual is a member of a Disaster Medical Assistant Team (DMAT), or other recognized state or federal organization;
 - (4) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
 - (5) Identification by current Hospital or Medical Staff member(s) who possess personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.
4. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer practitioner presented to the Memorial Healthcare System. In the extraordinary circumstance that primary source verification cannot be completed in seventy-two (72) hours, e.g., no means of communication or lack of resources, primary source verification will be done as soon as possible and there will be documentation of why primary source verification was not completed in the required time frame.

5. Volunteer practitioners and/or allied health practitioners will be paired with a member of the active Medical Staff and will act only under the direct supervision of an active Medical Staff member. The Medical Staff oversees the professional practice of the volunteer licensed independent practitioners.

TELEMEDICINE PRIVILEGES

The Medical Staff has determined that telemedicine is an acceptable use of electronic communication and practitioners providing telemedicine services and communications must do so in accordance with all District, Hospital, and Medical Staff Policies and Procedures. Practitioners providing telemedicine services will be credentialed in accordance with the Medical Staff Bylaws and all applicable policies and procedures.

Applicants who are applying for telemedicine appointment and privileges may be credentialed through one of the following processes. Regardless of whether or not the credentialing is performed in the Hospital or the telemedicine practitioner's primary site, the applicant must meet the criteria defined in Section 4.2 of the Bylaws, with the exception of the residency requirements set forth in 4.2.G., and Medical Affairs will perform the queries for the National Practitioner Data Bank, licensure, DEA, etc.

1. Credential and grant privileges to the practitioner in the same manner as for all other applicants in accordance with Sections 5.1 and 5.2; or
2. Credential and grant privileges to the practitioner through a Delegated Credentials Agreement which utilizes credentialing information from the practitioner's primary hospital/group provided that the hospital/group is accredited by The Joint Commission. The Delegated Credentials Agreement will ensure that all services are provided by a licensed independent practitioner that meets Joint Commission credentialing requirements. Qualifications for inclusion in a telemedicine Delegated Credentialing Agreement will include, but may not be limited to the following:
 - a. The practitioner has not had his or her license to practice in any jurisdiction voluntarily or involuntarily suspended, terminated, limited, or revoked.
 - b. The practitioner has not had his or her appointment or clinical privileges at any other hospital or healthcare facility restricted, reduced, limited, suspended or terminated.
 - c. The practitioner is board certified or progressing towards board certification in accordance with the Medical Staff Rules and Regulations, unless extended for good cause by the Executive Committee and shall maintain such certification during the time that practitioner holds privileges at the Hospital.
 - d. The practitioner has not been convicted of any offense related to the provision of health care services or excluded from participation in any federal or state health care program.
 - e. Documentation of the practitioner's health status attesting to his or her ability to perform the essential functions of the privileges requested addressing the practitioner's physical, mental, and behavioral health.

- f. Documentation of quality and peer data as it relates to clinical competency.
 - g. Current unrestricted medical license.
 - h. Additional information that may be requested as needed to determine the practitioner's qualification for telemedicine appointment and privileges.
2. Once the credentialed application is received by Medical Staff Services, it will be reviewed for completion and accuracy. If the application is complete, it will be forwarded to the appropriate Department Chief(s) and Credentials Committee for consideration and recommendation.

PRIVILEGE SPECIFICATIONS:

1. Eligibility for clinical privileges is defined in the Medical Staff Bylaws.
2. The process of "grandfathering" allows for criteria for privileges to be updated without penalizing practitioners who currently hold the privilege. The new criteria will apply to all subsequent applicants. If the ACGME or ALA-accredited training program, board certification, etc., did not exist at the time of the practitioner's training, the practitioner may be "grandfathered" if current experience and competence for the privilege (s) can be demonstrated. The exception to the "grandfathering" rule is when a clinical activity requirement, volume requirement, or CME requirement is added to reappointment requirements; in this instance, all practitioners must meet reappointment criteria upon their next reappointment.
3. Proctoring is the process through which skills and/or knowledge that a practitioner asserts he/she already possesses are confirmed. Proctoring may be conducted by a credentialed member of the MHS Medical staff, in the same specialty, who currently possesses that privilege. For procedures new to MHS, proctoring by an appropriate member of the vendor team may be provided. Proctors must complete all applicable evaluation forms.
4. Privileges will be granted only to those Medical Staff Members and Allied Health Practitioners who demonstrate current clinical competence in the privileges requested. Current clinical competence includes the following factors:
 - a. Mental and physical health status appropriate in relation to the clinical privileges requested;
 - b. Clinical activity sufficient to maintain skills;
 - c. Education/training in requested privileges as evidenced by recommendations from training programs, appropriate board certification and maintenance of certification
 - d. Chief/peer recommendations attest to current competence;
 - e. Ongoing professional practice evaluation data which includes outcomes related to exercise of privileges, and comparative data, when appropriate

- f. Specifications as outlined on Delineation of privilege forms, i.e. volume requirements, etc.
5. Approval pathway for new privilege items/procedures:
- a. Proposed new privileges will be reviewed by the Governance Committee/Chief Medical Officer meeting to determine if the request is a duplicate of an existing procedure, or feasibility from an efficiency aspect, if new equipment is to be purchased or training required for staff, etc., and the initial and reappointment clinical standards.
 - b. Approvals then must be obtained by the relevant department (s) at all facilities, unless the privilege(s) will be available only to specific facilities, i.e. (OB, cardiac cath, cardiac surgery). If the privilege(s) applies to more than one specialty, credentialing criteria does not have to be the same for all specialties, but there must be consensus among the involved specialties that these criteria ensure the standard of care is met.
 - c. Once departmental approval has been obtained, it will be reviewed by the Credentials Committee. The submission must contain the exact name of the procedure/privilege, applicable specialties and delineation of privilege forms, required training, certification, and criteria for initial and/or reappointment, and the plan to validate competency, i.e. proctoring or routine FPPE/OPPE.
 - d. The Medical Executive Committee at each relevant facility will take action on the Credentials Committee recommendations.
 - e. Applicants must request the new privileges as per the “additional privileges” process or at the time of reappointment.

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ONGOING PROFESSIONAL PRACTICE EVALUATION POLICIES AND PROCEDURES

TITLE: Ongoing Professional Practice Evaluation (“OPPE”) policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: Memorial Healthcare System’s Ongoing Professional Practice Evaluation (OPPE) is designed to continuously evaluate a practitioner’s performance and competency. This process allows for any potential problem with a practitioner’s performance or quality that may impact patient safety and quality of care to be identified and addressed in a timely manner. Information obtained from the Ongoing Professional Practice Evaluation can be used to provide a snapshot of a practitioner’s current standing and determine whether that practitioner’s membership and/or clinical privilege(s) should be limited, proctored, or revoked.

POLICY and PROCEDURE:

1. On a routine basis the Chief Medical Officer and respective Hospital or Hospital Division Chief Medical Officer shall query and review the System-wide OPPE report as generated by Crimson. If a report cannot be generated thru Crimson (e.g through no attribution or if the practitioner is an AHP), MHS shall capture relevant clinical data via other means. Aggregate data and information captured in the OPPE includes, but is not limited to mortality, morbidity, readmissions, procedures, risk, infections, and other quality indicator related occurrences, as applicable. Practitioners are rated against like practitioners, case mix, and severity. Reports are shared with practitioners as needed and/or available upon their request.
2. The OPPE report is run in Crimson every eight (8) months or sooner. The Chief Medical Officer at the designated Hospital or Hospital Division will review the report.
 - Should the Department Chief and/or the Hospital or Hospital Division Chief Medical Officer believe there are no evident issues and/or trends of concern that would impact the quality of care and patient safety, the report will be signed off in Crimson and the process completed.
 - Should the Department Chief and/or the Hospital or Hospital Division Chief Medical Officer believe there are evident issues and/or trends of concern that would impact the quality of care and patient safety, the practitioner in question shall be required to meet and discuss in detail the concern(s) of the Department Chief and/or the Hospital or Hospital Division Chief Medical Officer. Pertinent findings from the meeting/discussion must be documented and include a recommendation of findings. These recommendations can include but are not limited to: additional periodic review, direct observation,

proctoring, and limitation or revocation of any existing privileges. Medical Staff Services shall receive a copy of the written recommendation for inclusion in the practitioners' credentials file and review by the Credentials Committee. Incidents or trending of quality and safety issues that impact the safety of patients will require immediate action by the Medical Staff. The Credentials Committee may recommend to the Medical Executive Committee for action, additional periodic review, direct observation, proctoring, maintain existing privilege(s), revise existing privilege(s), limit or revoke an existing privilege prior to or at the time of the practitioners' renewal.

- All recommendations for “corrective action” will be processed in accordance with the procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws.
 - All recommendations constituting “alternatives to corrective action” will not trigger the investigation process or hearing and appellate review procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws.
5. There may be circumstances where a single incident or evidence of a clinical practice trend may be identified through the OPPE process. If so, this will trigger a focused review/evaluation, which will be conducted according to the Peer Review Policy. Additionally, behavior identified as a potential issue will be addressed in accordance with the Disruptive Practitioner Policy and will be followed as a component of OPPE. Risk management reviews are also conducted on a quarterly basis between Medical Staff Services and the Risk Manager. Issues identified may also trigger a focused review/evaluation.
 6. Any physician who sponsors an AHP holding clinical privileges at a Hospital must complete and return an OPPE evaluation form for every AHP that the physician sponsors. Failure to complete the OPPE evaluation form may result in the physician's inability to continue to serve as the AHP's sponsor and utilize such AHP's services within Memorial Healthcare System.

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FOCUSED PROFESSIONAL PRACTICE EVALUATION POLICY AND PROCEDURE

TITLE: Focused Professional Practice Evaluation (“FPPE”) policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To assure that the Memorial Healthcare System Hospitals, through the activities of its Medical Staff, assess the professional practice and competence of its practitioners, and use the results of such assessment and evaluations to improve professional competency, practice, quality and patient care.

DEFINITION: FPPE is a process whereby the Memorial Healthcare System evaluates the privilege-specific competence of a practitioner who does not have documented evidence of competently performing the requested privilege(s) in the Memorial Healthcare System. This process may also be used when a question arises regarding a currently privileged practitioner’s ability to provide safe, high quality patient care. FPPE is a time-limited period during which the Memorial Healthcare System evaluates and determines the practitioner’s professional performance.

SCOPE: Medical doctors (M.D.), doctors of osteopathy (D.O.), oral maxillofacial surgeons, dentists, podiatrists, psychologists, allied health practitioners, and any other practitioners who are granted clinical privileges in accordance with the Medical Staff Bylaws.

POLICY:

1. The Focused Professional Practice Evaluation Policy will identify the process used to evaluate privilege-specific competence of practitioners practicing within the Memorial Healthcare System. Effective October 2011, this policy will apply to the following:
 - All new practitioners with clinical privileges.
 - All newly requested clinical privileges for existing practitioners.
 - All practitioners returning from a leave of absence.
 - Practitioners where an issue is identified regarding one’s ability to provide safe, quality patient care.
2. A Focused Professional Practice Evaluation will be implemented for all initially requested privileges for duration of four (4) months beginning with the date said privileges are approved by the Board.
3. Practitioners should be evaluated on their current medical and clinical competence, technical and clinical skills, professional judgment, interpersonal communication skills, and professionalism.

PROCEDURE:

1. **For Medical Staff Members**, the FPPE should include the review of a minimum of five (5) cases and may be conducted in the form of a concurrent review or retrospective review. Information to be considered during the review may include but is not limited to: quality indicator data, chart reviews, surgical case reviews, proctoring, medical records currency, and discussion with other care givers (i.e., consulting practitioners, nursing staff or administrative personnel).
2. **For Allied Health Professionals**, the FPPE will include at least five (5) proctored or reviewed cases by the sponsoring physician.
3. **For practitioners requesting a new or additional privilege**, a minimum of three (3) cases will be reviewed by the Department Chief, or his or her designee, unless a specific number of cases is referenced on the individual privileges request form.
4. A single or sentinel event or adverse trend may also trigger a period of FPPE. This may be initiated by any Officer of the Medical Staff, Chief or Vice Chief of a department, the System Chief Medical Officer, Hospital or Hospital Division Chief Medical Officer, Administrator, or CEO.
5. The FPPE should be performed by the Department Chief, or his or her designee, and may be performed at any MHS Hospital where the practitioner holds membership and privileges.
6. If competency is substantiated for those privileges granted as determined upon completion of the FPPE period without the need for further evaluation, the period of FPPE will be discontinued and the practitioner's performance will be evaluated through the periodic OPPE process. Should the focused evaluation be inconclusive, focused evaluation may continue for an additional amount of time or for a specified number of cases as determined by the Department Chief, or his or her designee.
7. Recommendations will be provided to the MHS Medical Staff Services for consideration and action by the Credentials Committee and Medical Executive Committee(s) of the Memorial Healthcare System Hospitals.
 - All recommendations for "corrective action" will be processed in accordance with the procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws.
 - All recommendations constituting "alternatives to corrective action" will not trigger the investigation process or hearing and appellate review procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

PEER REVIEW AND MULTI-DISCIPLINARY PEER REVIEW COMMITTEE POLICY AND PROCEDURE

TITLE: Peer review and multi-disciplinary peer review committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: The Medical Staff has, through the Department Chief (or his or her designee), the ongoing responsibility to perform peer review and performance improvement activities. It is the responsibility of all Medical Staff members and practitioners holding clinical privileges, including Allied Health Practitioners as they are included within the definition of "practitioner," to perform peer review and performance improvement activities to assess the performance of all practitioners holding Medical Staff membership and/or clinical privileges within the Memorial Healthcare System and utilize the results of such assessments to: (1) improve the quality of care provided within the Memorial Healthcare System; (2) monitor practitioners' performance; (3) identify opportunities for performance improvement; (4) monitor significant trends through data analysis; and (5) ensure the peer review process is clearly defined, fair, timely, and useful.

Peer review may be conducted in the following circumstances: (a) for any case that is identified by screening of standard performance improvement indicators; (b) for complaints from patients, family, staff, or other practitioners; (c) risk management issues; and (d) any issue identified that impacts patient care or customer service. These are discussed more specifically below.

POLICY:

1. The process for peer review is as follows:
 - a. Peer review referrals may be generated from the following sources:
 - Screening of standard Quality Indicators
 - Patient/Family Complaints (verbal or written)
 - Hospital staff reporting via incident report or verbal communication
 - Physicians
 - Infection Control
 - Mortality/Autopsy reviews
 - Chart reviews
 - Clinical Effectiveness
 - Outside regulatory agencies
 - Risk Management

- b. The Clinical Effectiveness (CE) Specialist, or his or her designee, will review the case and summarize the pertinent issues. The CE Specialist, or his or her designee, will enter the case into the Memorial Healthcare System quality monitoring database. After final review, the CE Specialist, or his or her designee, will record the outcome of the review, as determined by the appropriate reviewer/committee, with a combination of letter/number designations below:
- 0 – System issue rather than practitioner performance
 - 1 – Screen Failure – No issues identified
 - 2 – Complication appropriately recognized and patient outcome managed
 - 3 – Issue in patient management with low potential for adverse effects
 - 4 – Issue in patient management with high potential for adverse effects
 - 5 – Issue in patient management resulting in adverse effect
 - 6 – Physician Behavior Issue
-
- A – No further action required
 - B – Education
 - C – Counseling
 - D – Potential Corrective Action
- c. Initial peer review will be conducted at the Department level as set forth in this policy upon receipt of a Peer Review Referral Form and/or electronic notification. The peer review process will be initiated within thirty (30) days after identification of the event, and completed within ninety (90) days after initiation of the review. The chairperson of the Multi-Disciplinary Peer Review Committee or peer review panel (as defined in subsection (e)) may grant an extension on complex cases.
- d. A review of the complaint, issues and relevant circumstances is conducted by peers. The definition of “peer” is physician to physician, dentist to dentist, podiatrist to podiatrist, etc. For purposes of performance improvement, a “peer” is further defined as a health care practitioner on the Medical Staff, a practitioner holding clinical privileges, or an outside expert whose training, experience, and current practice is in the same field as the practitioner being reviewed or whose training, experience and current practice is relevant to the procedure(s) being reviewed.
- The Hospital or Hospital Division Chief Medical Officer may function as a Peer Reviewer for behavioral issues.
 - At his or her discretion, the Chief of the Department may function as a peer reviewer for cases that result in a 0-2 outcome. All other cases are referred to the peer review panel, in accordance with subsection (e).
- e. The Chief of the Department will appoint a panel of “peers” to review the case. All panels reviewing the case must have at least three (3) members.
- f. Where possible, the peers appointed to the committee or panel will be individuals who are not: (a) individuals having a present or prior relationship with the affected practitioner of shared medical practice, including without limitation, partnership,

employment or compensation arrangement; (b) relatives of the affected practitioner; (c) individuals exhibiting racial, religious, ethnic, or other prohibited prejudice; or (d) individuals who are creditors or debtors of the affected practitioner.

- g. Peer review by an outside agency may be required in cases where there are no peers available or all peers have a conflict of interest or in ambiguous or difficult cases in which the Multi-Disciplinary Peer Review Committee, Hospital or Hospital Division Chief Medical Officer, Memorial Healthcare System Chief Quality Officer, Administrator, or System Chief Medical Officer requests the case be reviewed externally.
- h. Participation by the individual whose performance is being peer reviewed is preferred, but is not required.
- i. After review of a case at the Department peer review panel level, the rating will be assigned.
- j. The results of the peer review panel will be documented on the Peer Review Referral Form and/or electronic form. If the outcome is a rating of 0-3, or 6, the case will be closed by the CE Specialist, or his or her designee, in the Memorial Healthcare System quality monitoring database.
- k. Cases to be referred to the Multi-Disciplinary Peer Review Committee include: (a) cases with an outcome rating of 4 or 5; (b) requests by the Chief Quality Officer and/or the Chief Medical Officer; and (c) cases meeting State of Florida Code 15 criteria and/or those determined to be a sentinel event that involve physician performance. In such circumstances, the Department Chief will be immediately notified. Preliminary review by the Departmental peer review panel is not required.

The individual under review by the Multi-Disciplinary Peer Review Committee shall be notified in advance of the review and afforded an opportunity to present his or her information regarding the case to the Multi-Disciplinary Peer Review Committee. The individual whose case is under review has the right to be present during the time the case is reviewed and discussed by the Multi-Disciplinary Peer Review Committee and provide additional information to the Multi-Disciplinary Peer Review Committee as necessary or as requested. Alternatively, the individual may submit a written statement to the Multi-Disciplinary Peer Review Committee for consideration as part of the review.

- l. Following its review, the Multi-Disciplinary Peer Review Committee will determine the appropriate rating (0-6) of the case and the actions to be taken, which may include:
 - No action.
 - B – Education*
 - C – Counseling*

* Ratings of B or C above are considered “alternatives to corrective action.”

All actions constituting “alternatives to corrective action” will not trigger the investigation process or hearing and appellate review procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws. The Department Chief may not unilaterally impose any alternative to corrective action. In the event the individual whose performance is being peer reviewed does not agree to the alternatives to corrective action utilized, the Department Chief or chairperson of the peer review panel or Multi-Disciplinary Peer Review Committee may make a request for corrective action to the Chief of Staff in accordance with Article 7 of the Bylaws.

Examples of “alternatives to corrective action” include:

- i. Informal discussions or formal meetings regarding the concerns raised about conduct or performance;
 - ii. Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;
 - iii. Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
 - iv. Suggestions that the individual seek continuing education, consultations, or other assistance in improving performance or interactions with others;
 - v. Warnings regarding the potential consequences of failure to improve conduct or performance;
 - vi. Recommendations to seek assistance for an impairment, as provided in the Bylaws; the Medical Staff Rules and Regulations, or policies and procedures of the Medical Staff or the Hospital; and
 - vii. Any other appropriate performance improvement plan or recommendation that does not constitute a reduction, termination, or suspension in Medical Staff membership and/or clinical privileges.
- All actions constituting “alternatives to corrective action” will not trigger the investigation process or hearing and appellate review procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws.
- m. Potential Corrective Action. The Multi-Disciplinary Peer Review Committee may make recommendations for corrective action. All recommendations for corrective action will be processed in accordance with the procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws, which shall preempt and take precedence over this policy.

- n. Documentation of the peer review will be trended as part of the Memorial Healthcare System quality monitoring database. The written back-up review material and related correspondence, along with a note documenting the action taken, will be filed in the practitioner's peer review file in the Medical Staff Services Department at the Hospital where the peer review was conducted. A copy will be sent to the Medical Staff Services Department for the Memorial Healthcare System and/or recorded in the electronic module. Results of the peer review activities will be aggregated and reported at the time Medical Staff reappointments when credentialing, competency and privileging decisions are made.
- o. The panel will keep formal minutes of its proceedings and will report its activities and minutes to the Department.

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PRACTITIONER HEALTH POLICY AND PROCEDURE

TITLE: Practitioner health policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: It is the policy of the Memorial Healthcare System to be sensitive to a practitioner's health or condition and to assist the practitioner in retaining or regaining optimal professional function, in order to provide quality patient care.

The goal of the Medical Staff is to assist with rehabilitation, rather than discipline, and to aid practitioners in retaining and regaining optimal professional functioning consistent with protection of patients.

POLICY:

1. The Medical Staff Leadership will provide education to the Medical Staff and Hospital staff about substance abuse and impairment recognition issues specific to practitioners. This may be accomplished through continuing medical education programs, distribution of information to the staff, or presentations at department/section meetings. Indications of impairment or substance abuse include, but are not limited to:
 - Disorientation;
 - Hallucinations;
 - Emotional instability;
 - Paranoia;
 - Smell of alcohol on breath;
 - Slurred speech;
 - Unsteady gait;
 - Red eyes;
 - Diversion of medications;
 - Report of substance abuse by a reliable and credible source (please see the requirements for documenting and evaluating the credibility of a complaint;

- Deterioration or inconsistencies in work performance;
- Chronic tardiness or unavailability; and
- Changes in behavior and decline in clinical or technical skills.

*This list is intended to be illustrative and not comprehensive of all signs and symptoms for impairment or substance abuse.

2. The Medical Staff Leadership will assist those willing to undergo treatment and rehabilitation. The Hospital or Hospital Division Chief Medical Officer may receive a referral from the practitioner whose health is at issue (self-referral), the Credentials Committee, Administration, the Board, or any concerned individual. The Medical Staff will assure the confidentiality of those individuals referring practitioners with potential health problems.
3. The Medical Staff Leadership will assist with facilitating the confidential diagnosis, treatment and rehabilitation of practitioners suffering from a potentially impairing condition. The Medical Staff Leadership and/or the Hospital or Hospital Division Chief Medical Officer may require that a practitioner undergo testing to ensure that the practitioner is free from any physical or mental impairment. Examples of such testing include drug testing, psychological testing, and cognitive testing. They will assist with the referral of the affected practitioner to the appropriate professional internal or external resources for evaluation, diagnosis and treatment of the condition or concern. When there is reason to suspect a practitioner may be impaired, the Hospital or Hospital Division Chief Medical Officer will contact the Professionals Resource Network of the State of Florida (P.R.N.), or an alternative substance abuse monitoring, treatment, or evaluation provider to assist in arranging for evaluation, monitoring, and/or treatment. The practitioner may be allowed to take a voluntary leave of absence.
4. The Professionals Resource Network, or alternative provider or organization, in accordance with the practitioner's contractual agreement will monitor the practitioner. The Hospital may impose any additional, or alternative, monitoring or testing requirements it deems appropriate until the rehabilitation or any corrective action or alternative to corrective action process is complete and may periodically review thereafter.
 - **If at any point during the process of diagnosis, evaluation, treatment or rehabilitation the Medical Staff member refuses or fails to cooperate or comply with the procedures outlined in this policy, the practitioner may be summarily suspended from the Medical Staff or other corrective action may be taken in accordance with Article 7 of the Medical Staff Bylaws.**
5. If at any time during diagnosis, treatment or rehabilitation, it is determined that a practitioner is unable to safely perform the privileges he or she has been granted, the matter will be forwarded to the Medical Staff Leadership and Administration for appropriate action, including strict adherence to any state or federally mandated reporting requirements.
 - All recommendations for "corrective action" will be processed in accordance with the procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws.

- All recommendations constituting “alternatives to corrective action” will not trigger the investigation process or hearing and appellate review procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws.
6. Documentation is required for evaluation of the credibility of a complaint, allegation or concern. Evidence substantiating the behavior of the impaired practitioner will include, but is not limited to, the following:
- Date and time of the behavior;
 - If the behavior affected or involved a patient in any way, the name of the patient;
 - Circumstances surrounding the situation;
 - Description of the behavior limited to factual and objective information;
 - Consequences of the behavior, if any, as it relates to patient care; and
 - Record of action taken to remedy the situation including date, time, place, action and name(s) of those intervening.

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DISRUPTIVE PRACTITIONER POLICY AND PROCEDURE

TITLE: Disruptive practitioner policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: It is the policy of the Memorial Healthcare System that all individuals within the Hospital be treated courteously, respectfully, and with dignity. To that end, all practitioners who are granted clinical privileges conduct themselves in a professional and cooperative manner while in any of the Hospitals.

The purpose of this policy is to facilitate appropriate patient care and effective operation of the Memorial Healthcare System by promoting a safe, cooperative, and professional environment, and to the extent possible, prevent or eliminate conduct that disrupts the operation of the Memorial Healthcare System, adversely affects the ability of others to do their jobs, creates a hostile work environment for employees and practitioners, interferes with an individual's ability to practice competently, or diminishes the image and reputation of the System and its Hospitals.

POLICY:

1. Unacceptable disruptive conduct includes, but is not limited to, the following:
 - a. Attacks (verbal or physical) leveled at other practitioners, System or Hospital personnel, trainees and students, volunteers, patients, family, visitors, or vendors which are personal, irrelevant, or go beyond the bounds of reasonable professional conduct;
 - b. Impugning the quality of care, or attacking particular physicians, allied health practitioners, nurses, or System policies, which may include, but should not be limited to, impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents;
 - c. Non-constructive criticism addressed to another individual in such a way as to intimidate, undermine confidence, belittle, imply stupidity, or imply incompetence;
 - d. Harassment as defined by the System's Board policy;
 - e. Use of racial, ethnic, sexual, or religious terms in a manner intended to insult, intimidate, disparage, or belittle; or

- f. Conduct or behavior that interferes with the ability of an individual or group to work, perform, or achieve desired goals, which may include, but not be limited to, lack of response to phone calls and emails.
2. All reports regarding potential disruptive behavior should include the following information and be submitted to the Hospital or Hospital Division Chief Medical Officer for investigation:
 - a. Date and time of the questionable behavior;
 - b. If the behavior affected or involved a patient in any way, the name of the patient;
 - c. Circumstances that precipitated the situation;
 - d. Description of the questionable behavior limited to factual, objective, language;
 - e. Consequences, if any, of the disruptive behavior as it relates to patient care; and
 - f. Record of action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.
3. In the event the disruptive individual is a medical student, intern, resident or fellow, the report shall be submitted to the Residency Program Director and/or the Chief Officer of Academic Affairs, who shall work with the System Chief Medical Officer to investigate the matter and resolve the matter in accordance with this policy and any policy or process developed by the Graduate Medical Education Committee.
4. If a practitioner fails to conduct himself or herself appropriately, the matter shall be addressed in accordance with the following policy:
 - a. A single documented incident will be investigated by the Hospital or Hospital Division Chief Medical Officer or his or her designee and a confidential one-on-one discussion may be held with the practitioner; or
 - b. A single egregious incident or a series of repeated incidents may be handled in the following manner: a formal meeting with the practitioner in question, the Chief of the Department, the Chief of Staff, the Hospital or Hospital Division Chief Medical Officer, and the Administrator will be held. If the individual is a medical student, intern, resident or fellow, such meeting shall include the Residency Program Director. The Chief of Staff, Chief of the Department, and the Hospital or Hospital Division Chief Medical Officer may elect to refer the practitioner to the Professionals Resource Network, or an alternative treatment provider or monitoring organization. The System may use Professionals Resource Network or an alternative treatment provider or monitoring organization for purposes of evaluation, monitoring, and/or treatment. Depending on the seriousness of the situation, corrective action or summary suspension may be warranted.

- All recommendations for “corrective action” will be processed in accordance with the procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws, as appropriate.
- All recommendations constituting “alternatives to corrective action” will not trigger the investigation process or hearing and appellate review procedures set forth in Articles 7 and 8 of the Medical Staff Bylaws.

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HONORARY AND HONORARY EMERITUS STAFF CATEGORY POLICY AND PROCEDURE

TITLE: Honorary and honorary emeritus staff category policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To develop a process whereby retired/resigned practitioners of the active Medical Staff may become members of the Honorary Medical Staff or Honorary Emeritus Medical Staff.

POLICY:

Consideration for membership on the Honorary Medical Staff or Honorary Emeritus Medical Staff will be reviewed by the Executive Committee, or Advisory Council in the case of the Memorial Regional Hospital Division or Joe DiMaggio Hospital Division.

1. Honorary Medical Staff. The Honorary Medical Staff shall consist of those retired/resigned Medical Staff members who were active staff members for at least twenty-five (25) years at one (1) or more Memorial Healthcare System Hospitals. In its discretion, the Executive Committee may confer Honorary Medical Staff membership upon an individual who did not hold active staff membership so long as the individual can show special dedication or service to the Memorial Healthcare System, its Hospitals, its Medical Staffs, or the community.
2. Honorary Emeritus Medical Staff. The Honorary Emeritus Medical Staff shall consist of members of the Honorary Medical Staff who have, in addition to meeting the criteria for Honorary Medical Staff, served in positions of leadership on the Medical Staff of one (1) or more Memorial Healthcare System Hospitals.

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PATIENT ENCOUNTER POLICY AND PROCEDURE

TITLE: Patient encounter policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a sufficient number of annual patient encounters for active Medical Staff members in accordance with the Medical Staff Bylaws to enable the Credentials Committee to review the practitioner's provision and quality of patient care and utilization upon reappointment.

POLICY:

1. Each active staff member must maintain at least twenty (20) patient care encounters in a two year credentialing cycle. However, all practitioners who hold pediatric clinical privileges must have twelve (12) pediatric patient encounters in a two (2) year credentialing cycle unless the practitioner is board certified by the American Board of Pediatrics, or has completed a pediatric fellowship, or has a certificate of clinical competence in a pediatric specialty. Practitioners meeting these qualifications shall be exempt from the pediatric encounter requirement. The overall patient encounter requirement may still apply.
2. Patient encounters will include both private and assigned patients. A patient encounter shall mean the following:
 - Admissions, including observation status;
 - Consultations;
 - Inpatient Surgical Procedures;
 - Outpatient Surgical Procedures; and
 - Preoperative evaluations done in a practitioner's office for a procedure performed in the Memorial Healthcare System and included in the patient's medical record.

Outpatient laboratory work or outpatient diagnostic radiology will not be considered a patient encounter.

Multiple procedures performed on a single patient during one episode of care will be considered as a single patient encounter.

"Pediatric patient encounter" shall be defined as the treatment of patients age 17 and below.

3. The patient encounters must be performed at a facility of the Memorial Healthcare System, except as otherwise permitted herein. Such facilities shall include any MHS affiliated ambulatory surgical center.
4. The following physicians/practitioners shall be exempted from the patient encounter requirements: (a) physicians who are employed by a contracted service line, or retained by a

contracted service line; (b) dermatologists; (c) oral and maxillofacial surgeons; (d) allergists; (e) rheumatologists; (f) ophthalmologists; (g) members of the Consulting Staff, (h) reproductive endocrinologists; (i) psychologists; (j) perinatologists; (k) primary care practitioners (internists, family practitioner, and primary care pediatricians); (l) dentists and (m) podiatrists with only core privileges in adult podiatry.

5. If a Department feels that the patient care encounter policy is adverse to members of the Department or jeopardizes service to the Hospital or community, the Department may petition the Executive Committee, or applicable Advisory Council, for an exemption. The Executive Committee will consider the Department's request only if it can be uniformly applied to all members of the Department and only when it is accompanied by a planned mechanism that specifically outlines how the Department will evaluate members who have minimal clinical activity in order to ensure quality patient care.

Other exemptions may be granted, upon request, by the Advisory Council of Memorial Regional Hospital Division or Joe DiMaggio Children's Hospital Division or the Executive Committee of the respective Hospital, upon a demonstration that the practitioner could not fulfill the requirement due to good cause. For purposes of this subsection, good cause is limited to illness and voluntary limitation of practice.

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NEW/TRANSPECIALTY PRIVILEGES POLICY AND PROCEDURE

TITLE: New/transpecialty privileges policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a process in accordance with the Medical Staff Bylaws to enable the Medical Staff and Credentials Committee to evaluate and establish new or transpecialty privileges.

POLICY:

1. The Credentials Committee shall review the need for, and appropriateness of a new procedure or service.
2. If appropriate, the Credentials Committee shall facilitate the establishment of Hospital-wide credentialing criteria for the new or transpecialty procedure, with the input of all appropriate Departments, with a mechanism designed to ensure that the same level of quality of patient care is provided by all individuals with such clinical privilege.
3. In establishing the criteria for such clinical privileges, the Credentials Committee may establish an ad hoc committee with representation from all appropriate Departments or the committee members may undertake the process themselves. Information may be requested from one or more practitioners or Departments, or from outside sources such as professional literature or specialty associations.
4. The recommendation of the Credentials Committee shall be forwarded to the Executive Committee, or applicable Advisory Council in the case of Memorial Regional Hospital Division or Joe DiMaggio Children's Hospital Division, for its review. The Advisory Council shall forward its recommendation onto the Memorial Regional Hospital Executive Committee. The recommendation of the Executive Committee and the approval of the Board shall be based, in part, on whether the new procedure or service is appropriate to the Hospital.

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USE OF ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS POLICY AND PROCEDURE

TITLE: Use of ancillary services by non-privileged practitioners policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a process in accordance with the Medical Staff Bylaws to enable the Medical Staff to evaluate the quality of care rendered by non-privileged practitioners who utilize the System's ancillary services.

POLICY:

1. The Hospital shall verify proof of current licensure;
2. The Hospital shall ensure that the practitioner is eligible to participate in federal and state health programs at the time of ordering tests or services and at least every six (6) months thereafter;
3. The practitioner shall be limited to ordering only those tests or services that are within the scope of his or her license to order. The orders shall be confined to those for outpatient laboratory, non-invasive radiology, rehabilitation services (including physical therapy, occupational therapy, and speech therapy), diagnostic cardiopulmonary or electrodiagnostic testing, or medications;
4. The practitioner's ordering practices may be subject to the supervision of the applicable Department Chief performing the test or service, or the Chief of Staff;
5. The practitioner's ordering practices may be subject to a review for medical appropriateness and necessity; and
6. Orders that lack evidence of medical appropriateness or necessity shall not be performed and the practitioner shall be notified immediately to be given the opportunity to clarify and/or justify the order.

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ADVISORY COUNCIL – MEMORIAL REGIONAL HOSPITAL DIVISION AND JOE DIMAGGIO CHILDREN'S HOSPITAL DIVISION COMMITTEE POLICY AND PROCEDURE

TITLE: Advisory Council – Memorial Regional Hospital Division and Joe DiMaggio Children's Hospital Division Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a separate and distinct Advisory Council for the Memorial Regional Hospital Division and a separate and distinct Advisory Council for the Joe DiMaggio Children's Hospital Division. Both of which shall report to the Memorial Regional Hospital Executive Committee.

POLICY: The organized Medical Staff of Memorial Regional Hospital and Joe DiMaggio Children's Hospital delegates the authority to the Advisory Council to act on their behalf by electing representatives to sit on the Advisory Council in accordance with the Bylaws. The functions, duties, procedures, and criteria specified in this policy apply equally to the Advisory Council of the Memorial Regional Hospital Division and the Joe DiMaggio Children's Hospital Division, except as specifically stated otherwise.

1. Members of the Advisory Council shall be licensed doctors of medicine or doctors of osteopathic medicine actively practicing in the respective Hospital. Each Department shall be entitled to one (1) vote on the Advisory Council for each twenty (20) active members in the Department, plus one (1) vote for each fraction thereof and excluding all Department members who are members of a group that has a contract with the Hospital or District to provide services. No individual on the Advisory Council shall personally cast more than two (2) votes. Each May, the number of active staff members in each Department will be recalculated to ensure proper representation at the Advisory Council. For purposes of counting members at the Memorial Regional Hospital Division, physicians who are in multiple Departments must designate one (1) Department as their primary Department.
 - a. The Advisory Council of the Memorial Regional Hospital Division shall consist of the following members of the Medical Staff:
 - (1) The Chief of Staff, Vice Chief of Staff, and the Secretary-Treasurer of the Memorial Regional Hospital Division, each elected by the Medical Staff with the procedures described in the Bylaws. Each of the three (3) officers of the Medical Staff shall have one (1) vote.
 - (2) The elected Chiefs of the Departments. As provided in above, each Chief of a Department with 1-20 active members (excluding all Department members who are members of a group that has a contract with the Hospital or District

to provide services) shall be entitled to one (1) vote and those Departments with 21-40 active members (excluding all Department members who are members of a group that has a contract with the Hospital or District to provide services) shall be entitled to two (2) votes.

- (3) Those Departments with 41-60 and 61-80 active members (excluding all Department members who are members of a group that has a contract with the Hospital or District to provide services) shall have its Vice Chief serve on the Advisory Council with the right to cast one (1) or two (2) votes, respectively. When Departments have over 80 active members (excluding all Department members who are members of a group that has a contract with the Hospital or District to provide services), similar increments shall continue in the same ratio. The Departments shall determine how they will elect members-at-large. Members-at-large shall take office on the first day of the Medical Staff year, May 1st, and shall serve a two (2) year term. Members-at-large may serve additional terms if so elected.
 - (4) The Memorial Regional Hospital South Physician Advisory Committee shall have one (1) vote on the Advisory Council of the Memorial Regional Hospital Division. The Chairperson of the Physician Advisory Committee, as a result of his or her position on the Physician Advisory Committee, shall become of a voting member of the Advisory Council of the Memorial Regional Hospital Division. The Medical Director of Rehabilitation shall be a member of the Advisory Council of the Memorial Regional Hospital Division, without a vote.
 - (5) The Senior Vice President & Chief Executive Officer of the Memorial Regional Hospital Division, the Administrator of Memorial Regional Hospital South, the Chief Medical Officer of the Memorial Regional Hospital Division and Memorial Regional South, the Senior Vice President & Chief Medical Officer of Memorial Healthcare System, and other administrative staff as deemed appropriate, shall be ex-officio members without vote.
 - (6) Members of other Memorial Healthcare System Executive Committees may sit on the Advisory Council, other than Officers, Department Chiefs and Vice Chiefs, and shall also be ex-officio members without a vote. Members shall be limited to sit on a maximum of two (2) Advisory Councils or Executive Committees.
 - (7) Specially invited guests are permitted to attend Advisory Council meetings upon the request of the Chief of Staff.
- b. The Advisory Council of the Joe DiMaggio Children's Hospital Division shall consist of the following members of the Medical Staff:
- (1) The Chief of Staff, Vice Chief of Staff, and the Secretary-Treasurer of the Joe DiMaggio Children's Hospital Division, each elected by the Medical Staff with the procedures described in the Bylaws. Each of the three (3) officers of the Medical Staff shall have one (1) vote.

- (2) The Department of Medicine will have a total number of votes equal to the total members of the Department divided by 30 plus one (1) for any remainder thereof. The following will each have one of the required total votes for the Department: Chief of Medicine, Vice Chief of Medicine, representative from radiology, a representative from emergency medicine, and a representative from the neuroscience section. Additional votes to equal the total votes for the Department will be at-large positions elected by the Department of Medicine. The at-large positions shall include a representative from the Neonatal Intensive Care and a representative from the Pediatric Intensive Care if they are not so represented by virtue of another Medical Staff leadership position. The Departments will determine how they will elect members-at-large. Members-at-large shall take office on the first day of the Medical Staff year, May 1st, and shall serve a two (2) year term. Members-at-large may serve additional terms if so elected.
 - (3) The Department of Surgery will have a total number of votes equal to the total members of the Department divided by 30 plus one (1) for any remainder thereof. The following will each have one representative of the required total votes for the Department: Chief of Surgery, Vice Chief of Surgery, representative from anesthesiology, representative from pathology, and a representative from the cardiovascular section. Additional votes to equal the total votes for the Department will be at-large positions elected by the Department of Surgery. The Departments will determine how they will elect members-at-large. Members-at-large shall take office on the first day of the Medical Staff year, May 1st; and shall serve a two (2) year term. Members-at-large may serve additional terms if so elected.
 - (4) The Administrator, the Chief Medical Officer of Joe DiMaggio Children's Hospital Division, the Senior Vice President & Chief Medical Officer of Memorial Healthcare System, and other administrative staff as deemed appropriate, shall be ex-officio members without vote.
 - (5) The Memorial Hospital Miramar Chief of Pediatrics shall be an ex-officio member of the Advisory Council of the Joe DiMaggio Children's Hospital Division, without vote.
 - (6) Members of other Memorial Healthcare System Executive Committees may sit on the Advisory Councils, other than Officers, Department Chiefs, and Vice Chiefs, and shall also be ex-officio members without a vote. Members shall be limited to sit on a maximum of two (2) Advisory Councils or Executive Committees.
- c. The following shall be considered additional conflicts of interest on the part of members of the Advisory Council, requiring exclusion from participation in any and all proceedings under Article 8 of the Bylaws: Advisory Council members who are:
- (a) individuals having a present or prior relationship with the affected practitioner of shared medical practice, including without limitation, partnership, employment, or compensation arrangement;
 - (b) relatives of the affected practitioner;
 - (c) individuals

exhibiting racial, religion, ethnic, or other prohibited prejudice as demonstrated by reasonable evidence as determined by the Advisory Council; (d) individuals who are creditors or debtors of the affected practitioner; and (e) individuals who demonstrate any conflict of interest, which could adversely affect such individual's ability to fairly and objectively review the matter under consideration, as determined in the judgment of the Advisory Council.

2. The duties of the Advisory Council shall be as follows:
 - a. To represent and act on behalf of the Medical Staff members of the applicable Hospital Division, subject to those limitations set forth in the Bylaws;
 - b. To coordinate the activities and general policies of the different clinical services;
 - c. To receive and act on reports of Medical Staff committees, Departments, and other assigned activity groups;
 - d. To implement those Medical Staff policies for which the Departments are not responsible;
 - e. To provide a liaison mechanism between the Medical Staff, the Administrator, and ultimately the Board;
 - f. To make recommendations to the Board, through the Administrator, on Hospital-management matters;
 - g. To fulfill the Medical Staff's responsibility to the Board by accounting for the medical care rendered to the Hospital's patients;
 - h. To ensure that the Medical Staff is kept abreast of The Joint Commission's standards, CMS Conditions of Participation, State of Florida practitioner licensure and/or hospital licensure requirements, and the requirements of other licensure and accreditation agencies and to inform the Medical Staff of the Hospital's accreditation status;
 - i. To provide for the preparation of all Medical Staff meeting programs, either directly or by delegating this responsibility to a program committee or some other individual;
 - j. To review the credentials of all applicants and to make subsequent recommendations regarding Medical Staff membership, assignment to Departments and delineation of clinical privileges to the Board;
 - k. To periodically review all available information regarding the performance and clinical competence of staff members and other practitioner's clinical privileges for making subsequent recommendations regarding reappointments and renewal of changes in clinical privileges;
 - l. To take all reasonable steps for ensuring competent clinical performance and

professionally ethical conduct by all members of the Medical Staff, including the initiation of and/or participation in warranted corrective or review measures for the Medical Staff;

- m. To provide each member of the Medical Staff with information regarding significant Advisory Council and Executive Committee actions;
 - n. Review and recommend amendments to the Bylaws;
 - o. To make recommendations regarding the mechanism to review credentials and delineated individual clinical privileges to the Board;
 - p. To organize the Medical Staff performance improvement activities and establish a mechanism designed to conduct, evaluate, and revise such activities;
 - q. To develop the mechanism by which Medical Staff membership may be terminated;
 - r. To represent and act on behalf of the Medical Staff, subject to those limitations set forth in these Bylaws; and
 - s. To make recommendations regarding the organized Medical Staff's structure.
3. The Advisory Council shall meet at least ten (10) times per year, preceding the regular Executive Committee meeting, unless specifically changed by the Chief of Staff. A permanent record of the proceedings and actions taken at these meetings shall be maintained and are available for review by members of the Medical Staff. Fifty percent (50%) of the duly-elected voting members, or their substitutes, will constitute a quorum. Only members of the Advisory Council and specially invited guests are permitted to attend these meetings.
 4. Actions taken by the Advisory Council will be forwarded to the Executive Committee for action. If the Advisory Council has considered a Medical Staff member's objection and has rejected it, then the procedure set forth in the Bylaws shall be followed.
 5. A member of the Medical Staff who is officially requested in writing by the Chief of Staff, the Administrator, or their designee by certified mail to appear at an Advisory Council meeting must appear at the time and place requested, unless excused by the Chief of Staff for good cause. Failure to appear may result in corrective action and the process outlined in Articles 7 and 8 shall be followed.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

BYLAWS COMMITTEE POLICY AND PROCEDURE

TITLE: Bylaws Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Bylaws Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The Bylaws Committee will be responsible for annually reviewing and revising, as necessary, the Medical Staff Bylaws so that they reflect current staff practices.

1. The Bylaws Committee shall consist of the officers of the Medical Staffs representing each of the Hospitals., The Chief of Staff, Vice Chief of Staff, and the Secretary-Treasurer will each be voting members. The Administrator and Chief Medical Officer from each of the Hospitals shall serve as ad-hoc members without a vote. The systems Chief Medical Officer shall chair the meeting and also serve as an ad-hoc member without a vote.
2. The Bylaws Committee shall review the Medical Staff Bylaws annually. This review shall consist of comparing the Bylaws to standards recommended by The Joint Commission and other accrediting bodies, as well as comparing the Bylaws to current practice. This Bylaws Committee will also review all proposals for amendments to the Bylaws and submit recommendations to the Executive Committee. This Bylaws Committee will meet as often as necessary, at the call of chairperson, but least once a year.
3. The Bylaws Committee must maintain a record of its proceedings and make timely reports to the Executive Committees.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

CANCER COMMITTEE POLICY AND PROCEDURE

TITLE: Cancer Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Cancer Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The Cancer Committee will be responsible for planning, initiating, stimulating, and assessing all cancer-related activities in the Memorial Healthcare System.

1. The Cancer Committee shall be multidisciplinary in nature and will include Medical Staff representatives from diagnostic radiology, pathology, surgery, medical oncology, radiation oncology, pain control, and pediatric oncology. The Committee shall also include: Vice President of Oncology Services, Administration, oncology nurse, ambulatory surgery oncology nurse, social worker, certified tumor registrar, quality improvement professional, clinical research nurse, dietary specialist, and pharmacist.
2. The Cancer Committee is responsible for:
 - a. Developing and evaluating the annual goals and objectives for the clinical community outreach, quality improvement, and programmatic endeavors related to cancer care;
 - b. Organizing, publicizing, conducting and evaluating educational and consultative cancer conferences that are multidisciplinary, patient oriented and focused;
 - c. Assuring consultative services from all major disciplines are available to all patients;
 - d. Annually reviewing and appointing coordinators for each of the areas of cancer committee activity: Tumor Registry, Cancer Conference, Quality Improvement, Psychosocial Services, Community Outreach and Education;
 - e. Defining coordinator roles and responsibilities, who shall regularly report to the Cancer Committee;
 - f. Recommending corrective action if activity falls below the annual goal or requirements;
 - g. Analyzing patient outcomes and disseminating the results of the analysis;
 - h. Planning and completing three (3) QI studies annually; and

- i. Encouraging a supportive care system for all cancer patients.
3. The Cancer Committee shall meet every other month or as required to meet category requirements as designated by the Commission on Cancer.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

CREDENTIALS COMMITTEE POLICY AND PROCEDURE

TITLE: Credentials Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Credentials Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The Credentials Committee will be responsible for all credentialing-related activities in the Memorial Healthcare System.

1. There will be Credentials Committees of the Memorial Healthcare System appointed for a period of two (2) years by the Chiefs of Staff. The Credentials Committee shall consist of co-chairpersons who are the elected Secretary-Treasurers of the Medical Staffs of the Memorial Healthcare System. The Chiefs of Staff of each of the Hospitals and Hospital Divisions and the Chief Medical Officer of the System shall be ex-officio members of Credentials Committee, without a vote.
 - a. The Credentials Committee shall consist of members of the active staff, appointed for a period of two (2) years by the Chiefs of Staff, and selected to ensure representation by the major clinical specialties, the hospital-based specialties, and the Medical Staffs at large. No Department Chief or Section Chief shall be eligible to serve on the Credentials Committee while serving as Department Chief or Section Chief. There will be representation from Administration.
 - b. The following shall be considered additional conflicts of interest on the part of members of the Credentials Committee, requiring exclusion from participation in any and all related Committee functions: Credentials Committee members who are: (a) individuals having a present or prior relationship with the affected practitioner of shared medical practice, including without limitation, partnership, employment, or compensation arrangement; (b) relatives of the affected practitioner; (c) individuals exhibiting racial, religious, ethnic, or other prohibited prejudice as demonstrated by reasonable evidence as determined the Executive Committee, or the applicable Advisory Council in the case of the Memorial Regional Hospital Division or Joe DiMaggio Children's Hospital Division; (d) individuals who are creditors or debtors of the affected practitioner; and (e) individuals who demonstrate any conflict of interest, which could adversely affect such individual's ability to fairly and objectively review the matter under consideration, as determined in the judgment of the Credentials Committee.
2. The Credentials Committee is responsible for:

- a. Reviewing the credentials of all applicants, making recommendations for membership and delineation of clinical privileges in accordance with the Bylaws;
 - b. Reporting to the Executive Committee, or applicable Advisory Council in the case of the Memorial Regional Hospital Division or Joe DiMaggio Children's Hospital Division, on each applicant for staff membership and/or clinical privileges, including specific consideration of the recommendations from the Departments in which the applicant has requested privileges;
 - c. Periodically reviewing all available information regarding the competency of the Medical Staff members and to make subsequent recommendations to the Executive Committee, or applicable Advisory Council, for granting of privileges, reappointments and the assignment of practitioners to the various Departments as provided in the Bylaws;
 - d. Investigating any breach of ethics reported to it; and
 - e. Reviewing any reports referred to it by the Executive Committee, the Quality Care and Patient Safety Council, the Department, and/or Chief of Staff.
3. The Credentials Committee shall meet as often as necessary to perform its functions, shall maintain a permanent record of its proceedings and actions and shall make regular reports of its recommendations to the Executive Committee, or applicable Advisory Council.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

CRITICAL CARE COMMITTEE POLICY AND PROCEDURE

TITLE: Critical Care Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a Critical Care Committee at each Hospital and Hospital Division.

POLICY: The Critical Care Committee will be responsible for providing guidance to address issues related to the critical care areas of each respective Hospital or Hospital Division.

1. Each Hospital and Hospital Division shall have a Critical Care Committee. The Critical Care Committee shall consist of a chairperson and such members as may be appointed by the Executive Committee, or applicable Advisory Council in the case of Memorial Regional Hospital Division or Joe DiMaggio Children's Hospital Division.
2. The Critical Care Committee shall be responsible for recommending policies and procedures for the critical care areas. The Critical Care Committee will provide guidance to the Hospital's or Hospital Division's critical care unit regarding problems arising within the units concerning practitioners, bed utilization and medical management concerns. The Critical Care Committee will also provide guidance regarding nursing staff training and on-going education to promote practitioner participation. The Critical Care Committee will also provide guidance regarding quality and appropriateness of care in the critical care units.
3. The Critical Care Committee shall maintain a record of its proceedings and make timely reports to the Executive Committee, or applicable Advisory Council in the case of Memorial Regional Hospital Division or Joe DiMaggio Children's Hospital Division.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

DISTRICT MEDICAL ADVISORY COMMITTEE POLICY AND PROCEDURE

TITLE: District Medical Advisory Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide District Medical Advisory Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The District Medical Advisory Committee will be responsible for assisting the Board with issues relating to Medical Staff credentialing and practitioner coverage for all District Hospitals.

1. The District Medical Advisory Committee will consist of: (1) the Chiefs of Staff of each Hospital and Hospital Division; (2) the Chairpersons of the Credentials Committee; (3) the Administrators of each Hospital and Hospital Division, or their designees; (4) the Chief Executive Officer, or his or her designee; (5) the Chief Medical Officers of each Hospital and Hospital Division (ex-officio without vote); and (6) the Chief Medical Officer of the System (ex-officio without a vote). The CEO of the District shall be the Chair of the District Medical Advisory Committee.
2. The District Medical Advisory Committee is responsible for:
 - a. Reviewing discordant credentials and privileges for consistency at all District Hospitals prior to being presented to the Board for approval;
 - b. Making recommendations regarding specific practitioner coverage needs at any District Hospital, including without limitation, emergency call; and
 - c. Dealing with conflicting Medical Staff issues at all District Hospitals.
3. The District Medical Advisory Committee shall meet as necessary or as required by the Bylaws. A permanent record of the proceedings and reports shall be maintained. Recommendations and reports of the District Medical Advisory Committee will be forwarded to the Board within thirty (30) days or as otherwise required by the Bylaws.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

EMERGENCY PREPAREDNESS COMMITTEE POLICY AND PROCEDURE

TITLE: Emergency Preparedness Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish an Emergency Preparedness Committee at each Hospital, with the exception of Memorial Regional Hospital Division and Joe DiMaggio Children's Hospital Division, which shall be combined.

POLICY: The Emergency Preparedness Committee will be responsible for assisting the Hospital in preparing and reviewing internal and external disaster plans.

1. Each Emergency Preparedness Committee shall consist of a chairperson and at least six (6) members of the Medical Staff. The Administrator may appoint suitable Hospital personnel to serve ex-officio without vote to any Hospital's Emergency Preparedness Committee.
 - a. For the combined committee of Memorial Regional Hospital Division and Joe DiMaggio Children's Hospital Division, five (5) of the members must be active staff members practicing at Memorial Regional Hospital and appointed by the Chief of Staff of Memorial Regional Hospital and one (1) of which is an active staff member practicing at Joe DiMaggio Children's Hospital and appointed by the Chief of Staff of the Joe DiMaggio Children's Hospital. The Chief of the Department of Emergency Medicine of Memorial Regional Hospital and the Chief of the Joe DiMaggio Children's Hospital Pediatric Emergency Room, or their designees, shall be members of this Committee.
2. The Emergency Preparedness Committee shall assist the Hospital in the preparation and review of internal and external disaster plans. The Emergency Preparedness Committee shall assist in promoting Medical Staff participation in disaster drills and will review the evaluation of these drills.
3. The Emergency Preparedness Committee will meet as often as necessary, at the call of the chairperson, but at least annually. The Emergency Preparedness Committee shall maintain a record of its proceedings and make timely reports to the Executive Committee.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

ETHICS COMMITTEE POLICY AND PROCEDURE

TITLE: Ethics Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Ethics Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The Ethics Committee will be responsible for assisting all District Hospitals in handling ethical issues and specific situations.

1. The Ethics Committee will consist of four (4) co-chairpersons representing each of the Medical Staffs and at least four (4) representatives from each District Hospital. A representative from the lay community will be appointed to the Ethics Committee, as well as a representative from the clergy. The Chief Medical Officers of each of the Hospitals and Hospital Divisions and the Chief Medical Officer of the System shall be ex-officio members of the Ethics Committee, without a vote. The Administrators may appoint other Hospital personnel to serve as ex-officio members of this committee, including legal representation.
2. The functions of the Ethics Committee shall include education of the Ethics Committee members, Medical Staff and Hospital employees, patients, and families; policy recommendations; and case review of problematic cases. The Hospital-specific representatives appointed to the System-wide Ethics Committee will handle emergency case reviews at the Hospital level.
3. The Ethics Committee shall make its recommendations to the Executive Committees. In case reviews, the Ethics Committee will make its recommendations to the attending practitioner, patient, and/or family members and submit a brief summation of its proceedings to the applicable Executive Committee.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

FORMULARY COMMITTEE POLICY AND PROCEDURE

TITLE: Formulary Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Formulary Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The Formulary Committee will be responsible for assisting in the development of a System-wide formulary that is reviewed annually.

1. The Formulary Committee shall consist of physician representatives from each Hospital appointed by the Chiefs of Staff, and Hospital representatives appointed by each Administrator.
2. The Formulary Committee shall meet at least four times per year and shall submit reports to the Executive Committees.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

HARDSHIP LIAISON COMMITTEE POLICY AND PROCEDURE

TITLE: Hardship Liaison Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Hardship Liaison Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The Hardship Liaison Committee shall be responsible for examining, considering, and facilitating, when possible, aid or assistance to members of any Medical Staff and their families affected by hardship or tragedy. The Hardship Liaison Committee shall report its actions to the Executive Committees of the Medical Staff of which the affected practitioner is/was a member.

1. The Hardship Liaison Committee shall consist of the Secretary/Treasurers of each Hospital's Medical Staff.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

INSTITUTIONAL REVIEW BOARD POLICY AND PROCEDURE

TITLE: Institutional Review Board policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Institutional Review Board performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: An Institutional Review Board designated by Memorial Healthcare System will review, approve, suspend, modify, and/or disapprove all research involving human subjects within Memorial Healthcare System as governed by the federal regulations for protection of human subjects. The IRB shall be responsible for review of all experimental procedures and the use of experimental drugs.

1. The Memorial Healthcare System Institutional Review Board (IRB) shall be made up of appropriate membership as appointed by the Chiefs of staff in order to maintain compliance with all applicable legal and regulatory requirements.
2. The Memorial Healthcare System Institutional Review Board shall consist of a chairperson and at least three (3) other members of the Medical Staffs, all appointed by the Chiefs of Staff. Administrators may recommend members to serve on the board. A lay representative (e.g. non-scientific) member and a member with no affiliation to the Institution and who is not part of the immediate family of a person who is employed by the Institution will also be appointed to the Institutional Review Board. Clergy, a clinical pharmacist, and legal counsel will serve on the Board. Membership should be sufficiently qualified through experience, expertise, and diversity to review the research and reflect sensitive issues related to community attitudes. When reviewing research involving a vulnerable population, such as children, pregnant women or handicapped or mentally disabled persons, the Institutional Review Board will include as members one or more members who are knowledgeable about and experienced in working with these subjects.
3. The Institutional research signatory official and/or Memorial Healthcare System Institutional Review Board can make individual project or multiple research project determinations as to whether Memorial Healthcare System can rely on another IRB for review of research being performed within Memorial Healthcare System. Medical staff members conducting research should follow the policies and procedures of the reviewing Institutional Review Board. At times, Memorial Healthcare System may rely on the review of research by other non-institutional institutional review boards. The determination of these institutional review boards are acceptable to review research conducted within Memorial Healthcare System will

be made at the discretion of the Memorial Healthcare System Institutional Review Board and/or Chief Medical Officer.

4. The Institutional research signatory official can disapprove an IRB-approved study when it is felt to be in the best interest of the System; however the Medical Staff cannot approve a study that has been disapproved by the Institutional Review Board.
6. Memorial Healthcare System does not participate in research involving prisoners or planned emergency research (under FDA 21 Part 50.24 and 45 CFR §46.101(i)).
7. The IRB will meet as necessary, at the call of the chairperson. The IRB shall maintain a record of its proceedings and make timely reports to the appropriate Executive Committees.

MEMORIAL HEALTHCARE SYSTEM
JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL
REGIONAL HOSPITAL AND JOEDIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL
HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL
HOSPITAL WEST
MHS LABORATORY MEDICINE FORMULARY COMMITTEE

TITLE: District Laboratory Medicine Formulary Committee policy and procedure for the Medical Staffs of Memorial Healthcare System

PURPOSE: To establish a system-wide Laboratory Medicine Formulary committee to perform functions for all of the Medical Staffs of the Memorial Healthcare System

POLICY: The Laboratory Medicine Formulary committee will be responsible for providing guidance to address issues related to Medical Laboratory Services of each respective Hospital or Hospital Division

1. The Formulary Committee will include Medical Staff representation from pathology, internal medicine, emergency medicine and appropriate subject matter experts. The Committee shall also include: District Vice President of Laboratory Services, District Laboratory Medical Director and Medical/Technical Directors, MHS District VP Chief Quality and Patient Safety Officer all District Chief Medical Officers, District Medical Director Centralized Utilization Review/Health Information Management, all District Medical Directors of Clinical Effectiveness, Chief Medical Information Officer , Chief Financial Officer and/or designee(s), and Director Business Intelligence Clinical Analytics,
2. This committee will rely upon the best evidence available in Peer Reviewed Literature, Clinical Medicine Guidelines, and Recommendations from Laboratory Testing oversight organizations, including but not limited to the College of American Pathologists, Adult and Pediatric Medical and Surgical Clinical Practice Guidelines, American Society of Clinical Pathologists Choosing Wisely (<http://www.choosingwisely.org>), and best practices established and/or published by major academic or quality-based healthcare centers.
3. The Committee's goal will be to promote utilization of the most accurate, informative, and efficient testing to permit correct and timely diagnoses, reduce costs, avoid error, and prevent duplicative or unnecessary testing.
4. The committee's assessment of test value will consider optimal patient care and throughput, and not test cost alone.
5. MHS Laboratory Medicine Formulary Advisories will be approved by the Committee and records of the Committee's proceedings will be maintained with timely reporting/distribution to Medical Executive Committees, MHS Medical Staff Members, Clinical Department Heads, MHS Administration, and South Broward Hospital District Board of Commissioners, informing them of decisions of the Committee, in the same fashion as Laboratory Medical/Technical Bulletins.
6. The Formulary Committee will meet bi-monthly, or as often as necessary to achieve its stated goals.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

MEDICAL INFORMATICS COMMITTEE POLICY AND PROCEDURE

TITLE: Medical Informatics Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Medical Informatics Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The Medical Informatics Committee shall be responsible for providing strategic direction and governance regarding the issues reviewed by the Medical Informatics Committee to the Memorial Healthcare System.

1. The Medical Informatics Committee will consist of: the Chief Medical Information Officer, the Chief Medical Officers for each Hospital and Hospital Division, the Chief Medical Officer of the System, the Executive Committee Vice Chair from each Hospital and Hospital Division, and active Medical Staff members from each Hospital and Hospital Division who will serve as physician champions.
2. The functions of the Medical Informatics Committee shall include providing strategic direction and governance for clinical informatics initiatives, and driving adoption of evidence-based order sets, computerized physician order management, and the electronic medical record.
3. The Medical Informatics Committee shall meet as necessary. The Medical Informatics Committee shall make its recommendations to the Executive Committee as an agenda item with the report being given by the Vice Chief who sits on the Medical Informatics Committee.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

PEDIATRIC CANCER COMMITTEE POLICY AND PROCEDURE

TITLE: Pediatric Cancer Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Pediatric Cancer Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The Pediatric Cancer Committee will discharge its duties and functions as delegated by the Executive Committees.

1. The Pediatric Cancer Committee shall be multidisciplinary in nature and will include, but not be limited to, Medical Staff representatives from diagnostic radiology, pathology, surgery, medical oncology, and radiation oncology. The Pediatric Cancer Committee shall also include: Pediatric Program Administrators, Administration, oncology nurse, outpatient oncology nurse, social worker, certified tumor registrar, quality improvement professional, dietary specialist, and pharmacist.
2. The Pediatric Cancer Committee shall meet as required to meet the category requirements as designated by the Commission on Cancer.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

PHARMACY & THERAPEUTICS COMMITTEE POLICY AND PROCEDURE

TITLE: Pharmacy & Therapeutics Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System Pharmacy & Therapeutics Committee performing its functions for the entire Healthcare System.

POLICY: The Pharmacy & Therapeutics Committee will be responsible for assisting in the development and surveillance of pharmacy and therapeutic policies and practices, ongoing planned and systematic review of drug usage, and the review of all untoward reactions.

1. The Pharmacy & Therapeutics Committee shall consist of a chairperson and Medical Staff representation from each hospital
 - a. The Director of the Hospital pharmacy shall be a member of each committee with a vote, as may also be such suitable Hospital personnel as the Administrator may appoint, which shall include nursing representation.
 - b. A Quorum will be comprised of the voting Medical staff members present, but not less than two (2) members of the active Medical Staff for the meeting to commence.
2. The Pharmacy & Therapeutics Committee shall be responsible for the development and surveillance of pharmacy and therapeutics policies and practices, ongoing planned and systematic review of drug usage, and the review of all untoward reactions.
3. The function and scope of the committee will be to:
 - a. serve in an advisory capacity to the Medical Staff and hospital administration in all matters pertaining to the use of medications;
 - b. recommend suitable educational materials for the professional staff on pertinent matters related to medications and their use;
 - c. review/approve policies regarding medication management;
 - d. review adverse drug reactions, medication errors, recalls, drug quality reports and process improvements;
 - e. review any applicable therapeutic and quality-related data.
3. The Pharmacy & Therapeutics Committee will meet as often as necessary, at the call of the chairperson, but at least quarterly. The Pharmacy & Therapeutics Committee shall maintain a record of its proceedings and make timely reports to the Executive Committee.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

PHYSICIAN ADVISORY COMMITTEE – MEMORIAL REGIONAL HOSPITAL SOUTH POLICY AND PROCEDURE

TITLE: Physician Advisory Committee – Memorial Regional Hospital South policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish Physician Advisory Committee for Memorial Regional Hospital South performing its functions on behalf of Memorial Regional Hospital South as a subcommittee of the Memorial Regional Hospital Division Advisory Council.

POLICY: The Physician Advisory Committee will be responsible for overseeing, improving, and standardizing the quality of care provided to patients of Memorial Regional Hospital South.

1. The Physician Advisory Committee shall have a Chairperson and who shall be appointed by the Chief of Staff of Memorial Regional Hospital Division and ratified by its Advisory Council. The Chief of Staff will also appoint a Vice Chairperson from among the members of the Advisory Committee, who will also be ratified by the Advisory Council of Memorial Regional Hospital Division. None of the Chiefs of the hospital-based services are eligible to be appointed as Chairperson or Vice Chairperson of the Physician Medical Advisory Committee. The Chairperson and Vice Chairperson shall be active Medical Staff members. In the event of a resignation or failure of the Chairperson to serve his or her term, the Vice Chairperson shall take over the position as Chairperson for the remainder of the unexpired term.
2. With the exception of the Chiefs of the hospital-based services, each Physician Advisory Committee member shall serve a two (2) year term, which shall run concurrently with the term(s) of the Officers of the Memorial Regional Hospital Division. The initial appointed Physician Advisory Committee members shall be appointed by the then-current Medical Staff Officers and shall serve a partial term (concurrent with the remaining term of the then-current Hospital Division Medical Staff Officers). Physician Advisory Committee members can be reappointed by the incoming Chief of Staff.
3. The Physician Advisory Committee shall have one (1) vote on the Advisory Council of Memorial Regional Hospital Division. The Chairperson of the Physician Advisory Committee, as a result of his or her position on the Physician Advisory Committee, shall become a voting member on the Advisory Council of the Memorial Regional Hospital Division. The Medical Director of Rehabilitation shall be a member of the Advisory Council of the Memorial Regional Hospital Division, without a vote.
4. The Physician Advisory Committee shall meet as required and shall make written reports and recommendations to the Advisory Council of Memorial Regional Hospital Division

summarizing the discussions at each meeting, as well as advising on certain of Memorial Regional South's clinical and Medical Staff issues.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

QUALITY CARE AND PATIENT SAFETY COMMITTEE POLICY AND PROCEDURE

TITLE: Quality Care and Patient Safety Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a Quality Care and Patient Safety Committee performing its functions for each Hospital and Hospital Division.

POLICY: The Quality Care and Patient Safety Committee shall be responsible for assisting in performance improvement activities of each Hospital's and Hospital Division's Departments.

1. Membership shall be determined by the Hospital's Executive Committee, or applicable Advisory Council in the case of Memorial Regional Hospital Division or Joe DiMaggio Children's Hospital Division, as set forth in the Medical Staff policies. The Quality Care and Patient Safety Committees will be chaired by the Vice Chiefs of Staff of each respective Hospital or Hospital Division, unless determined otherwise by the Executive Committee or Advisory Council.
2. The Quality Care and Patient Safety Council shall be responsible for assisting in performance improvement activities within the Hospital. The review will include, but not be limited to, the performance improvement activities of the Hospital Departments, the Medical Staff Departments, the Medical Staff functions including surgical case review, blood usage review, drug usage, medical records, utilization review, infection control, mortality review, and development of standards and criteria for medical care.
3. The Quality Care and Patient Safety Council shall meet at least quarterly, shall maintain a permanent record of its findings proceedings and actions. They shall make a quarterly report to the Executive Committee.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

TRANSFUSION COMMITTEE POLICY AND PROCEDURE

TITLE: Transfusion Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Transfusion Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The Transfusion Committee shall be responsible for reviewing the use of blood products within the Memorial Healthcare System.

1. The Transfusion Committee shall consist of a chairperson and other members, three (3) of which are active staff members practicing at Memorial Regional Hospital Division and appointed by the Chief of Staff of Memorial Regional Hospital and one (1) of which is an active staff member practicing at Joe DiMaggio Children's Hospital Division and appointed by the Chief of Staff of Joe DiMaggio Children's Hospital Division, three (3) of which are members of the Medical Staff of Memorial Hospital West, three (3) of which are members of the Medical Staff of Memorial Hospital Pembroke, and three (3) of which are members of the Medical Staff of Memorial Hospital Miramar. The supervisor of the blood bank at Memorial Regional Hospital shall be an ex-officio member without vote, as may also be such suitable Hospital personnel as each Administrator may appoint.
2. The Transfusion Committee will be responsible for the evaluation of all confirmed transfusion reactions, the development or approval of policies and procedures relating to the distribution, handling, use and administration of blood and blood components, the review of the adequacy of transfusion services to meet the needs of patients and review of ordering practices for blood and blood products. The Transfusion Committee will assist the clinical departments in the development and review of screening criteria for blood usage review.
3. The Transfusion Committee shall maintain a record of its proceedings and make timely reports to the Executive Committees.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

RESIDENCE, PRIMARY OFFICE LOCATION, and COMMUNICATION REQUIREMENTS POLICY AND PROCEDURE

TITLE: Residence, primary office location, and communication requirements policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish residence, primary office location and communication requirements for all practitioners holding privileges within the Memorial Healthcare System.

POLICY: All practitioners must maintain a bona fide residence and primary office for practice ("primary" being defined as the office where the practitioner spends seventy-five percent (75%) of his or her office hours each week) within a reasonable travel time to the Hospital that ensures availability.

1. "Reasonable travel time" shall be defined as requiring a *bona fide* residence and primary office location within Miami-Dade, Broward, or Palm Beach counties. The Executive Committee may waive these requirements in specific instances.

Exceptions:

- a. Consulting Staff (Section 3.3 of the Bylaws);
 - b. Relief of Duties (Section 5.4 of the Bylaws);
 - c. Contract Practitioners (Section 3.11 of the Bylaws); however, if a practitioner is no longer a contract practitioner but continues to have privileges, the practitioner must fulfill the residence and primary office location requirements of the Bylaws and this policy unless otherwise exempt; and
 - d. Full-time hospitalists. A "hospitalist" is defined as a physician whose primary professional focus is the general medical care of hospitalized patients. Full-time hospitalists are required to provide a business office address including an office phone and fax number.
2. In order to provide on call emergency services or participate in on call emergency coverage, a practitioner must maintain a location while providing call coverage to respond onsite to the Hospital within thirty (30) minutes.
 3. Communication
 - a. All communication regarding patients will be via mechanisms that ensure protection of Protected Health Information (PHI).
 - b. The platform in current use at Memorial Healthcare System for secure texting must be used, e.g. Epic Secure Chat.

- c. Providers must supply a cell phone number for emergency use, and allow its publication in Memorial Healthcare System internal sites, such as Physician Directory and Physician Portal.
- d. The email address issued by Memorial Healthcare System is to be used for all hospital-related business, including notifications and credentialing activities. External email addresses will not be maintained or utilized.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

HUMANITARIAN USE DEVICE (OFF-LABEL USES) COMMITTEE POLICY AND PROCEDURE

TITLE: Humanitarian Use Device (Off-Label Uses) policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: A humanitarian use device (“HUD”) is a commercially marketed device that is intended to benefit patients by treating or diagnosing a disease or condition that affects or is manifested in fewer than 4,000 individuals in the United States per year. When the FDA approves a device for humanitarian use, its effectiveness has not yet been demonstrated; however the FDA has determined that there is “sufficient information provided that the device does not pose an unreasonable or significant risk of illness or injury, and that the probable benefit to health outweighs the risk of injury or illness from its use, taking into account the probable risks and benefits of currently available devices or alternative forms of treatment.”

POLICY: The Memorial Healthcare System IRB must first approve, and then will supervise, clinical testing of use of a HUD for its labeled indication. The Memorial Healthcare System IRB will also approve a practitioner it determines is qualified through training and expertise to use the HUD device for its labeled indication. The following procedure must be followed prior to any use of a HUD for *any purpose other than its labeled indication*.

1. The practitioner wishing to use an off-label HUD should notify the IRB office in writing within five (5) working days of his/her use of the HUD with a description of the proposed off-label use. Prior to allowing the HUD to be used for a purpose other than its labeled indication, the Chief of the applicable medical staff Department or Section, or his or her designee, and the Memorial Healthcare System Chief Medical Officer, or his or her designee, must review and approve of the off-label use of HUD device. The medical Department may develop a protocol for the off-label HUD device use, with notification to the IRB. The Chiefs must also determine whether the practitioner is qualified to use the device in the clinical situation, as in some cases special training is required to use these devices.
2. To the extent clinically appropriate, HUDs will only be used by Memorial Healthcare System IRB-approved HUD practitioners with the assistance, involvement, or supervision of a Memorial Healthcare System IRB-approved HUD practitioner. The participation of a Memorial Healthcare System IRB-approved HUD practitioner may be waived when the Chief of the Department or Section, or his or her designee, and the Chief Medical Officer, or his or her designee, agree that participation is not clinically appropriate.
3. Informed consent must be obtained in accordance with informed consent for treatment purposes. If use is for research, research consent would apply. The practitioner who wishes to use the HUD for an off-label use must ensure that reasonable patient protection measures

are followed, such as devising schedules to monitor the patient, taking into consideration the patient's specific needs, and the limited information available about the risks and benefits of the device.

4. The practitioner must comply with the HDE holder's requirements (the manufacturer of the HUD) with regards to off-label use notifications. This may include submission of a follow-up report to the HDE holder on the patient's condition and/or if the HUD may have caused or contributed to a death or serious injury, or has malfunctioned and would likely cause or contribute to a death or serious injury if the malfunction were to recur.
5. The practitioner must provide the Memorial Healthcare System IRB with all required follow up information.

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

TRAINING AND EDUCATION REQUIREMENTS FOR CERTAIN PRACTITIONERS REQUESTING ADMITTING PRIVILEGES

TITLE: Training and Education Requirements for Certain Practitioners Requesting Admitting Privileges policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish alternative training and education requirements for certain primary care practitioners requesting admitting privileges, but do not meet the training and education requirements set forth in Section 4.2.D of the Medical Staff Bylaws.

POLICY: Section 4.2.D of the Medical Staff Bylaws require new applicants desiring active staff membership with admitting privileges to have (1) hospital experience in the preceding twelve (12) month period prior to the applicant's request for such privileges; or (2) in the absence of such hospital experience, obtain formal training from a recognized training program accredited by the Accreditation Council for Graduate Medical Education and subsequently obtain written documentation from the training program director that indicates that the applicant is currently competent to perform the privileges specifically requested. Section 4.2.D provides an exemption from these training and education requirements for primary care practitioners (internists, family practitioner, and primary care pediatricians); however, such primary care practitioners will be ineligible to hold admitting privileges unless such primary care practitioner has completed additional training and education as outlined in this Policy.

1. Pediatricians. Pediatric practitioners who do not meet the requirements in Section 4.2.D of the Bylaws, but desire to perform well-baby check-ups, which require admitting privileges, must meet the following requirements:
 - be board certified in pediatrics,
 - show experience with office-based newborn care within the preceding twelve (12) month period; and
 - have an observation period of thirty (30) patient encounters with a credentialed member of the Medical Staff pediatric newborn nursery privileges, who must verify their competency upon completion of the observation period.

MEMORIAL HEALTHCARE SYSTEM

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CONTINUING MEDICAL EDUCATION COMMITTEE

TITLE: Continuing Medical Education (CME) Committee policy and procedure for the continuous professional development of Memorial Healthcare System staff physicians.

PURPOSE: To establish a system wide CME committee performing its functions for all of the staff physicians of Memorial Healthcare System.

POLICY: The CME Committee is responsible for ensuring that all continuing medical education programs are planned and implemented in accordance with ACCME guidelines and Standards for Commercial Support as well as the overall educational mission of Memorial Healthcare System.

1. The CME Committee, at minimum, shall consist of:
 - a. The Chief Academic Officer
 - b. CME Chair
 - c. CME Director
 - d. CME Coordinators
 - e. A representative sample of Program Directors for Symposia, Courses and Regularly Scheduled Series
 - f. Quality Improvement, Patient Safety
 - g. Administrative Director of Graduate Medical Education
 - h. Director of Undergraduate Medical Education
2. The CME Committee must meet a minimum of once every quarter during each academic year.
3. CME Committee Responsibilities must include:
 - a. Oversight of the overall ACCME accreditation status of Memorial Healthcare System and each of its ACCME-accredited activities including ensuring that:
 - i. CME activities address the professional practice gaps of the learners

- ii. CME activities advance improvements in physician competence, performance or patient care outcomes
 - iii. CME activities are designed using best available scientific evidence
 - iv. CME activities are designed in the context of desirable physician competencies
 - v. CME activities are devoid of commercial bias and conflicts of interest are disclosed and resolved
 - vi. CME activities use a variety of education formats appropriate to the activity including didactics, hands-on, and small group interactive sessions
 - vii. CME activities lead to measurable achievement of desired educational outcomes
 - viii. The overall CME program is evaluated annually including recommendations for improvement
- b. Review and make recommendations for operational efficiencies
 - c. Review and make recommendations for budgetary and fiscal matters related to CME
 - d. Review and Approval of:
 - i. Institutional CME policies and procedures
 - ii. Applications for new and existing CME programs

Ad hoc invitees as needed: Nursing, Mid-Levels, Pharmacy, Chief Resident(s)

MEMORIAL HEALTHCARE SYSTEM

JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR, AND MEMORIAL HOSPITAL WEST

GRADUATE MEDICAL EDUCATION COMMITTEE

TITLE: Graduate Medical Education (GME) Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a system wide GME committee performing its functions for all of the Interns, Residents, and Fellows of the Memorial Healthcare System.

POLICY: The GME Committee will be responsible for annually reviewing and revising, as necessary, the institutional policies so that they reflect current system practices.

1. The GME Committee, at minimum, shall consist of:
 - a. The Designated Institutional Official
 - b. A representative sample of program directors (minimum of two) from its ACGME-accredited programs.
 - c. A minimum of two peer-selected residents/fellows from among its ACGME-accredited programs.
 - d. A quality improvement or patient safety officer or designee.
2. The GME Committee must meet a minimum of once every quarter during each academic year.
3. GME Committee Responsibilities must include:
 - a. Oversight of:
 - i. The ACGME accreditation status of the Sponsoring Institution and each of its ACGME-accredited programs;
 - ii. The quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites;
 - iii. The quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME;
 - iv. Common and specialty/subspecialty-specific Program Requirements;

- v. The ACGME-accredited program(s)' annual evaluation and improvement activities;
 - vi. All processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution.
- b. Review and Approval of:
- i. Institutional GME policies and procedures;
 - ii. Annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits;
 - iii. Applications for ACGME accreditation of new programs
 - iv. Requests for permanent changes in resident/fellow complement;
 - v. Major changes in each of its ACGME-accredited programs' participating sites;
 - vi. Appointment of new program directors;
 - vii. Progress reports requested by a Review Committee;
 - viii. Responses to Clinical Learning Environment Review (CLER) reports;
 - ix. Request for exception to duty hour requirements
 - x. Voluntary withdrawal of ACGME program accreditation;
 - xi. Request for appeal of an adverse action by a Review Committee; and
 - xii. Appeal presentations to an ACGME Appeals Panel.

MEMORIAL HEALTHCARE SYSTEM
JOINT POLICIES AND PROCEDURES OF THE MEDICAL STAFFS OF MEMORIAL
REGIONAL HOSPITAL AND JOE DIMAGGIO CHILDREN'S HOSPITAL, MEMORIAL
HOSPITAL PEMBROKE, MEMORIAL HOSPITAL MIRAMAR AND MEMORIAL HOSPITAL
WEST

UTILIZATION REVIEW COMMITTEE

TITLE: Utilization Review Committee policy and procedure for the Medical Staffs of Memorial Healthcare System

PURPOSE: To establish a Utilization Review Committee at each Hospital, with the exception of Memorial Regional Hospital and Joe DiMaggio Children's Hospital, which shall be combined, in accordance with the Utilization Review Plan.

POLICY:

1. The Utilization Review (UR) committee shall be multidisciplinary in nature and will include Medical Staff representatives from a variety of specialties
2. There shall be a separate and distinct Utilization Review Committee for each Hospital, with the exception of Memorial Regional Hospital and Joe DiMaggio Children's Hospital, which shall be combined. The Utilization Review Committee shall consist of a chairperson and at least four (4) other members, appointed by the Chief of the Medical Staff.
3. For Memorial Regional Hospital and Joe DiMaggio Children's Hospital, three (3) of which are active staff members practicing at Memorial Regional Hospital and appointed by the Chief of Staff of Memorial Regional Hospital, and one (1) of which is an active staff member practicing at Joe DiMaggio Children's Hospital and appointed by the Chief of Staff of Joe DiMaggio Children's Hospital.
4. The Medical Director of Clinical Effectiveness for the Hospital, Medical Director for Utilization Review/Health Information Management, and the Chief Medical Officer of each Hospital and Hospital Division, and Hospital personnel shall be ex-officio members without vote.
5. The Utilization Review Committee will be responsible for oversight of all utilization, clinical resource, length of stay, and appropriateness of care issues.
6. The Utilization Review Committee shall meet quarterly, and as often as necessary at the call of the chairperson. The committee shall maintain a record of its proceedings and make timely reports to the Executive Committee.

Approval of Joint Policies & Procedures

WHEREAS Article 16 of the Joint Bylaws of the Medical Staff of Memorial Regional Hospital, Memorial Regional Hospital South, and Joe DiMaggio Children's Hospital; and the Medical Staff of Memorial Hospital Pembroke, and the Medical Staff of Memorial Hospital Miramar; and the Medical Staff of Memorial Hospital West of the South Broward Hospital District dba Memorial Healthcare System, Hollywood, Florida provides the procedure for adoption and amendment of the Joint Rules and Regulations and Joint Policies and Procedures of the Medical Staff of Memorial Regional Hospital, Memorial Regional Hospital South, and Joe DiMaggio Children's Hospital; and the Medical Staff of Memorial Hospital Pembroke; and the Medical Staff of Memorial Hospital Miramar; and the Medical Staff of Memorial Hospital West of the South Broward Hospital District dba Memorial Healthcare System, Hollywood, Florida {"Joint Rules and Regulations and Joint Policies and Procedures"});

WHEREAS the amended Joint Policies and Procedures were presented and approved at the Medical Executive Committees of Memorial Regional Hospital, Memorial Regional Hospital South, and Joe DiMaggio Children's Hospital on August 18, 2021,

WHEREAS the amended Joint Policies and Procedures were presented and approved at the Medical Executive Committee of Memorial Hospital Pembroke on August 12, 2021;

WHEREAS the amended Joint Policies and Procedures were presented and approved at the Medical Executive Committee of Memorial Hospital Miramar on August 11, 2021; and

WHEREAS the amended Joint Policies and Procedures were presented and approved at the Medical Executive Committee of Memorial Hospital West on August 9, 2021;

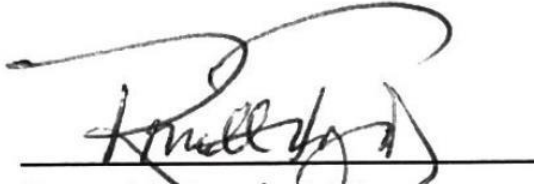
NOW THEREFORE, the amendments to the Joint Rules and Regulations and Policies and Procedures as described in the June 29, 2021 Bylaws Committee minutes are approved by the Chief Medical Officers of each Hospital and Hospital

Division, and the Chief Medical Officer of Memorial Healthcare System as set forth by their signatures below :



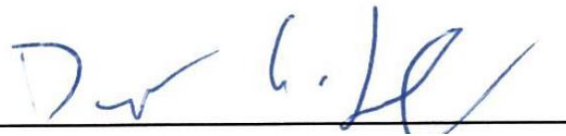
Date: August 30, 2021

Donald Kim, MD
Chief Medical Officer, Memorial Regional Hospital/Memorial Regional Hospital South



Date: August 30, 2021

Ronald Ford, MD
Chief Medical Officer, Joe DiMaggio Children's Hospital



Date: August 30, 2021

Dexter Sereda, MD
Chief Medical Officer, Memorial Hospital Pembroke



Date: August 30, 2021

Eric Freling, MD
Chief Medical Officer Memorial Hospital West



Date: August 30, 2021

Todra Anderson-Rhodes, MD
Chief Medical Officer, Memorial Hospital Miramar



Date: August 30, 2021

Marc Napp, MD
Senior Vice President, and Chief Medical Officer, Memorial Healthcare System