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
# TABLE OF CONTENTS

- CREDENTIALING POLICIES AND PROCEDURES ................................................................. 3
- INITIAL APPOINTMENT PROCEDURES ......................................................................... 3
- REQUEST FOR APPLICATION/APPLICATION PACKET .................................................. 3
- RECEIPT & REVIEW OF APPLICATION PACKET FROM APPLICANT .......................... 4
- PROCESSING OF APPLICATION/VERIFICATION OF CREDENTIALS ......................... 4
- REVIEW OF COMPLETED APPLICATION ...................................................................... 5
- CATEGORIES, APPLICATION ........................................................................................ 5
- PRESENTATION TO THE CREDENTIALS COMMITTEE, MEDICAL EXECUTIVE COMMITTEE AND BOARD .......................................................... 6
- EXPEDITED APPOINTMENT PROCEDURES ............................................................... 7
- RECEIPT & REVIEW OF EXPEDITED APPLICATION PACKET .................................... 8
- PROCESSING OF EXPEDITED APPLICATION/VERIFICATION OF CREDENTIALS .......... 8
- VERIFICATION OF EXPIRABLES .................................................................................. 8
- VERIFICATION/TERMINATION .................................................................................. 8
- MEDICAL STUDENTS, INTERNS, RESIDENTS, AND FELLOWS ................................ 9
- ALLIED HEALTH PROFESSIONALS .......................................................................... 10
- TEMPORARY PRIVILEGES/LOCUM TENENS ............................................................ 10
- EMERGENCY AND DISASTER PRIVILEGES ............................................................ 11
- TELEMEDICINE PRIVILEGES .................................................................................. 12
- ONGOING PROFESSIONAL PRACTICE EVALUATION POLICIES AND PROCEDURES 14
- FOCUSED PROFESSIONAL PRACTICE EVALUATION POLICIES AND PROCEDURES 16
- PEER REVIEW POLICY AND PROCEDURE ............................................................... 18
- PRACTITIONER HEALTH POLICY AND PROCEDURE ............................................ 23
- DISRUPTIVE PRACTITIONER POLICY AND PROCEDURE ....................................... 26
- HONORARY STAFF CATEGORY POLICY AND PROCEDURE ..................................... 26
- PATIENT ENCOUNTER POLICY AND PROCEDURE ................................................... 29
- NEW/TRANSPECIALTY PRIVILEGES POLICY AND PROCEDURE ............................ 31
- USE OF ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS POLICY AND PROCEDURE .......................................................... 32
- ADVISORY COUNCIL – MEMORIAL REGIONAL HOSPITAL DIVISION AND JOE DIMAGGIO CHILDREN’S HOSPITAL DIVISION POLICY AND PROCEDURE ............ 33
- BYLAWS COMMITTEE POLICY AND PROCEDURE .................................................. 39
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 receipt of a request for application, the following will be given to applicants:

   a. Memorial Healthcare System Application for Appointment to the Medical Staff
   b. Memorial Healthcare System “Important Tips” Cover Sheet
   c. Memorial Healthcare System Medicare Acknowledgement Statement
   d. Memorial Healthcare System Pharmacy Department Drug Enforcement Agency Card
   e. Delineation of Privileges Form(s) for specialty requested

Applicants are referred to the Memorial Healthcare System Bylaws and Rules and Regulations of the Medical Staff, available on the internet at www.mhs.net.

If an applicant is 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) the applicant should be referred to that group.
RECEIPT & REVIEW OF APPLICATION PACKET FROM APPLICANT

1. Upon receipt of application packet from applicant, the application will be date stamped and assigned to a Credentials Coordinator for processing.

2. The Credentials Coordinator will review application to ensure that the applicant meets the minimum requirements for each Hospital where Medical Staff membership is being requested.

   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. Notification may be sent via email or certified mail, return receipt requested.

3. 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 information that is missing from the application.

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 Cornerstone or OIG
   - Background check
AMA and AOA Physician Profiles may be used as primary source verification of Medical School Degree, ECFMG, DEA, Medicare/Medicaid Sanctions and specialty Board Certification.

When verifying credentials, a written release statement signed by the applicant must accompany all written requests. Additionally, when verifying the applicant’s clinical privileges, 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 in those procedures 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. In the event that there is undue delay in obtaining such required information or if the institution requires clarification of such information, the Credentials Coordinator will request the Applicant’s assistance. Under these circumstances, the Medical Staff may modify its usual and customary time periods for processing the application. 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 deem the application as being withdrawn voluntarily. The result of the withdrawal is automatic 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 and designated as a Category 1 or Category 2. If the practitioner is making application to multiple Hospitals within the Memorial Healthcare System, each Hospital where membership/privileges are being sought shall receive a copy of the credentials file. Each Hospital’s Medical Staff Office will be responsible for obtaining departmental review and recommendation for appointment and approval of clinical privileges.

If request for interview is made by a Department Chief, the interview will be set up between the applicant and the Department Chief. The meeting must take place prior to the Executive Committee meeting for the Hospital where appointment is being requested. The Department Chief, or his or her designee, will document the results of the clinical interview.

CATEGORIES, APPLICATION

Initial applications, upon completion of the verification process, will be classified into two (2) categories, Category 1 and Category 2. Category 1 applications will not require review by a
member of the Credentials Committee. All Category 2 applications will require Credentials Committee review.

Category 1 Applications
- There was no difficulty in verifying information
- No malpractice actions
- No reports of disciplinary actions, licensure restriction, or any corrective action
- Information returned in a timely manner and contains nothing that suggests the practitioner is anything other than highly qualified
- Practitioner requested privileges consistent with training

Review will be conducted by Section/Department Chiefs and presented to the Credentials Committee.

Category 2 Applications
- One or more malpractice claims
- Letter of reference contain suggestions that the practitioner may have slight problems in getting along with others or in providing patient care
- Applicant had many hospital affiliations at various locations throughout the country
- Substantial number of medical licenses scattered throughout the country
- Clinical privileges revoked, diminished, or otherwise altered by another health care organization
- Disciplinary action taken by a state license board, Medicare/Medicaid sanctions, or action by other agencies, or a criminal conviction
- Prior illness or problem that may affect ability to practice
- Any negative comments received from any primary source verifications
- Request for privileges varies from that generally associated with the specialty

Review will be conducted by Memorial Healthcare System’s Chief Medical Officer, Section/Department Chief, and the Credentials Committee.

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 as a provisional member, rejection for staff membership, or for another thirty (30) day deferment. 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 via mail signed by the Chief Executive Officer. Notification of unfavorable recommendations will be sent in accordance with the Medical Staff Bylaws.

EXPEDITED APPOINTMENT PROCEDURES

When a practitioner currently affiliated with one or more of the Hospitals in the Memorial Healthcare System wishes to extend his or her Medical Staff membership and privileges to another Memorial Healthcare System Hospital, he or she can do so via an Expedited Application For Appointment to the Medical Staff. This expedited application is reserved exclusively for practitioners currently holding membership and/or privileges at a Memorial Healthcare System Hospital. Procedure for an expedited appointment cannot be used by a practitioner who has been reappointed “with concern.” Upon receipt of a request for application, the following will be given to the practitioner making the request.

a. Memorial Healthcare System Expedited Application for Appointment to the Medical Staff
b. Physician Expedited Application Cover Letter
c. Memorial Healthcare System Medicare Acknowledgement Statement
d. Memorial Healthcare System Pharmacy Department Drug Enforcement Agency Card
e. Pre-selected Delineation of Privileges Form(s) for current practicing specialty signifying those privileges currently held by applicant in the MHS.
Applicants are referred to the Memorial Healthcare System Bylaws and Rules and Regulations of the Medical Staff, available on the internet at www.mhs.net.

RECEIPT & REVIEW OF EXPEDITED APPLICATION PACKET

1. Upon receipt of the expedited application packet from applicant, the application will be date stamped and assigned to a Credentials Coordinator for processing.

2. The Credentials Coordinator will review application for completion and submittal of all required documentation. If upon review application is deemed incomplete, the applicant shall be notified via email or mail of information that is missing from the application.

PROCESSING OF EXPEDITED APPLICATION/VERIFICATION OF CREDENTIALS

3. The assigned Credentials Coordinator will review and update any necessary information from the application into the credentialing database.

4. The Credentials Coordinator will verify those affiliations for which new membership has been obtained since the applicant was granted membership in the Memorial Healthcare System.

5. The following sources will also be queried/verified:
   - National Practitioner Data Bank (NPDB)
   - Current insurance carrier
   - 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 Cornerstone or OIG
   - Quality Report for the past (2) two years or since the applicants last reappointment in the MHS
   - Review of Quality File
   - Review of Patient Encounter Report/Cases for quality and utilization review

VERIFICATION OF EXPIRABLES

All professional licenses, registrations and certificates are verified, at a minimum, at the time of a practitioner’s initial appointment, reappointment, upon expediting membership and privileges to another Memorial Healthcare System Hospital, and upon the request for additional privileges. Additionally, the Department of Medical Affairs shall track expirables on an ongoing basis.

VERIFICATION/TERRMINATION

Should the Department of 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 the Department of 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 MHS Pharmacy Safety & Medication Officer, Directors of Pharmacy, Directors of Medical Affairs and Directors of Medical Staff at each Hospital are notified via email that said practitioner no longer holds prescribing privileges.

Please refer to Medical Staff Bylaws and Rules and Regulations for board certification requirements and effect of expiration on membership and privileges.

Should the Department of Medical Affairs identify that a practitioner’s ATLS, ACLS, PALS, CPR or other life support certificate has expired, the Department of Medical Affairs will verify if such certificate is part of the practitioner’s criteria for maintaining privileges. Should such be the case, that practitioner’s privileges at all System Hospitals shall be automatically terminated in accordance with the Medical Staff Bylaws. If the practitioner’s expired certificate is not required as part of their credentials criteria, the practitioner is notified and a current copy is requested.

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

MEDICAL STUDENTS, INTERNS, RESIDENTS, AND FELLOWS

Medical students, interns, residents, and fellows shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the applicable Hospital and the school or program. Credentialing information shall be made available to the Hospital upon request and as needed by the Medical Staff in making any training assignments and in the performance of their supervisory function. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a medical student, intern, resident, or fellow practitioner to provide services at a Hospital. In absence of credentialing by the medical school or training program, the credentialing will be performed by the applicable Hospital in accordance with this policy.

The written affiliation agreement between the applicable Hospital and the sponsoring medical school or training program shall identify the individual or entity responsible for providing professional liability insurance coverage for the practitioner and the amounts of coverage.

The Executive Committee, or Advisory Council in the case of Memorial Regional Hospital Division or Joe DiMaggio Children’s Hospital Division, must establish protocols, in conjunction with the sponsoring medical school or training program, regarding the scope of a medical student, intern, resident, or fellow practitioner’s authority and mechanisms for their direction and supervision by the Hospital, Medical Staff, and sponsoring medical school or training program.
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 Registered Nurse Practitioner
- Certified Clinical Perfusionist
- Certified Neuro Intraoperative Monitorist
- Certified Nurse Midwife
- Certified Orthotist
- Certified Prosthetist
- Certified Orthotist/Prosthetist
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialist
- “House Physician”*
- Physician Assistant
- Pathology Assistant
- PhD
- PsyD
- Registered Nurse First Assist
- Surgical Assistant

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

TEMPORARY PRIVILEGES/LOCUM TENENS

Circumstances for which the granting of temporary privileges may be considered are as follows:

1. **To fulfill an important patient care need, service or treatment:** In this circumstance, temporary privileges may be granted on a case-by-case basis when there is an important patient care need that mandates immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. For example, when a specific licensed independent practitioner has the necessary skills to provide care to a patient that a member of the Medical Staff currently privileged does not possess. In these circumstances, temporary privileges may be granted by the applicable Administrator of the Hospital, upon recommendation of the applicable Department Chief and the Chief of Staff and only after verification of current licensure in the State of Florida and current competence.

   **AND**

2. **When an applicant with a complete application is awaiting a recommendation from the Executive Committee and approval by the Board:** In this circumstance, temporary privileges may be granted when the new applicant for Medical Staff membership or
privileges is awaiting a recommendation by the Executive Committee and approval by the Board. Temporary privileges may be granted for a limited period of time, not to exceed one hundred and twenty (120) days, by the applicable Administrator upon recommendation of the Department Chief and the Chief of Staff provided that:

a. there is verification of current licensure, relevant training or experience, current competence, ability to perform privileges requested;

b. the results of the NPDB query have been obtained and evaluated;

c. there are no current or previously successful challenges to licensure or registration;

d. the applicant has not been subject to involuntary termination of Medical Staff membership at another organization;

e. the applicant has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges; and

f. there has been a favorable recommendation by the Credentials Committee.

3. Temporary privileges may be granted to a locum tenens practitioner by the applicable Administrator of the Hospital, upon recommendation of the applicable Department Chief and the Chief of Staff and only after verification of current licensure in the State of Florida and current competence. The locum tenens must also meet all of the qualifications for membership described in Section 4.2 of the Bylaws, including 4.2.G., even if residence is temporary. In addition, a letter from the practitioner being replaced, requesting the locum tenens for a specified period of time and endorsing the application of the prospective locum tenens must accompany the locum tenens application.

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 Chief Medical Officer, Director of Medical Affairs, 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 Medical Staff Unit leader 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**

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 the Medical Staff Office 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.

3. Once the credentialed application is received by the Medical Staff Office, it will be reviewed for completion and accuracy. If the application is complete, it will be forwarded to the appropriate Department Chief and Credentials Committee for consideration and recommendation.
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

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 Director of the Department of Medical Affairs shall query and review the System-wide OPPE report as generated by Crimson. 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.

2. The OPPE report is run in Crimson every eight (8) months or sooner. The Director of Medical Affairs at the designated Hospital will review the report.

   • Should the Department Chief and/or the Director of Medical Affairs 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 as complete. The practitioner will be notified that the review was done and the report made available. The practitioner will then be reviewed again during the next OPPE review.

   • Should the Department Chief and/or the Director of Medical Affairs 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 of the Department Chief and/or the Director of Medical Affairs. Pertinent findings from the meeting/discussion must be documented and include a recommendation of findings. These recommendations can include but are not limited
additional periodic review, direct observation, proctoring, and limitation or revocation of any existing privileges. The Office of Medical Affairs 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 address 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 Affairs and the Risk Manager. Issues identified may also trigger a focused review/evaluation.
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 ofcompetently 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 three (3) 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 caregivers (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, co-signed by the Department Chief, or his or her designee.

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 Chief Medical Officer, Director of Medical Affairs, 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 for any privilege, 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 Department of Medical Affairs 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.
PEER REVIEW POLICY AND PROCEDURE

TITLE: Peer review 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 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 will be conducted in the following circumstances: (a) for any case that is identified from 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. The Quality Management Specialist, or his or her designee, initiates the peer review through case review and summarizes the pertinent issues. The Quality Management Specialist, or his or her designee, will enter the case into the Memorial Healthcare System quality monitoring database.
   
b. The following are examples of circumstances that may require peer review:

      • Mortalities
      • Peri/post-operative mortalities (death within thirty (30) days of a procedure)
      • Unscheduled returns to the operating room
      • Unscheduled returns to the ICU within seventy-two (72) hours
      • Any iatrogenic events
      • Unexpected transfers to a higher level of care
      • Care not consistent with established standards
• Identified patterns, trended over time, that exceed pre-established thresholds
• Unanticipated readmissions within thirty (30) days for the same or similar diagnosis
• Incomplete or not timely documentation
• Blood usage not meeting established criteria

c. Peer review referrals may be generated from the following sources:

• 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

d. Initial peer review will be conducted at the Department level as set forth in this policy upon receipt of a Peer Review Referral Form. 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 peer review committee or panel may grant an extension on complex cases.

e. 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.

f. The Chief of the Department will appoint a committee or panel of “peers” to review the case. All committees or panels reviewing the case must have at least three (3) members.

g. 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.
h. 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.

i. Participation by the individual whose performance is being peer reviewed will include letters of inquiry or the steps outlined in Article 7 of the Medical Staff Bylaws if corrective action is recommended.

j. In the event corrective action procedures are recommended or implemented pursuant to Article 7 of the Medical Staff Bylaws, the procedures in the Bylaws shall preempt and take precedence over this policy.

- 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.

k. The peer review committee or panel may implement any “alternatives to corrective action” when warranted following peer review of the practitioner under this policy. 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 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.

1. The results of the peer review panel or committee will be documented on the Peer Review Referral Form. If the outcome is a rating of 0-3, the case will be closed by the Quality Management Specialist, or his or her designee, in the Memorial Healthcare System quality monitoring database.

m. If further peer review is warranted and/or there is an outcome rating of 4 or 5, the case will be forwarded to the Multi-Disciplinary Peer Review Committee. Cases meeting State of Florida Code 15 criteria and/or those determined to be a sentinel event that involve physician performance will result in automatic referral to the Multi-Disciplinary Peer Review Committee and the Department Chief shall be immediately notified.

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 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. 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 peer review committee or panel will keep formal minutes of its proceedings and will report its activities and minutes to the Department.

2. The following actions will be taken as a result of the initial peer review:

a. Peer review committee or panel finds no issue or no deviation from standard of care and no complication or adverse event - A note should be placed in the practitioner’s file.

b. Peer review committee or panel identifies an issue with the case that may be a deviation from the standard of care - A letter of inquiry should be sent to the practitioner.

- If the practitioner’s response explains the event – A note should be placed in the practitioner’s file.
• If the practitioner’s response is not accepted, but the issue is minor – A letter of education should be sent to the practitioner and a copy of such letter should be placed in the practitioner’s file.

• If the practitioner’s response is not accepted and the issue is serious or if there is a trend of similar problems - A letter of concern should be sent to the practitioner and corrective action may be warranted. A copy of the letter of concern and documentation of any alternatives to corrective action implemented by the peer review committee or panel should be placed in the practitioner’s file.

c. Whenever a letter of inquiry, education, or concern is sent to a practitioner, the letter should be signed by the Chief of Department or his or her designee.

d. In the case of letters of inquiry, the letter should be sent certified mail and the letter should include a statement that a response is expected within thirty (30) days. If a response is not received within thirty (30) days, the Director or Associate Director of Medical Affairs should be notified and the Director or Associate Director may elect to call or write the practitioner. If no response is received within fourteen (14) days of this notification, a request for corrective action may be made in accordance with Article 7 of the Medical Staff Bylaws.

e. Documentation of the peer review will be included as part of the Morrisey Concurrent Care Manager (MCCM), and the written back-up review material and related correspondence 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, with a copy sent to the Medical Staff Services Department for the System for consideration at the time of reappointment when credentialing and privileging decisions are considered.

f. If for any reason there is concern or disagreement regarding the findings made by the peer review panel or committee, the case should be presented to the Director of Medical Affairs for his or her review.
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 Director of Medical Affairs 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 Director of Medical Affairs 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 Director of Medical Affairs 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.
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, volunteers, patients, or family 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 Director of Medical Affairs 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. 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 Director of Medical Affairs 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 Director of Medical Affairs, and the Administrator will be held; the Chief of Staff, Chief of the Department, and the Director of Medical Affairs 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.

     • 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.
HONORARY STAFF CATEGORY POLICY AND PROCEDURE

TITLE: Honorary 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.

The Honorary Emeritus Medical Staff shall consist of members of the Honorary Medical Staff who have, in addition served in positions of leadership and have otherwise distinguished themselves as skilled and dedicated practitioners.

POLICY:

Consideration for membership on the Honorary 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, which will refer potential candidates to a committee consisting of the three (3) past and/or present Chiefs of Staff. This committee will review the member’s service to the Hospital, Medical Staff, and the community and make a recommendation to the Executive Committee, or Advisory Council, as applicable, for recommendation 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

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 and provisional active 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 and provisional active staff member must maintain at least ten (10) patient care encounters for each year he or she is a member of the Medical Staff. 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, has completed a fellowship, or has a certificate of clinical competence in a pediatric specialty.

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 the Ambulatory Surgical Facility (“ASF”) East and West facilities.
4. The following physicians/practitioners shall be exempted from the patient encounter requirements: (a) physicians with current effective contracts with the Hospital to provide services; (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) perinatalogists; and (k) primary care practitioners (internists, family practitioner, and primary care pediatricians). All practitioners with clinical privileges may undergo Focus Professional Practice Evaluation in accordance with The Joint Commission accreditation standards.

5. Active and provisional active staff members who do not meet the requirement of twenty (20) patient encounters in the two (2) year reappointment period or the ten (10) patient encounters in the one (1) year appointment period will be allowed to remain on staff, but their privileges shall default to the appropriate staff category and the staff member shall have six (6) months to obtain the necessary patient encounters. When the staff member can demonstrate a minimum of twenty (20) or ten (10) patient encounters, based on their reappointment cycle, he or she may request that his or her privileges status be re-evaluated.

6. 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.
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.
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

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.
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

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 re-calculated 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.
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.

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.

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.

The Senior Vice President & Chief Executive Officer of the Memorial Regional Hospital Division, the Administrator of Memorial Regional Hospital South, the Director of Medical Affairs 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.

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.

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 Director of Medical Affairs, 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.
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 co-chairmen representing each of the Hospitals, as well as Medical Staff representation from each of the Hospitals.

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 chairman, but least once a year.

3. The Bylaws Committee must maintain a record of its proceedings and make timely reports to the Executive Committees.
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.
CREDENTIALS COMMITTEE POLICY AND PROCEDURE

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

PURPOSE: To establish two (2) System-wide Credentials Committees 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 two (2) distinct Credentials Committees of the Memorial Healthcare System appointed for a period of two (2) years by the Chiefs of Staff as follows: (1) a committee to handle all pediatric-related credentialing issues; and (2) a committee to handle all credentialing issues that are not pediatric-related. The adult credentials committee shall consist of co-chairperson who are the elected Secretary-Treasurers of the Medical Staffs of the Memorial Healthcare System. The pediatric credentials committee shall consist of a single chairperson who will be the Secretary-Treasurer of the Joe DiMaggio Children’s Hospital Division. The Directors of Medical Affairs of each of the Hospitals and Hospital Divisions and the Chief Medical Officer of the District shall be ex-officio members of both Credentials Committees, without a vote.

a. The Credentials Committees 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. 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.
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 chairman 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 Chairmen 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 Directors of Medical Affairs of each Hospital and Hospital Division (ex-officio without vote); and (6) the Chief Medical Officer of the District (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.
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 chairman 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 chairman, but at least annually. The Emergency Preparedness Committee shall maintain a record of its proceedings and make timely reports to the Executive Committee.
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 Directors of Medical Affairs of each of the Hospitals and Hospital Divisions and the Chief Medical Officer of the District 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.
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 as often as necessary 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.
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 chairman. The IRB shall maintain a record of its proceedings and make timely reports to the appropriate Executive Committees.
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 Directors of Medical Affairs for each Hospital and Hospital Division, the Chief Medical Officer, 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.
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.
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 Pharmacy & Therapeutics Committee performing its functions for each Hospital, with the exception of Memorial Regional Hospital Division and Joe DiMaggio Children’s Hospital Division, which shall be combined.

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. Each Pharmacy & Therapeutics Committee shall consist of a chairman and at least four (4) other members, appointed by the Chief of Staff.
   a. For the Pharmacy & Therapeutics Committee of Memorial Regional Hospital Division and Joe DiMaggio Children’s Hospital Division, three (3) of which are active staff members practicing at Memorial Regional Hospital Division and appointed by the Chief of Staff for Memorial Regional Hospital Division 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 the Joe DiMaggio Children’s Hospital Division.
   b. 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.

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 Pharmacy & Therapeutics Committee will meet as often as necessary, at the call of the chairman, 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.
PROFESSIONAL GRADUATE EDUCATION AND CONTINUING MEDICAL EDUCATION COMMITTEE POLICY AND PROCEDURE

TITLE: Professional Graduate Education and Continuing Medical Education Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a System-wide Professional Graduate Education and Continuing Medical Education Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System.

POLICY: The Professional Graduate Education and Continuing Medical Education Committee shall be responsible for reviewing residency programs affiliated with Memorial Healthcare System.

1. The Professional Graduate Education and Continuing Medical Education Committee will be chaired by a member of the Medical Staff involved in graduate medical education, who shall be appointed by the Board, and shall have a representative from each Hospital, appointed by each Hospital’s or Hospital Division’s Chief of Staff. The Directors of Medical Affairs of each Hospital and Hospital Division and the Chief Medical Officer shall be members of this Committee.

2. The Professional Graduate Education and Continuing Medical Education Committee shall meet at least annually and will be responsible for reviewing the residency programs affiliated with the Memorial Healthcare System, reviewing the safety and quality of patient care provided by the residents, reviewing the supervisory needs of the residency programs, and providing an annual written report to the each Hospital’s Executive Committee, which will in turn report to the Board. The Professional Graduate Education and Continuing Medical Education Committee will also assist in developing written training protocols to delineate the roles, responsibilities, and patient care activities of the residents and which level of resident may write patient orders, and under what circumstances they may do so, and what entries a supervising practitioner must countersign. The protocol will also describe the mechanisms through which resident directors make decisions about a resident’s progressive involvement and independence in delivering patient care.
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.
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 chairman 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

MULTI-DISCIPLINARY PEER REVIEW COMMITTEE POLICY AND PROCEDURE

TITLE: Multi-Disciplinary Peer Review Committee policy and procedure for the Medical Staffs of Memorial Healthcare System.

PURPOSE: To establish a Multi-Disciplinary Peer Review Committee at the following Hospitals: Memorial Regional Hospital Division, Memorial Hospital Pembroke, Memorial Hospital Miramar, and Memorial Hospital West and to establish a System-wide Pediatric Multi-Disciplinary Peer Review Committee performing its functions for all of the Medical Staffs of the Memorial Healthcare System in the area of pediatrics. The Medical Staff has the ongoing responsibility to perform peer review and performance improvement activities through participation in the Multi-Disciplinary Peer Review Committee. It is the responsibility of all Medical Staff members and practitioners holding clinical privileges 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.

POLICY: The Multi-Disciplinary Peer Review Committees shall be responsible for reviewing all cases referred to it from the Department level where it is determined that further peer review is warranted and/or there is an outcome rating of 4 or 5. The Chief of Staff and Director of Medical Affairs of the respective Hospital shall appoint the members of the Multi-Disciplinary Peer Review Committee. The Chief Quality Officer and Chief Medical Officer shall be ex-officio members without a vote.

1. Upon receipt of a case from the Department level, the Multi-Disciplinary Peer Review Committee will review the record and assign the case one of the following ratings:

   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

2. 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 may grant an extension on complex cases.

3. The peers appointed to the Multi-Disciplinary Peer Review Committee 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.

4. 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, Director of Medical Affairs, Memorial Healthcare System Chief Quality Officer, Administrator, or Chief Medical Officer requests the case be reviewed externally.

5. 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.

6. Following its review, the Multi-Disciplinary Peer Review Committee will determine the appropriate disposition of the case and the actions to be taken, which may include:

- No action.
- Imposition of “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. 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 committee may make a request for corrective action to the Chief of Staff in accordance with Article 7 of the Bylaws.
- A recommendation 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.

7. Examples of “alternatives to corrective action” include:
a. Informal discussions or formal meetings regarding the concerns raised about conduct or performance;

b. Written letters of guidance, reprimand or warning regarding the concerns about conduct or performance;

c. Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;

d. Suggestions that the individual seek continuing education, consultations, or other assistance in improving performance or interactions with others;

e. Warnings regarding the potential consequences of failure to improve conduct or performance;

f. 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

g. 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.

8. 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 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. 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.

9. The Multi-Disciplinary Peer Review Committee will keep formal minutes of its proceedings and will report its activities and minutes to the Department.
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 AND PRIMARY OFFICE LOCATION REQUIREMENTS POLICY AND PROCEDURE

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

PURPOSE: To establish residence and primary office location 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 3.4 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.

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.
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 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. The practitioner who wishes to use the HUD for an off-label use must obtain informed consent from the patient or his/her authorized representative and 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 submit a follow-up report to the HDE holder (the manufacturer of the HUD) 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.