MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

METHODIST LE BONHEUR HEALTHCARE

MEDICAL STAFF ORGANIZATION MANUAL

Adopted by the Medical Staff: June 4, 2021
Approved by the Board: June 24, 2021

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

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

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Manual is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

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

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Manual, substantial compliance is required. Technical or minor deviations from the descriptions set forth within this Manual do not invalidate any review or action taken by any involved committee.

ARTICLE 2

CLINICAL DEPARTMENTS

2.A. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

(1) Clinical departments shall be created and may be consolidated or dissolved by the MEC upon approval by the Board as set forth below.

(2) The following factors shall be considered in determining whether a clinical department should be created:

(a) there exists a minimum of ten members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in this Manual and in the bylaws);

(b) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;

(c) a majority of the voting members of the proposed department vote in favor of the creation of a new department;

(d) it has been determined by the Medical Staff leadership and the Hospital President that there is a clinical and administrative need for a new department; and

(e) the voting Medical Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) The following factors shall be considered in determining whether the dissolution of a clinical department is warranted:

(a) there is no longer an adequate number of members of the Medical Staff in the clinical department to enable it to accomplish the functions set forth in this Manual or in the bylaws;

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

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

(d) no qualified individual is willing to serve as chair of the department; or

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

2.B. LIST OF CLINICAL DEPARTMENTS

The following clinical departments are established:

Anesthesiology
Cardiology
Cardiothoracic Surgery
Critical Care
Emergency Medicine
Gastroenterology
General/Plastic Surgery
Internal Medicine/Family Practice
Neurology
Neurosurgery
OB/GYN
Ophthalmology
Orthopedics
Otolaryngology
Pathology
Pediatric Medicine
Radiology
Urology

2.C. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS

The functions and responsibilities of departments, Department Chairs, and Vice Chairs are set forth in the Medical Staff Bylaws.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of the Hospital that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.

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

(3) This Article details the standing members of each Medical Staff committee. However, other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Staff committee meeting in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. All such individuals are an integral part of the credentialing, quality assurance, and professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of such committees.

3.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical Staff committee, members must acknowledge and agree to the following:

(1) have the willingness and ability to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent on the full participation of its members;

(2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;

(3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee's functions may be performed in an informed, efficient, and effective manner;

(4) attend meetings on a regular basis to promote consistency and good group dynamics;

(5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid off-topic or sidebar conversations;

(6) voice disagreement in a respectful manner that encourages consensus-building;

(7) understand and strive for "consensus" decision-making, thereby avoiding the majority vote whenever possible;

(8) speak with one voice as a committee and support the actions and decisions made (even if they were not the individual's first choice);

(9) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

(10) bring any conflicts of interest to the attention of the committee chair, in advance of the committee meeting, when possible;

(11) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the committee chair outside of committee meetings;

(12) participate in the development of an annual committee work plan and ensure that committee plans are in alignment with the strategic goals of the Hospital and Medical Staff; and

(13) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

3.C. MEETINGS, REPORTS AND RECOMMENDATIONS

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

3.D. COMMITTEE FOR PROFESSIONAL ENHANCEMENT ("CPE")

3.D.1. Composition:

(a) The CPE shall consist of the following voting members:

(1) Two experienced past Medical Staff Leaders;

(2) Eight to ten additional Medical Staff members who are:

(i) broadly representative of the clinical specialties on the Medical Staff;

(ii) interested or experienced in credentialing, privileging, PPE/peer review, or other Medical Staff affairs;

(iii) supportive of evidence-based medicine protocols; and

(iv) consistent with the non-disciplinary nature of the CPE, generally do not also serve on the MEC.

In appointing these individuals, the Leadership Council will give preference to Practitioners who have been selected to either serve as an individual Clinical Specialty Reviewer or to chair a committee that functions as a Clinical Specialty Reviewer, as described in the Professional Practice Evaluation Policy (Peer Review); and

(3) An Advanced Practice Professional.

(b) The following individuals shall serve as non-voting members to facilitate the CPE's activities:

(1) System CMO or, if no System CMO has been appointed, the Vice President and Chief Clinical Transformation Officer;

(2) Chief Quality and Patient Safety Officer, Senior Vice President Clinical Effectiveness; and

(3) One or more PPE Specialists.

(c) The Medical Staff Leadership Council shall appoint the CPE members and shall designate two voting members as CPE Co-Chairs.

(d) To the fullest extent possible, CPE members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.

(e) Before any CPE member begins serving, the member must review the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on professional practice evaluation, with the nature of the training to be identified by the Medical Staff Leadership Council or CPE.

(f) Other appropriate individuals (e.g., Associate Chief of Staff, Associate Chairperson, Clinical Specialty Reviewers, or other Medical Staff members; Advanced Practice Professionals; Chief Nursing Executive; other Hospital personnel; Employer representative, etc.) may be invited to attend a particular CPE meeting (as guests, without vote) in order to assist the CPE in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present

only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the CPE.

(g) Between meetings of the CPE, the CPE Chair, in conjunction with the CMO or another CPE member, may take steps as necessary to implement and operationalize the decisions of the CPE. By way of example and not limitation, this may include providing clarifications to a Practitioner regarding the CPE's decisions or expectations, reviewing and approving communications with the Practitioner, responding to questions posed by an internal or external reviewer, and similar matters.

3.D.2. Duties:

The CPE is a non-disciplinary body whose primary charge is to attempt to resolve the clinical performance issues referred to it in a constructive and successful manner. The CPE makes recommendations to colleagues when appropriate but does not have the authority to require any particular action. Only the MEC, acting in accordance with the Medical Staff Bylaws documents, possesses disciplinary authority. The CPE shall perform the following specific functions:

(a) oversee the implementation of the Professional Practice Evaluation Policy (Peer Review) ("PPE Policy") and ensure that all components of the process receive appropriate training and support;

(b) review reports showing the number of cases being reviewed through the PPE Policy, by department or specialty, in order to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;

(c) review, approve, and periodically update Ongoing Professional Practice Evaluation ("OPPE") data elements that are identified by individual departments and sections, and adopt Medical Staff-wide data elements;

(d) review, approve, and periodically update the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;

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

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

(g) develop, when appropriate, Voluntary Enhancement Plans for practitioners, as described in the PPE Policy;

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

(i) work with Department Chairs to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through peer learning sessions in the division or through some other mechanism; and

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

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

The CPE shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The CPE shall submit reports of its activities to the MEC and the Board on a regular basis. The CPE's reports will provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty; types and numbers of dispositions for the cases; listing of education initiatives based on reviews; listing of system issues identified). These reports will generally not include the details of any reviews or findings regarding specific practitioners.

3.E. CREDENTIALS COMMITTEE

3.E.1. Composition:

(a) The Credentials Committee shall consist of the following voting members:

(1) Co-Chairs (one representing adult specialties and one representing pediatric specialties);

(2) Medical Staff Chief of Staff;

(3) at least five members of the Medical Staff selected to be broadly representative of the specialties of the Medical Staff, and at a minimum are representative of the core Departments, with preference given to individuals who have served in Medical Staff leadership positions and/or who have a particular interest in credentialing and privileging functions (at least two Committee members shall have their primary practice location at Methodist Healthcare – Olive Branch Hospital); and

(4) an Advanced Practice Professional.

(b) The System CMO, Facility CMOs, Facility Presidents, Chief Nurse Executive, Chief Quality and Patient Safety Officer, Senior Vice President of Clinical Effectiveness, Chief Clinical Transformation Officer, and members of Medical Staff Services Support Staff shall serve as non-voting members to facilitate the activities of the Credentials Committee.

(c) To the fullest extent possible, Credentials Committee members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for one additional, consecutive term.

3.E.2. Duties:

The Credentials Committee shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants seeking Medical Staff Appointment, Reappointment, and Clinical Privileges as well as all applicants seeking to practice as Licensed Independent Practitioners and Advanced Practice Professionals, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff, Licensed Independent Practitioners, or Advanced Practice Professionals and, as a result of such review, make a written report of its findings and recommendations; and

(c) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.1 pertaining to the development and ongoing review of privilege delineations, Section 4.A.3 ("Clinical Privileges for New Procedures"), and Section 4.A.4 ("Clinical Privileges That Cross Specialty Lines") of the Credentials Policy.

3.F. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the MEC are set forth in Section 5.C of the Medical Staff Bylaws.

3.G. MEDICAL STAFF LEADERSHIP COUNCIL

3.G.1. Composition:

(a) The Medical Staff Leadership Council shall be comprised of the following voting members:

(1) Medical Staff President;

(2) Medical Staff President-Elect;

(3) Medical Staff Chief of Staff;

(4) Medical Staff Vice Chief of Staff;

(5) Co- Chairs, Committee for Professional Enhancement ("CPE"); and

(6) Medical Staff Representative to the Governing Board.

(b) The following individuals shall serve as non-voting members to facilitate the Medical Staff Leadership Council's activities:

(1) System CMO or, if no System CMO has been appointed, the Vice President and Chief Clinical Transformation Officer;

(2) Chief Quality and Patient Safety Officer; Senior Vice President Clinical Effectiveness and

(3) One or more PPE Specialists designated by the voting members of the Leadership Council.

(c) Other appropriate individuals (e.g., Associate Chief of Staff, Associate Chairperson, or other Medical Staff members; Advanced Practice Professionals; Chief Nursing Executive; other Hospital personnel; Employer representative, etc.) may be invited to attend a particular Medical Staff Leadership Council meeting (as guests, without vote) in order to assist the Medical Staff Leadership Council in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the Medical Staff Leadership Council review process and are bound by the same confidentiality requirements as the standing members of the Medical Staff Leadership Council.

(d) Between meetings of the Medical Staff Leadership Council, the Medical Staff President as Chair, in conjunction with the CMO or another Medical Staff Leadership Council member, may take steps as necessary to implement and operationalize the decisions of the Medical Staff Leadership Council. By way of example and not limitation, this may include providing clarifications to a Practitioner regarding the Medical Staff Leadership Council's decisions or expectations, reviewing and approving communications with the Practitioner, and similar matters.

3.G.2. Duties:

The Medical Staff Leadership Council is a non-disciplinary body, whose primary charge is to attempt to resolve the performance issues referred to it in a constructive and successful manner. The Medical Staff Leadership Council makes recommendations to colleagues when appropriate but does not have the authority to require any particular action. Only the MEC, acting in accordance with the Medical Staff Bylaws documents, possesses disciplinary authority. The Medical Staff Leadership Council shall perform the following specific functions:

(a) review and address concerns about practitioners' professional conduct as outlined in the Medical Staff Professionalism Policy;

(b) review and address issues regarding practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy (Peer Review);

(c) meet, as necessary, to consider and address any situation involving a practitioner that may require immediate action;

(d) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;

(e) identify and nominate a slate of qualified individuals to serve as the Medical Staff Officers and any at-large members of the MEC, to be presented to and elected by the Medical Staff;

(f) review the qualifications of individuals who are under consideration for nomination as Associate Chief of Staff-Elect and provide a report to the Division Senior Leadership Council;

(g) after obtaining input from the departments, identify and nominate qualified individuals to serve as department chairs, to be presented to and elected by the relevant departments;

(h) after obtaining input from the Department Chairs, identify qualified individuals to serve as section chiefs, to be presented to and selected by the relevant department chairs;

(i) appoint the chairs and members of all Medical Staff committees, except for the MEC;

(j) cultivate a physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future; and

(k) perform any additional functions as may be requested by the CPE, the MEC, or the Board.

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

The Medical Staff Leadership Council shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The Medical Staff Leadership Council shall report to the CPE, the MEC, and others as described in the Policies noted above. The Medical Staff Leadership Council's reports to the MEC will provide summary and aggregate information regarding the committee's activities. These reports will generally not include the details of any reviews or findings regarding specific practitioners.

3.H. PHARMACY & THERAPEUTICS COMMITTEE

3.H.1. Composition:

(a) The Pharmacy & Therapeutics Committee shall be comprised of a Chair and a Vice Chair and at least five Medical Staff members selected to be representative of the specialties of the Medical Staff (at least one shall have their primary practice location at Methodist Healthcare – Olive Branch Hospital), the Senior Vice President, Clinical Effectiveness, Chief Quality & Patient Officer, the System Pharmacy Director, the System Medication Safety Officer, the System Director of Clinical Nutrition Therapy, representatives from the Pharmacy Department, representatives from Nursing, and such additional administrative representatives as may be necessary.

(b) The Chair and the Vice Chair of the Committee shall serve two-year terms. The Vice Chair shall become the Chair upon the expiration of his or her term as Vice Chair.

3.H.2. Duties:

The Pharmacy & Therapeutics Committee shall be responsible to address the six critical elements involved in medication management:

(a) selection and procurement of medications, including development of a list of medications that are available at all times (formulary medications), and a process for obtaining medications that are considered non-formulary;

(b) storage and control of medications;

(c) ordering and transcribing processes that direct the selection, preparation, or administering of medications;

(d) preparing and dispensing medications to be administered to patients;

(e) administration of medications to patients; and

(f) monitoring the effects of medications, through the performance of the following tasks:

(i) identification and maintenance of lists of drugs that are routinely available policy development related to the drug use process establish programs and procedures that help ensure safe, evidence-based, and cost-effective drug therapy;

(ii) participation in quality improvement activities related to the use of medications;

(iii) review and operationalization of recommendations from Medication Safety Committee;

(iv) advising the Departments of Pharmacy in the implementation of effective drug distribution and control procedures; and

(g) appointing one or more subcommittees as may be necessary to fulfill functions related to adult and pediatric formularies, antimicrobial stewardship, the provision of effective cancer care, and the functioning of outpatient pharmacies.

3.I. PRACTITIONER WELLBEING COMMITTEE

3.I.1. Composition:

(a) The Practitioner Wellbeing Committee shall be comprised of the following voting members:

(1) Chair;

(2) Co-Chairs of the Credentials Committee;

(3) Co-Chairs, Committee for Professional Enhancement ("CPE"); and

(4) one Active Staff member who has had past experience in a Medical Staff Leadership role to serve a three-year term (and who may be reappointed to serve one additional three-year term).

(b) The following individuals shall serve as non-voting members to facilitate the Practitioner Wellbeing Committee's activities:

(1) System CMO;

(2) Chief Quality and Patient Safety Officer; and

(3) One or more PPE Specialists designated by the voting members of the Medical Staff Leadership Council.

(c) The Chair shall serve a three-year term and may be reappointed to serve one additional three-year term.

(d) Other appropriate individuals may be invited to attend a particular Practitioner Wellbeing Committee meeting (as guests, without vote) in order to assist the Practitioner Wellbeing Committee in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the Practitioner Wellbeing Committee review process and are bound by the same confidentiality requirements as the standing members of the Practitioner Wellbeing Committee.

3.I.2. Duties:

The Practitioner Wellbeing Committee shall fulfill the functions as set forth in the Practitioner Health Policy and shall also provide educational opportunities for the Medical Staff and other Practitioners related to health issues and wellbeing.

3.J. SENIOR LEADERSHIP COUNCILS

3.J.1. Composition:

The Facility Presidents and Associate Chiefs of Staff work together to determine the composition of the Senior Leadership Council which may include, but is not limited to, the following:

(a) Associate Chief of Staff, who shall serve as the Chair;

(b) Associate Chief of Staff-Elect;

(c) Facility President;

(d) Facility Chief Operating Officer;

(e) Facility CMO;

(f) Facility Chief Nursing Officer; and

(g) Such other members as may be appointed by the Associate Chief of Staff.

3.J.2. Duties:

The duties of each Senior Leadership Council shall be to provide the forum and coordinating mechanism for discussion of Facility-specific performance and quality of care issues and to disseminate all relevant actions from the MEC.

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

The Senior Leadership Councils shall meet as often as necessary to perform their duties and shall maintain a permanent record of their findings, proceedings, and actions. The Senior Leadership Councils shall report to the MEC and relevant clinical departments and shall report to nursing services, the System CEO, and relevant Hospital departments as may be necessary.

ARTICLE 4

AMENDMENTS

(A) This Manual may be amended by a majority vote of the members of the MEC, which may consult with any other Medical Staff Leader or leadership body as may be necessary.

(B) Notice of all proposed amendments shall be provided to each voting member of the Medical Staff at least seven days prior to the MEC meeting. Any voting member of the Medical Staff may submit written comments to the MEC.

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

ARTICLE 5

ADOPTION

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

Medical Staff: June 4, 2021

Board of Directors: June 24, 2021

Reference	Subject of Revision	Board Approved
Committee for Professional Enhancement Composition -3.D.1,c; MSLC Composition 3.G.1; Practitioner Well Being Composition3.I.1.	Revised CPE Chair to Co-Chairs	August 18, 2021
3.D.1,2; 3.E.1,B; 3.G.1, b,(2); 3.H.1,a	Revisions to update organizational titles into committee compositions	September 15, 2021
3.E.1	Revised Composition of Credentials Committee, non-voting members. Added Chief Clinical Transformation Officer.	November 17, 2021