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ARTICLE 1

GENERAL

1.A: DEFINITIONS

The following definitions shall apply to terms used in this Manual:

(1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services.

(2) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.

(3) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(4) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed to act as the chief medical officer of the Hospital. The Chief Medical Officer shall work in cooperation with the President of the Medical Staff.

(5) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(6) "DAYS" means calendar days.

(7) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(8) "HOSPITAL" means St. Mary's Hospital.

(9) "MEDICAL EXECUTIVE COMMITTEE" or "MEC" means the Executive Committee of the Medical Staff.

(10) "MEDICAL STAFF" means all physicians, dentists, and podiatrists who have been appointed to the Medical Staff by the Board.

(11) "MEDICAL STAFF LEADER" means any Medical Staff Officer, department chief, and committee chair.
"MEMBER" means any physician, dentist, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

"NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.

"PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

"PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

"SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

1.B: TIME LIMITS

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

1.C: DELEGATION OF FUNCTIONS

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

(2) When a Medical Staff member is unavailable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.
ARTICLE 2

CLINICAL DEPARTMENTS

2.A: LIST OF DEPARTMENTS

The following clinical departments are established:

- Anesthesiology
- Cardiology
- Emergency Medicine
- Eye, Ear, Nose and Throat Medicine
- Neurological Sciences
- Obstetrics and Gynecology
- Orthopedic Surgery
- Pain Management
- Pathology
- Pediatrics
- Radiology
- Surgery

2.B: FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS

The functions and responsibilities of departments and department chiefs are set forth in Article 4 of the Medical Staff Bylaws.
ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A: MEDICAL STAFF COMMITTEES AND FUNCTIONS

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

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

3.B: MEETINGS, REPORTS AND RECOMMENDATIONS

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

3.C: ALLIED HEALTH PROFESSIONALS COMMITTEE

3.C.1. Composition:

(a) The Allied Health Professionals Committee ("AHP Committee") shall consist of at least seven members who are appointed by the Credentials Committee and who are broadly representative of the different categories of AHPs practicing at the Hospital. The chair of this committee shall be selected by the members and confirmed by the Chair of the Credentials Committee.

(b) Depending on the specific category of AHP being reviewed, the Committee may also obtain assistance, on an ad hoc basis, from other individuals, such as the relevant department head(s) and nurse manager(s).

3.C.2. Duties:

The AHP Committee shall:

(a) as may be requested, review and recommend the need for new categories of AHPs in the Hospital;

(b) as may be requested, develop and recommend policies for each specific category of AHPs permitted by the Board to practice at the Hospital;
(c) review the credentials of all applicants seeking to practice as Licensed Independent Practitioners or Advanced Dependent Practitioners, conduct a thorough review of their applications, interview such applicants as may be necessary, and make a written report of its findings and recommendations, including department assignment, to the Credentials Committee;

(d) develop and implement ongoing and focused professional practice evaluation processes for the AHPs functioning in the Hospital; and

(e) review, as questions arise and when requested, all information available regarding the clinical competence and behavior of AHPs currently permitted to practice at the Hospital and, as a result of such review, make a written report of its findings and recommendations to the Credentials Committee and MEC.

3.D: BYLAWS COMMITTEE

3.D.1. Composition:

The Bylaws Committee shall be chaired by the Immediate Past President of the Medical Staff, and consist of at least six members of the Medical Staff, including at least three Past Presidents of the Medical Staff who are still active at the Hospital and the Secretary-Treasurer of the Medical Staff.

3.D.2. Duties:

The Bylaws Committee shall:

(a) conduct a review of the bylaws and rules, regulations, procedures, and forms promulgated in connection therewith at least every three years;

(b) act upon all matters relating to the review of the bylaws and related documents as may be referred by the Board, the MEC, the departments, the President of the Medical Staff, the CEO, and/or a Medical Staff committee; and

(c) submit recommendations to the MEC and to the Board for changes in these documents.

3.E: CONTINUING MEDICAL EDUCATION COMMITTEE

3.E.1. Composition:

The Continuing Medical Education Committee shall consist of at least five members of the Medical Staff.
3.E.2. Duties:

The Continuing Medical Education Committee shall:

(a) develop and plan programs of continuing medical education which are designed to keep the Medical Staff informed of significant new developments and new skills in the field of medicine which are responsive to evaluation findings;

(b) evaluate the effectiveness of the educational programs developed and implemented;

(c) act upon continuing medical education recommendations from the MEC, the departments, or other committees responsible for patient care audit and other quality assurance and monitoring functions;

(d) analyze the Hospital's and Medical Staff's needs for library services; and

(e) maintain a record of education and library activities and submit periodic reports to the MEC concerning these activities.

3.F: CREDENTIALS COMMITTEE

3.F.1. Composition:

The Credentials Committee shall consist of the President-Elect of the Medical Staff and at least six other Active Staff members who are broadly representative of the major clinical specialties of the Medical Staff. Particular consideration is to be given to Past Presidents of the Medical Staff and to other physicians knowledgeable in the credentialing and quality improvement processes.

3.F.2. Duties:

The Credentials Committee shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) in accordance with the Policy on Allied Health Professionals, review the credentials of all applicants seeking to practice as Licensed Independent Practitioners or Advanced Dependent Practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;
review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Professionals and, as a result of such review, make a written report of its findings and recommendations; and

review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.3 ("Clinical Privileges for New Procedures") and Section 4.A.4 ("Clinical Privileges That Cross Specialty Lines") of the Credentials Policy.

3.G: INFECTION CONTROL COMMITTEE

3.G.1. Composition:

The Infection Control Committee shall consist of at least two members of the Medical Staff. At least one representative each from Nursing, Pharmacy, Home Health, Critical Care, Emergency Room, Surgical Services, Employee Health, Safety, Risk Management, Performance Improvement, Engineering, Education, and Community Services shall also serve on the committee.

3.G.2. Duties:

The Infection Control Committee shall:

(a) serve as the approval body for the Infection Control Program;

(b) maintain surveillance of Hospital infection potentials;

(c) identify and analyze the incidence and cause of infections to the extent practicable;

(d) develop and implement a preventive and corrective program designed to minimize infection hazards;

(e) supervise infection control in all phases of the Hospital's activities, including operating rooms, delivery rooms, special care units, sterilization procedures by heat, chemicals, or otherwise, isolation procedures, prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment, testing of Hospital personnel for carrier status, disposal of infectious material, and other situations as requested by the MEC;

(f) act upon recommendations related to infection control received from the President of the Medical Staff, the MEC, the departments, and other Medical Staff and Hospital committees; and
(g) review the clinical use of antibiotics, including the prophylactic use of antibiotics.

3.H: MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the Medical Executive Committee are set forth in Section 5.D of the Medical Staff Bylaws.

3.I: PHARMACY AND THERAPEUTICS COMMITTEE

3.I.1. Composition:

The Pharmacy and Therapeutics Committee shall consist of at least six members of the Medical Staff. The Pharmacist and at least one representative each from Administration and from Nursing shall also serve on the committee.

3.I.2. Duties:

The Pharmacy and Therapeutics Committee shall:

(a) be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital;

(b) assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital;

(c) advise the Medical Staff and the pharmaceutical department on matters pertaining to the choice of available drugs;

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

(e) develop and review periodically a formulary or drug list for use in the Hospital;

(f) evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

(g) establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs; and

(h) perform such other duties as are assigned by the President of the Medical Staff or the MEC.
3.J: PROFESSIONAL PRACTICE EVALUATION COMMITTEE

3.J.1. Composition:

The Professional Practice Evaluation Committee shall consist of at least six members of the Medical Staff who are widely representative of the medical and surgical specialties at the Hospital. Particular consideration is to be given to Past Presidents of the Medical Staff and to other physicians knowledgeable about the quality improvement and peer review processes. The Peer Review Coordinator and the CMO shall also serve on the committee.

3.J.2. Duties:

The Professional Practice Evaluation Committee shall:

(a) oversee the implementation of the Hospital's Professional Practice Evaluation Policy;

(b) review and approve quality indicators developed by the Medical Staff departments and the Performance Improvement Department;

(c) review and maintain familiarity with patient care protocols and evidence-based guidelines developed by national organizations;

(d) review patient care protocols or evidence-based guidelines that have been adopted by Medical Staff departments and the Performance Improvement Department and approved by the MEC;

(e) review cases referred to it as outlined in the Professional Practice Evaluation Policy;

(f) develop, when appropriate, performance improvement plans for practitioners;

(g) submit reports of its actions and recommendations to the Medical Staff department chiefs, MEC, and Board on a regular basis; and

(h) review the effectiveness of the Professional Practice Evaluation Policy on a continuous basis and recommend revisions or modifications as may be necessary.
3.K: UTILIZATION REVIEW/MEDICAL RECORDS COMMITTEE

3.K.1. Composition:

The Utilization Review/Medical Records Committee shall consist of at least six members of the Medical Staff, including a Hospitalist. The Senior Vice President of Patient Care Services, the Director of Hospital Information Management, Patient Financial Services, the Director of Compliance, and the Director of Case Management shall also serve on the committee.

3.K.2. Duties:

Utilization Review:

The Utilization Review/Medical Records Committee shall:

(a) develop a utilization review plan based on patient needs appropriate to the Hospital and the requirements of law, and which included provisions for review of admissions to the Hospital and of continued lengths of stay, discharge planning, and data collection and reporting;

(b) require that the utilization review plan be in effect, be known to the Medical Staff members, and be functioning; and

(c) conduct such studies, take such actions, submit such reports, and make such recommendations as are required by the utilization plan.

Medical Records:

The Utilization Review/Medical Records Committee shall:

(a) review and evaluate medical records to determine that they: adequately describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken; are sufficiently complete at all times so as to facilitate continuity of care and communications among all those providing patient care services in the Hospital; and are adequate in form and content to permit patient care audit and other quality assurance activities to be performed;

(b) review Medical Staff and Hospital policies and rules and regulations relating to medical records, including medical record completion, forms, formats, filing, indexing, storage, and availability, and recommend methods of enforcement and revision;
(c) act upon recommendations from the MEC and the departments or other committees responsible for patient care audit and other quality assurance and monitoring functions;

(d) provide liaison with Hospital administration and medical records personnel on matters relating to medical records practices;

(e) conduct periodic reviews of summary information regarding the timely completion of all medical records and make recommendations as appropriate; and

(f) recommend a medical record abbreviation list.
ARTICLE 4

AMENDMENTS

(a) An amendment to this Manual may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists.

(b) Notice of all proposed amendments shall be provided to each Active Staff member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place, and any such member may submit written comments on the amendments to the MEC. In addition, any Active Staff member may personally address the MEC concerning the proposed amendments, provided this individual notifies the President of the Medical Staff of this request at least two days prior to the meeting.

(c) No amendment shall be effective unless and until it has been approved by the Board.
ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Originally adopted by the Medical Staff: December 29, 2006
Most recent revisions adopted by the MEC: April 11, 2017
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