



NCH HEALTHCARE SYSTEM MEDICAL STAFF ORGANIZATION AND FUNCTIONS MANUAL

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

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

1.B. TIME LIMITS

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

1.C. DELEGATION OF FUNCTIONS

- (1) When a function is to be carried out by a member of the Hospital Administration, by a member of the Medical Staff, or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees.
- (2) When a Medical Staff member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

CLINICAL DEPARTMENTS AND SECTIONS

2.A. DEPARTMENTS AND SECTIONS

The Medical Staff will be organized into the following departments and sections:

Department of Anesthesiology (Pain Management)

Department of Emergency Medicine

Department of Family Medicine

Department of Medicine

Section of Allergy

Section of Cardiology/Invasive Cardiology

Section of Critical Care/Pulmonology

Section of Dermatology

Section of Endocrinology

Section of Gastroenterology

Section of Geriatrics

Section of Hematology/Oncology

Section of Hospitalist

Section of Infectious Disease

Section of Internal Medicine

Section of Nephrology

Section of Rheumatology

Section of Radiation Oncology

Department of Obstetrics/Gynecology Section of Perinatology

Section of Gynecology/Oncology Department of Pathology

Department of Pediatrics

Section of Pediatrics (Cardiology/Hematology-Oncology/etc.)

Department of Neurology

Section of Physical Medicine and Rehab

Department of Psychiatry

Department of Surgery

Section of Cardiovascular Surgery

Section of Otolaryngology

Section of General Surgery

Section of Neurosurgery

Section of Ophthalmology

Section of Oral Maxillofacial Surgery

Section of Orthopaedics

Section of Plastic Surgery

Section of Podiatry Section of Urology

Section of Vascular Surgery

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND DEPARTMENT CHAIRPERSONS

The functions and responsibilities of departments and department chairpersons and vice chairpersons are set forth in Article 4 of the Medical Staff Bylaws.

2.C. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

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

- (2) The following factors will be considered in determining whether a clinical department should be created:
- (a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in the Bylaws);
 - (b) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;
 - (c) a majority of the voting members of the proposed department vote in favor of the creation of a new department;
 - (d) it has been determined by the Medical Staff leadership and the Chief Executive Officer that there is a clinical and administrative need for a new department; and
 - (e) the voting Medical Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill the designated responsibilities and functions, including, where applicable, meeting requirements.
- (3) The following factors will be considered in determining whether the dissolution of a clinical department is warranted:
- (a) there is no longer an adequate number of members of the Medical Staff in the clinical department to enable it to accomplish the functions set forth in the Bylaws and related policies;
 - (b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;
 - (c) the department fails to fulfill designated responsibilities and functions, including, where applicable, its meeting requirements;
 - (d) no qualified individual is willing to serve as chairperson of the department; or
 - (e) a majority of the voting members of the department vote for its dissolution.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

- (1) This Article outlines the committees of the Medical Staff that carry out peer review, performance improvement, and other supporting functions on behalf of the Board.
- (2) Procedures for the appointment of committee chairpersons and committee members are set forth in Article 5 of the Medical Staff Bylaws.
- (3) From time to time, the Medical Executive Committee may identify the need to appoint other committees to perform such functions as performance improvement activities, monitoring and evaluation.

3.B. ALLIED HEALTH COMMITTEE

3.B.1. Composition:

- (a) The Allied Health Committee will be comprised of at least the following members:
 - (1) one member of the Credentials Committee;
 - (2) two additional members of the Medical Staff;
 - (3) one advanced practice practitioner and/or licensed independent practitioner;
 - (4) a representative of the Nursing Administration; and
 - (5) the Chief Medical Officer.
- (b) The President of the Medical Staff will appoint the physician members of the Allied Health Committee and will appoint one of the physician members to serve as chairperson.
- (c) Depending on the type of allied health practitioner being considered, the Allied Health Committee may also obtain assistance, on an ad hoc basis, from the relevant department chairperson(s), section chiefs and nursing managers.

3.B.2. Duties:

The Allied Health Committee will perform the following duties:

- (a) evaluate and make recommendations regarding the need for the services that could be provided by classes of allied health practitioners that are not currently practicing at the Hospital;
- (b) develop and recommend policies for each class of allied health practitioner permitted by the Board to practice at the Hospital;
- (c) review the qualifications of advanced practice practitioners and licensed independent practitioners who apply to practice at the Hospital, interview such applicants, and make a written report of its findings and recommendations, including department assignment;
- (d) perform ongoing reviews of the quality of care provided by allied health practitioners (e.g., advanced practice practitioners and licensed independent practitioners) who have been granted clinical privileges to practice at the Hospital; and
- (e) review, as requested, and as questions arise, information available regarding the clinical competence and behavior of allied health practitioners (e.g., advanced practice practitioners and licensed independent practitioners) who have been granted clinical privileges to practice at the Hospital and, as a result of such review, make a written report of its findings and recommendations.

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

- (a) The Allied Health Committee will meet as often as necessary to accomplish its duties. The committee will maintain a permanent record of its proceedings and actions.
- (b) The Allied Health Committee will report its recommendations after each meeting to the Credentials Committee for action. The chairperson of the Allied Health Committee will be available to meet with the Credentials Committee and the Board on recommendations made by the committee.

3.C. BYLAWS COMMITTEE

3.C.1. Composition:

The Bylaws Committee will consist of at least five members of the Active Medical Staff.

3.C.2. Duties:

The Bylaws Committee will review the Medical Staff Bylaws, the Credentialing Policy, the Organization and Functions Manual, the Medical Staff Rules and Regulations and other general Medical Staff policies and procedures and receive and consider recommendations for changes in these documents from sources and make recommendations for appropriate amendments and revisions.

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

The Bylaws Committee will meet as frequently as necessary, but at least annually, to prepare documents for review and recommendation to the Medical Executive Committee.

3.D. CREDENTIALS COMMITTEE

3.D.1. Composition:

- (a) The Credentials Committee will consist of five to eight members of the Active Staff selected for their interest or experience in credentialing matters and who meet the eligibility criteria set forth in Section 3.B of the Medical Staff Bylaws.
- (b) The President of the Medical Staff will appoint a committee chairperson. The chairperson of the Credentials Committee will be appointed for a term of three years and may be reappointed for additional terms.
- (c) Members of the Credentials Committee will also be appointed for an initial term of three years, with members replaced on a rotating basis to ensure continuity, with the option of reappointment. Members may be appointed for additional terms.
- (d) Service on the Credentials Committee will be considered the primary Medical Staff obligation of each member, and other Medical Staff duties, of an administrative nature, will not interfere.
- (e) New members of the Credentials Committee are expected to obtain specific education and training regarding the credentialing process.

3.D.2. Duties:

The Credentials Committee will, in acting to further the quality of care rendered to patients in the Hospital, perform the following duties:

- (a) review the credentials of applicants for Medical Staff appointment and clinical privileges and prepare a written report of its findings and recommendations;
- (b) review the credentials of applicants to practice as allied health practitioners and prepare a written report of its findings and recommendations;

- (c) make recommendations regarding the duration and terms of each individual's provisional appointment;
- (d) review the credentials of individuals seeking Medical Staff reappointment and the renewal of clinical privileges and prepare a written report of its findings and recommendations;
- (e) review, as questions arise and as requested, information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and, as a result of such review, make a written report of its findings and recommendations;
- (f) review and recommend, as questions arise, criteria for new clinical privileges and for privileges that involve different specialties and, upon request from Administration, recommend whether new procedures or services should be offered to patients at the Hospital;
- (g) provide oversight to the Allied Health Committee; and
- (h) review, approve, and make recommendations to the Medical Executive Committee on the Credentials policy and provides guidance to Hospital staff on the credentialing and privileging process and overall credentialing program.

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

The Credentials Committee will meet as often as necessary to fulfill its responsibilities. The committee will maintain a permanent record of its proceedings and actions and report its recommendations to the Medical Executive Committee, the Chief Executive Officer and the Professional Capabilities Committee of the Board.

3.E. LEADERSHIP COUNCIL

3.E.1. Composition:

- (a) The Leadership Council will be comprised of the following voting members:
 - (1) President of the Medical Staff, who will act as chairperson;
 - (2) Chairperson of the Physician Excellence Committee;
 - (3) Chairperson of the Credentials Committee; and
 - (4) Physician Advisor.

- (b) The following individuals will serve as *ex officio* members, without vote, to facilitate the Leadership Council's activities:
 - (1) Chief Medical Officer; and
 - (2) PPE Support Staff or Director of Medical Staff Services.
- (c) Other Medical Staff members or Hospital personnel may be invited to attend a particular Leadership Council meeting (as guests, without vote) in order to assist the Leadership Council in its discussions and deliberations regarding issues on its agenda. These individuals will be present only for the relevant agenda items and will be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.E.2. Duties:

The Leadership Council will perform the following duties:

- (a) review and address concerns about professional conduct of practitioners as outlined in the Medical Staff Code of Conduct Policy;
- (b) review and address concerns about the health status and the ability of practitioners to provide safe and competent care as outlined in the Practitioner Health Policy;
- (c) review and address issues regarding the clinical practice of practitioners as outlined in the Professional Practice Evaluation Policy;
- (d) appoint reviewers to function in accordance with the Professional Practice Evaluation Policy;
- (e) meet, as necessary, to consider and address any situation that may require immediate action;
- (f) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any department or unit within the Hospital; and
- (g) perform any additional functions as outlined in the Professional Practice Evaluation Policy or as may be requested by the Practitioner Excellence Committee, the Medical Executive Committee, or the Board.

3.E.3. Meetings:

The Leadership Council will meet as often as necessary to perform its duties and will maintain a record of its findings, proceedings, and actions. The Leadership Council will

report to the Practitioner Excellence Committee, the Medical Executive Committee, and others as described in applicable policies.

3.F. MEDICAL EXECUTIVE COMMITTEE

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

3.G. NOMINATING COMMITTEE

The composition, duties and meeting requirements of the Nominating Committee are set forth in Section 3.D of the Medical Staff Bylaws.

3.H. PERFORMANCE IMPROVEMENT COMMITTEE

3.H.1. Composition:

- (a) The Performance Improvement Committee will consist of the chairpersons of the following committees:
 - (1) Cancer Services Committee;
 - (2) Continuing Medical Education Committee;
 - (3) Critical Care Committee;
 - (4) Infection Prevention and Control Committee;
 - (5) Health Information Management Committee;
 - (6) OR Operations Committee;
 - (7) Patient Blood Management;
 - (8) Pharmacy and Therapeutics Committee;
 - (9) Utilization Review Committee; and
 - (10) Point of Care Ultrasound Committee.
- (b) Additional members may be added as deemed necessary. The President of the Medical Staff will appoint an officer of the Medical Staff to serve as chairperson of the Performance Improvement Committee, with vote, and with reporting responsibilities to the Medical Executive Committee.
- (c) Terms of appointment to the Performance Improvement Committee will be for a period of three years.

3.H.2 Duties:

The Performance Improvement Committee will perform the following duties:

- (a) integrate Hospital-based operational committee activities which assess processes of care, Hospital services and operations;
- (b) review issues of a Hospital-wide operational nature to recommend policy changes to support a culture of improvement of health outcomes systemwide;
- (c) submit reports of its actions and recommendations to the Medical Executive Committee; and
- (d) perform other duties as requested by the Medical Executive Committee to support a culture of continuous performance improvement.

3.H.3. Reporting:

The Performance Improvement Committee will meet as often as necessary. It will maintain a permanent record of its proceedings and actions and report its recommendations to the Medical Executive Committee.

3.I. PRACTITIONER EXCELLENCE COMMITTEE

3.I.1. Composition:

- (a) The Practitioner Excellence Committee will consist of eight to ten members of the Active Staff selected for their interest or experience in peer review matters and who meet the eligibility criteria set forth in Section 3.B of the Medical Staff Bylaws.
- (b) The President of the Medical Staff will appoint a committee chairperson who will serve *ex officio* on the Medical Executive Committee, with vote.
- (c) Terms of appointment to the Practitioner Excellence Committee will be for a period of three years, with members replaced on a rotating basis to ensure continuity.
- (d) Service on the Practitioner Excellence Committee will be considered the primary Medical Staff obligation of each member, and other Medical Staff duties, of an administrative nature, will not interfere.
- (e) New members of the Practitioner Excellence Committee are expected to obtain specific education and training regarding the peer review process.

3.I.2. Duties:

The Practitioner Excellence Committee will perform the following duties:

- (a) oversee the implementation of the peer review and professional practice evaluation activities on behalf of the Medical Staff;
- (b) review cases referred to the committee as outlined in the Professional Practice Evaluation Policy;
- (c) develop, when appropriate and in conjunction with the applicable committee, performance improvement plans for practitioners;
- (d) submit reports of its actions and recommendations to the Medical Staff department chairpersons as part of the physician's reappointment process;
- (e) oversee the ongoing professional performance evaluation process;
- (f) oversee the focused professional practice evaluation process to confirm competence of new members or existing members seeking new privileges in addition to focused review when concerns are raised with regard to existing members; and
- (g) perform other duties as outlined in the Professional Practice Evaluation Policy.

3.I.3. Reporting:

The Practitioner Excellence Committee will meet as often as necessary, but at least bimonthly. It will maintain a permanent record of its proceedings and actions and report its recommendations to the Medical Executive Committee.

3.J. PRACTITIONER HEALTH COMMITTEE

3.J.1. Composition:

The Medical Executive Committee will appoint a Practitioner Health Committee to receive inquiries and reports on the health, well-being, or impairment of practitioners.

3.J.2. Duties:

The Practitioner Health Committee may review and provide advice, counseling or referrals as may seem appropriate for matters involving individual practitioners.

3.K. MEDICAL STAFF LEGAL AFFAIRS COMMITTEE

3.K.1. Composition:

The Medical Staff Legal Affairs Committee shall be a standing committee. Current members shall serve a six-year term. The terms shall be served on a rotating basis, with one-third of the committee members rotating off the committee every two years. The President of the Medical Staff shall fill any vacancies on this committee.

3.K.2. Duties:

The Medical Staff Legal Affairs Committee will perform the following duties:

- (a) work with and assist the independent legal counsel to the Medical Staff and Medical Executive Committee with respect to any issues, projects or other work, as determined by the Medical Executive Committee or the President of the Medical Staff;
- (b) advise the Medical Staff Leadership of the status of its work, and provide insight to the Medical Staff Leadership with respect to its work on issues affecting the Medical Staff, the Medical Staff Bylaws, the Medical Staff membership or the practice of medicine as a member of the Medical Staff of Naples Community Hospital, or any other current legal issues being addressed at the time;
- (c) advise the Medical Staff Leadership of any issues the Committee believes warrants its attention, and the attention of the Medical Executive Committee; and
- (d) carry out any other related duties and responsibilities delegated to it by the Medical Executive Committee or the President of the Medical Staff.

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

The Legal Affairs Committee will meet as often as necessary to fulfill its responsibilities. The committee will maintain a permanent record of its proceedings and actions and report its recommendations to the Medical Executive Committee, the Chief Executive Officer and the Professional Capabilities/Joint Conference Committee of the Board.

ARTICLE 4

HOSPITAL STAFF OPERATIONAL COMMITTEES

4.A. OVERVIEW

- (1) The Medical Executive Committee will provide leadership for measuring, assessing and improving processes that primarily depend on the activities of members of the Medical Staff and Allied Health Professional Staff, and review the activities set forth below. These activities will be carried out by Hospital Staff Operational Committees.
- (2) This Article outlines the Hospital Staff Operational Committees that have reporting responsibilities to the Medical Executive Committee.
- (3) Unless otherwise stated, the Hospital Staff Operational Committees will meet as often as necessary. They will maintain a permanent record of their proceedings and actions and, except as otherwise provided, report their recommendations to the Medical Executive Committee as often as necessary, but at least quarterly.

4.B. CANCER SERVICES COMMITTEE

4.B.1. Composition:

- (a) The Cancer Services Committee will include Medical Staff representation from each of the following specialties: surgery, medical oncology, radiation oncology, diagnostic radiology and pathology and other medical specialties based on the major sites that are diagnosed and treated at the Hospital.
- (b) Non-physician members will be appointed by the Hospital Administration.
- (c) Both physician and non-physician members of the Cancer Services Committee will serve with vote.
- (d) The ACS Cancer Liaison Physician will serve with vote.

4.B.2. Duties:

The Cancer Services Committee will perform the following duties:

- (a) evaluate the quality of care provided to patients with cancer;
- (b) develop and evaluate annual goals and objectives for the clinical, educational and programmatic endeavors related to cancer care;

- (c) promote and coordinate a multidisciplinary approach to patient management;
- (d) assure that consultative services are available to patients with cancer through multidisciplinary physician attendance at conferences;
- (e) assure that cancer conferences include major cancer sites yearly and are primarily patient-oriented and prospective;
- (f) reevaluate effectiveness of the patient care evaluation program;
- (g) ensure an active supportive care system for patients, families and staff;
- (h) monitor quality management and improvement through completion of patient care studies that focus on quality, access to care, and outcomes;
- (i) promote clinical research;
- (j) actively supervise the cancer registry for quality control of abstracting, staging, and reporting;
- (k) serve as registry physician-advisors; and
- (l) publish and distribute an annual report reflecting the activity of the institution and the entire cancer program.

4.C. CONTINUING MEDICAL EDUCATION COMMITTEE

4.C.1. Composition:

- (a) The Continuing Medical Education Committee will include Medical Staff representation from each of the primary specialties represented on the Medical Staff, who will serve with vote.
- (b) A chairperson and a vice-chairperson will be designated by the Medical Executive Committee.
- (c) Non-physician members will be appointed by the Hospital Administration to serve with vote as designated to carry out the functions of the committee.
- (d) The composition of the committee and appointment of the chairperson and vice-chairperson will meet requirements as outlined by the Florida Medical Association, which serves as the accrediting body for the NCH Healthcare System CME Program.

- (e) The CME Coordinator will be designated to have administrative responsibility for the CME program and to be responsible for maintaining contact with the Florida Medical Association.

4.C.2. Duties:

The Continuing Medical Education Committee will perform the following duties:

- (a) develop CME activities appropriate for designation of AMA Category 1 credit; and
- (b) approve jointly-sponsored programs in which NCH Healthcare is involved.

4.D. CRITICAL CARE COMMITTEE

4.D.1. Composition:

- (a) The Critical Care Committee will include Medical Staff representation, appointed by the President of the Medical Staff.
- (b) Non-physician members will be appointed by the Hospital Administration.
- (c) Both physician and non-physician members of the Critical Care Committee will serve with vote.

4.D.2. Duties:

The Critical Care Committee will perform the following duties:

- (a) monitor and evaluate the quality and appropriateness of patient care provided in the Critical Care Unit of the Hospital;
- (b) be responsible for the formulation, review, and implementation of policies for the Critical Care Unit of the Hospital;
- (c) review and make recommendations regarding adequate staffing and equipment in the Critical Care Unit;
- (d) formulate rules regulating admission to, and discharge from, the Critical Care Unit to ensure optimal utilization of this specialized area and monitor and adjudicate questions regarding the utilization of intensive care beds; and
- (e) assist in the training and equipping of the cardiac resuscitation team and periodically review records of specific resuscitation efforts and consider problems involved in specific resuscitation efforts.

4.E. INFECTION PREVENTION AND CONTROL COMMITTEE

4.E.1. Composition:

- (a) The Infection Prevention and Control Committee will include Medical Staff representation, appointed by the President of the Medical Staff.
- (b) Non-physician members, including the Infection Control Officer and the Infection Control Coordinators, will be appointed by the Hospital Administration.
- (c) Both physician and non-physician members of the Infection Prevention and Control Committee will serve with vote.

4.E.2. Duties:

The Infection Prevention and Control Committee will perform the following duties:

- (a) be responsible for the directing, monitoring, and evaluation of the hospital Infection Control Program;
- (b) develop uniform criteria to define nosocomial infection for the purpose of surveillance, as well as specific indications of the need for and the procedures to be used in isolation;
- (c) define specific surveillance targets based on previous data, high risk, high volume, or those infections which impact patients most and those that have a high economic impact; new and revised policies and procedures for infection control will be approved by the committee;
- (d) develop a practical system for reporting, evaluating and recording infections among patients and personnel in order to establish endemic occurrence of infections and in order to identify epidemic occurrence of infections;
- (e) assist in developing and overseeing the Hospital's employee health program with regard to infection control standards;
- (f) evaluate equipment and supplies used for sterilization, disinfection and decontamination purposes, cleaning procedures, agents, and schedules, and hospital disposal systems for regulatory compliance;
- (g) oversee and implement infection control standards set forth by regulatory agencies; and
- (h) through the committee chairperson and/or the Hospital Epidemiologist, along with the Infection Control Officer and the Infection Control Coordinator, institute any appropriate control measures or studies when there is considered to be a danger to

any patient or personnel, according to its authority as approved by the Chief Executive Officer and the Medical Executive Committee.

4.F. HEALTH INFORMATION MANAGEMENT COMMITTEE

4.F.1. Composition:

- (a) The Health Information Management Committee will include Medical Staff representation, appointed by the President of the Medical Staff.
- (b) Non-physician members will be appointed by the Hospital Administration.
- (c) Both physician and non-physician members of the Health Information Management Committee will serve with vote.

4.F.2. Duties:

The Health Information Management Committee will perform the following duties:

- (a) oversee the organization's record review program, primarily consisting of concurrent, ongoing review, but also including review of discharged charts, to identify opportunities for improvement;
- (b) review and approve forms and format for the medical record, including electronic applications;
- (c) ensure medical records are reviewed on an ongoing basis at the point of care based on organizational defined indicators that address the presence, timeliness, readability, quality, consistency, clarity, accuracy, completeness, and authentication of data and information contained in the record, as well as appropriate scanning and indexing for document imaging;
- (d) establish standards for acceptable abbreviations and assist in the development of a "do not use" abbreviation list;
- (e) monitor delinquency statistics and make recommendations to the President of the Medical Staff and Chief Medical Officer when practitioners with delinquent records need to be suspended from admitting and surgical privileges until such charts are completed; and
- (f) make recommendations to the Medical Executive Committee when action needs to be taken to improve the quality of documentation that impacts patient care.

4.G. MEDICAL INFORMATICS COMMITTEE

4.G.1. Composition:

- (a) The Medical Informatics Committee will include Medical Staff representation, appointed by the President of the Medical Staff.
- (b) Non-physician members will be appointed by the Hospital Administration.
- (c) Both physician and non-physician members of the Medical Informatics Committee will serve with vote.

4.G.2. Duties:

The Medical Informatics Committee will perform the following duties:

- (a) oversee the organization's electronic medical record development, including, but not limited to, PowerChart, PowerNote and Computerized Provider Order Entry utilization; and
- (b) review and approve electronic application forms and format for the medical record.

4.H. OR OPERATIONS COMMITTEE

4.H.1. Composition:

- (a) The OR Operations Committee will include Medical Staff representation, appointed by the President of the Medical Staff.
- (b) Non-physician members will be appointed by the Hospital Administration.
- (c) Both physician and non-physician members of the OR Operations Committee will serve with vote.

4.H.2. Duties:

The OR Operations Committee will perform the following duties:

- (a) monitor, evaluate and conduct ongoing review of quality and appropriateness of care rendered to surgical inpatients;
- (b) review information regarding blood administration, drug usage, mortality, morbidity, and clinical pertinence of surgical inpatients;
- (c) review and evaluate surgery performed in the Hospital, whether or not a specimen is produced, to determine if the surgery was clinically indicated. Cases may be

screened to identify those in which a significant discrepancy exists between the pre-operative and pathological diagnoses;

- (d) ensure that anesthesia services are consistent with patient needs and practices through ongoing monitoring and evaluation of the quality and appropriateness of anesthesia care provided;
- (e) report quality of care problems identified to the appropriate clinical departments; and
- (f) serve as a process improvement committee whose function is to examine operating room procedures with respect to quality of care utilization as well as patient and physician satisfaction.

4.I. PATIENT BLOOD MANAGEMENT COMMITTEE

4.I.1. Composition:

- (a) The Patient Blood Management Committee will include Medical Staff representatives appointed by the President of the Medical Staff.
- (b) Non-physician members will be appointed by the Hospital Administration.
- (c) Both physician and non-physician members of the Patient Blood Management Committee will serve with vote.

4.I.2. Duties:

The Patient Blood Management Committee will perform the following duties:

- (a) establish and maintain criteria for the appropriate use of blood and blood products;
- (b) continually evaluate the use of blood against clinically realistic criteria;
- (c) consistently report information concerning the use of blood and blood products to Medical Staff departments;
- (d) organize periodic continuing education programs related to blood and blood products for the Medical Staff;
- (e) evaluate the overall adequacy of the blood bank in meeting patient needs; and
- (f) periodically evaluate the adequacy of policies and procedures used in the distribution, handling, and dispensing of blood and blood products.

4.J. PHARMACY AND THERAPEUTICS COMMITTEE

4.J.1. Composition:

- (a) The Pharmacy and Therapeutics Committee will include Medical Staff representation, appointed by the President of the Medical Staff.
- (b) Non-physician members will be appointed by the Hospital Administration.
- (c) Both physician and non-physician members of the Pharmacy and Therapeutics Committee will serve with vote.

4.J.2. Duties:

The Pharmacy and Therapeutics Committee will perform the following duties:

- (a) assist in formulating broad professional policies regarding drugs, including diagnostic testing evaluation, selection, procurement, distribution, handling, use, safety procedures, evaluation of reported drug reactions, evaluation of medication errors and other matters relating to drugs used in the Hospital;
- (b) advise the Medical Staff and Administration on matters pertaining to the choice of drugs;
- (c) add to and delete from the list of drugs approved for use in the Hospital;
- (d) prevent unnecessary duplication in the stock of the same basic drug and its preparation;
- (e) make recommendations concerning drugs to be stocked on the nursing units and in other areas;
- (f) evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;
- (g) develop a Hospital formulary or drug list of accepted drugs for use in the Hospital and evaluate the appropriate use of investigational drugs; and
- (h) review and approve standing orders used by physicians that involve medications.

4.K. UTILIZATION REVIEW COMMITTEE

4.K.1. Composition:

- (a) The Utilization Review Committee will include five to eight members of the Active Staff selected for their interest and/or experience in utilization review matters and

who meet the eligibility criteria set forth in Section 3.B of the Medical Staff Bylaws.

- (b) The President of the Medical Staff will appoint a committee chairperson. The chairperson of the Utilization Review Committee will be appointed for a three- year term with the option for reappointment.
- (c) Members of the Utilization Review Committee will be appointed for an initial three-year term and may be reappointed for additional terms. Members will be replaced on a rotating basis to ensure continuity of the committee.
- (d) The committee is assisted by professional personnel, including the Director of Outcomes Management, the Director of Health Information Management, the Director of Patient Business Services, the Chief Nursing Officer, and the Chief Financial Officer.
- (e) New members of the Utilization Review Committee are expected to obtain specific education and training regarding the utilization review process.
- (f) Two or more members of the committee may act as Physician Advisors for case review.

4.K.2. Duties:

The Utilization Review Committee will, in action to further the quality of care rendered to patients in the Hospital, perform the following duties:

- (a) establish and carry out a program of admission review and extended stay review of patients in accordance with applicable statutes and regulations;
- (b) monitor utilization to identify overutilization, underutilization, and the efficient use of resources;
- (c) study patterns of care and use of evidence-based order sets and protocols and other plans of care developed in collaboration with appropriate disciplines and approved by the Medical Staff;
- (d) review appropriateness of the utilization of support services;
- (e) oversee utilization activities of other departments;
- (f) assist in ongoing modifications of review criteria, practice guidelines, and standards of care;
- (g) recommend changes in hospital procedure or Medical Staff practices as indicated on analysis of utilization review; and

- (h) serve as a resource to assist in developing corrective action plans for issues as indicated by Florida Medical Quality Assurance, Inc. (Medicare), eQHealth (Medicaid), and quality improvement organizations in Florida.

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

- (a) The Utilization Review Committee may meet as often as necessary, but at least quarterly, to fulfill its responsibilities.
- (b) The Utilization Review Committee will keep a permanent record of its proceedings and actions. Copies of minutes will be transferred to the Performance Improvement Committee routinely as prepared, with recommendations from the Utilization Review Committee transmitted to the Medical Executive Committee through the Performance Improvement Committee.

4.L. POINT OF CARE ULTRASOUND COMMITTEE

4.L.1. Composition:

- (a) The Point of Care Ultrasound Committee will be an interdisciplinary team that consists of five to eight members of the Active Staff selected for their interest or experience in point of care ultrasound matters and who meet the eligibility criteria set forth in Section 3.B of the Medical Staff Bylaws and representatives from Nursing Leadership, Finance, Health Information Management, Infection Prevention, Credentialing Committee, Staff Education and Continuing Medical Education. Additional members may be added as deemed necessary.
- (b) The President of the Medical Staff will appoint a committee chairperson. The chairperson of the Point of Care Ultrasound Committee will be appointed for a term of three years and may be reappointed for additional terms.
- (c) Members of the Point of Care Ultrasound Committee will also be appointed for an initial term of three years, with members replaced on a rotating basis to ensure continuity, with the option of reappointment. Members may be appointed for additional terms.
- (d) Service on the Point of Care Ultrasound Committee will be considered the primary Medical Staff obligation of each member, and other Medical Staff duties, of an administrative nature, will not interfere.
- (e) New members of the Point of Care Ultrasound Committee are expected to obtain specific education and training regarding point of care ultrasound.

4.L.2. Duties:

The Point of Care Ultrasound Committee will, in acting to further the quality of care rendered to patients in the Hospital, perform the following duties:

- (a) review evidence-based guidelines for utilization and reprocessing of point of care ultrasound probes on an ongoing basis. Develop policies, guidelines and protocols for compliance and education and prepare a written report of its findings and recommendations;
- (b) review the utilization and reprocessing of point of care ultrasound probes for cleaning and preparing external and internal use of ultrasound transducers between patients, safe handling, and the use of ultrasound Coupling gel and prepare a written report of its findings and recommendations;
- (c) make recommendations regarding point of care ultrasound;
- (d) review, as questions arise and as requested, information available regarding the clinical competence and behavior of persons utilizing the point of care ultrasound as a result of such review, make a written report of its findings and recommendations;
- (e) review and recommend specialties and, upon request from Administration, recommend whether new procedures or services should be offered to patients at the Hospital as it relates to point of care ultrasound; and
- (f) provide oversight to the point of care ultrasound process.

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

The Point of Care Ultrasound Committee will meet as often as necessary to fulfill its responsibilities. The committee will maintain a permanent record of its proceedings and actions and report its recommendations to the Performance Improvement Committee, the Medical Executive Committee, the Chief Executive Officer and the Professional Capabilities Committee of the Board.

ARTICLE 5

AMENDMENTS AND ADOPTION

- (a) The amendment process for this Manual is set forth in the Bylaws.
- (b) This Medical Staff Organization and Functions Manual is adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter herein, and henceforth department and committee activities of the Medical Staff and of each individual serving as a member of a department or Medical Staff committee will be undertaken pursuant to the requirements of the Bylaws or this Manual.

Approved by the Medical Executive Committee: July 10, 2018
Approved by the Board: July 12, 2018

Revised by the Medical Executive Committee: April 14, 2020
Revisions approved by the Board: May 12, 2020