MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

OF

UPMC PINNACLE HOSPITALS (Harrisburg, West Shore and Community Osteopathic)

MEDICAL STAFF ORGANIZATION MANUAL

TABLE OF CONTENTS

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 Credentials Policy.

1.B. TIME LIMITS

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

1.C. DELEGATION OF FUNCTIONS

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

(2) When a Medical Staff member is unavailable or unable to perform an assigned function, one (1) or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

(3) The President of the Medical Staff shall perform yearly reviews of the committee structures by January 31 per the recommendation of the respective chair for all committees outlined in this Manual.

ARTICLE 2

CLINICAL DEPARTMENTS

2.A. DEPARTMENTS

The Medical Staff shall be organized into the following departments:

Anesthesiology

Cardiovascular Services

Emergency Medicine

Family Medicine

Medicine

Obstetrics & Gynecology

Orthopedics

Pathology

Pediatrics

Radiology

Surgery

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

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

2C. DEPARTMENT MEETINGS

Each Department shall hold at least quarterly meetings at times reasonably determined to maximize attendance by department members. Minutes shall be kept at all department meetings and final minutes shall be submitted to the Medical Executive Committee for review.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

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

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

3.B. MEETINGS, REPORTS, AND RECOMMENDATIONS

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

3.C. ADVANCED PRACTICE PROVIDER LEADERSHIP COUNCIL

3.C.1. Composition:

The Advanced Practice Provider Leadership Council shall consist of Allied Health Professionals from multiple disciplines. The members of the committee shall be appointed by the committee.

3.C.2. Duties:

The Allied Heath Oversight Committee shall:

(a) Establish standard policies and procedures in writing, pertaining to the scope and circumstances of practice for Allied Health Professionals in the medical management of the patient; and

(b) develop and maintain policies and procedure that serve as operational guidelines for Allied Health Professionals.

3.C.3. Meetings and Reports:

The Advanced Practice Provider Leadership Council shall meet at minimum twice a year and submit a report to the Medical Executive Committee on its activities.

3.D. BLOOD USAGE COMMITTEE

3.D.1. Composition:

The Blood Usage Committee shall consist of the Medical Director of the Hospital's Blood Bank, a member of the Department of Anesthesiology, and members from the Departments of Surgery, Cardiovascular Services, Obstetrics & Gynecology, Orthopedics and Medicine.

3.D.2. Duties:

The Blood Usage Committee shall:

(a) oversee the appropriate usage of blood and blood products used in the Hospital;

(b) review blood transfusions to determine proper utilization, including a review of the use of whole blood and component blood elements; and

(c) evaluate and report on actual and suspected blood transfusion reactions, determine the causes thereof and recommend institution of procedures to counter the recurrence of such events where feasible using clinically valid criteria.

3.D.3. Meetings and Reports:

The Blood Usage Committee shall meet at least quarterly and submit a report to the Medical Executive Committee on its activities.

3.E. BYLAWS COMMITTEE

3.E.1. Composition:

The Bylaws Committee shall consist of the President of the Medical Staff, Medical Staff President-Elect, Medical Staff Secretary/Treasurer, Immediate Past Medical Staff President, Vice President of Medical Affairs and a chair, a vice chair, an advanced practice provider, and additional members appointed by the President of the Medical Staff. Members of the Active and Active Community Staff from any given department may also be appointed.

3.E.2. Duties:

The Bylaws Committee shall meet at least once a year and shall:

(a) review the Medical Staff Bylaws, the Credentials Policy, the Allied Health Professionals Policy, the Organization Manual, and the Medical Staff Rules and Regulations and make recommendations for appropriate amendments and revisions;

(b) receive and consider all recommendations for changes to these documents made by any committee or department of the Medical Staff, any individual appointed to the Medical Staff, the Vice President of Medical Staff Affairs, and/or the Hospital President and provide a report to the Medical Executive Committee regarding them; and

(c) edit or devise other descriptive terminology to assist the Medical Executive Committee in its administration of the Medical Staff, when specifically directed in writing by the Medical Executive Committee.

3.F. CANCER COMMITTEE

3.F.1. Composition:

(a) The Cancer Committee shall be comprised of at least one (1) board certified physician representative from Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, Pathology, Gynecologic Oncology, an advanced practice provider and must include the cancer liaison physician.

(b) Non-physician membership will include representatives from Administration, Patient Care Services Pharmacy, Social Work, Cancer Registry, and Performance Improvement.

(c) The Cancer Committee's purpose will be to provide leadership to plan, initiate, stimulate, and assess all cancer-related activities.

3.F.2. Duties:

The Cancer Committee shall:

(a) develop and evaluate the annual goals and objectives for the clinical, educational, research, and programmatic activities related to cancer care;

(b) ensure that educational and consultative cancer conferences cover all major sites and are available to the Medical Staff and Allied Health Professionals;

(c) supervise the cancer registry, perform quality control of registry data, and ensure accurate and timely abstracting, staging and follow-up reporting;

(d) demonstrate quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes;

(e) ensure an active supportive care system is in place for patients, families and staff;

(f) encourage data usage and regular reporting, including that the annual report is published by November 1 of the following year; and

(g) promote clinical research.

3.F.3. Meetings and Reports:

The Cancer Committee shall meet at least quarterly as a policy and advisory committee body with documentation of activities, and shall submit a report to the Medical Executive Committee on its activities.

3.G. CLINICAL CARE & HEALTH SUPPORT COMMITTEE (CCHSC)

3.G.1. Composition:

The CCHSC shall consist of four (4) or five (5) Active or Active Community Medical Staff members. The members will be appointed by the President of the Medical Staff, in consultation with the chair of the Medical Staff Quality Committee and the Vice President of Medical Affairs. The Members must be familiar with the Medical Staff Bylaws/Rules and Regulations, the peer review process, and professional practice evaluation policies.

3.G.2. Duties:

The CCHSC shall:

(a) conduct a focused review of an individual provider for specific clinical or health concerns upon request by a department chair or Quality Committee;

(b) coach the department chair or Quality Committees for appropriate review and documentation of clinical concerns or health issue concerns;

(c) make recommendations for possible interventions and helpful resources to the provider and/or Department chair; and

(d) Develop an annual education plan for the medical and allied health staff on provider health and impairment and provide regular communication to the Medical and Allied Health Staff regarding the importance of provider health.

3.G.3. Meetings and Reports:

The CCHSC will meet quarterly and on an ad hoc basis as determined by the chair and submit a report to the Medical Executive Committee on its activities.

3.H. CREDENTIALS COMMITTEE

3.H.1. Composition:

The Credentials Committee shall consist of a representatives from each clinical department, and an advanced practice provider appointed by the respective department chair. The chair of the Committee shall be appointed by the President of the Medical Staff. Members must be on the Active and Active Community Staff and cannot concurrently serve as a department chair or section chief.

3.H.2. Duties:

The Credentials Committee shall:

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

(b) review, as may be requested by the Medical Executive Committee or department chair, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff and, as a result of such review, make a report of its findings and recommendations;

(c) review and approve credentialing policies and procedures, specialty-specific criteria for ongoing professional practice evaluation, and specialty-specific triggers for review that are identified by each department;

(d) recommend appropriate threshold eligibility criteria for clinical privileges, including clinical privileges for new procedures and clinical privileges that cross specialty lines; and

(e) perform such other functions as assigned in the Medical Staff Bylaws and other applicable policies.

3.H.3. Meetings and Reports:

The Credentials Committee shall meet at least monthly, but more often whenever required by the chair, keep minutes of all such meetings and be accountable to the Medical Executive Committee. The Credentials Committee shall submit written monthly reports to the President of the Medical Staff through the Medical Executive Committee, with a copy to the Vice President of Medical Affairs of its findings, actions, and recommendations.

3.I. MEDICAL EXECUTIVE COMMITTEE

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

3.J. HEALTH INFORMATION COMMITTEE

3.J.1. Composition:

The Health Information Committee shall consist of physician representatives from medical staff departments, the Vice President of Organizational Quality or designee, Chief Information Officer, physician leadership from UPMC Pinnacle Medical Group and UPMC Pinnacle Cardiovascular Institute, and the Director of Health Information. The Chair of the Committee shall be appointed by the President of the Medical Staff.

3.J.2. Duties:

The Health Information Committee shall:

(a) supervise the maintenance of medical records at the required standard of completeness and review current inpatient and outpatient medical records for presence, timeliness, legibility and authentication of data and information, as appropriate to maintain quality patient care and as appropriate to the Hospital's needs;

(b) recommend policies to assure that sufficient data is recorded to allow evaluation of patient care and discipline any member of the Medical Staff or House Staff whose medical record fails to conform with necessary record-keeping requirements;

(c) assure the proper filing, indexing, storage, retention, and availability of patient records;

(d) approve changes in forms and formats for the medical record; and

(e) advise, with the aid of legal counsel and Management, in matters of privileged communication and release of medical record information.

3.J.3. Meetings and Reports:

The Health Information Committee shall meet monthly and maintain a permanent record of its proceedings and activities. The Health Information Committee shall present a written report of its findings and recommendations to the Medical Executive Committee.

3.K. MEDICAL PRACTICE CPOE COMMITTEE

3.K.1. Composition:

(a) The Medical Practice CPOE Committee, also referred to as the Medical Care Evaluation Committee, shall consist of representatives from the Medical Staff, Pharmacy, Nursing, Informatics, Quality and Administration. Membership shall include representatives from each of the key Medical Staff departments, as well as the Chair of the Quality Counsel.

(b) Other members will include: Vice President of Medical Affairs, DIO, (residency or designated program leadership), and a representative from nursing leadership.

3.K.2. Duties:

The Medical Practice CPOE Committee shall:

(a) oversee standards of care and clinical practice within UPMC Pinnacle;

(b) define optimal care for specific medical conditions as selected by this Committee;

(c) develop and implement clinical standards of care

(d) evaluate the dimensions of quality, to include, access to care and appropriateness of care

3.K.3. Meetings and Reports:

The Medical Practice CPOE Committee shall meet every other month and submit a report to both the Medical Executive Committee and the Outcomes Management Department of its activities.

3.L. MEDICAL STAFF QUALITY COMMITTEE (MSQC)

3.L.1. Composition:

(a) The Medical Staff Quality Committee ("MSQC") shall consist of representatives recommended by each department chair and appointed by the President of the Medical Staff for a two (2) year term. The President of the Medical Staff will appoint the chair of the MSQC for a term of two (2) years.

(b) The Vice President of Medical Affairs and Vice President of Organizational Quality will serve on the MSQC as *ex officio* members.

3.L.2. Duties:

The Medical Staff Quality Committee shall:

(a) provide oversight for the approach to mechanisms for medical care review performed by the Medical Staff departments and committees and provide assistance to the Medical Staff departments and committees in their effort to establish procedures for and evaluate results of medical care review as needed;

(b) review and analyze quality data from a variety of sources to identify needs;

(c) review the activities of departmental and other quality assessment committees to ensure that trends, patterns of performance and potential problems are being detected and evaluated, and that appropriate action is taken;

(d) review and recommend quality assessment indicators for departments and other committees of the Medical Staff;

(e) participate, as necessary, and determine time frames for follow-up in the problem solving process, establishment of taskforces, and assigning responsibility for action planning and implementation of measures to address identified quality concerns;

(f) refer concerns regarding the performance of individual physicians to the relevant department and/or the Credentials Committee;

(g) assure consistency in delivery of care and facilitate resolution across departmental lines;

(h) participate in evaluation of processes and outcomes of patient care and organizational functions, from a multidisciplinary and interdepartmental approach, and recommend actions to Hospital Administration for identified issues;

(i) recommend CME programs based on findings of committee activities;

(j) ensure compliance with, and propose changes in, medical care review as required by the Joint Commission, third-party payors, and other regulatory bodies, and assist Medical Staff departments and committees with implementation; and

(k) maintain records of committee meetings, reports, review of findings and follow-up actions.

3.L.3. Meetings and Reports:

The Medical Staff Quality Committee shall meet every other month and maintain a permanent record of its proceedings and activities. The Medical Staff Quality Committee shall present a written report of its findings and recommendations to the Medical Executive Committee.

3.M. NOMINATING COMMITTEE

The composition and duties of the Nominating Committee are set forth in the Medical Staff Bylaws.

3.N. OPERATING ROOM COMMITTEE

3.N. 1. Composition:

(a) The Operating Room Committee shall consist of the department chair from Surgery, Anesthesiology, Obstetrics & Gynecology, and Orthopedics. The Committee shall include at least one (1) practitioner from each of the following clinical departments/sections of General Surgery, Orthopedics, Obstetrics and Gynecology, Cardiovascular Services, Medicine/Gastroenterology, Pathology, Radiology and an advanced practice provider. The members of the committee, chair and co-chair shall be appointed by the President of the Medical Staff in consultation with the Vice President of Medical Affairs.

(b) Senior Director of Operations or Site Vice Presidents and an infection control practitioner will serve as ex officio, non-voting members.

3.N.2. Duties:

The Operating Room Committee shall:

(a) conduct a continuous evaluation of operating room policies and procedures; and

(b) develop and maintain policies and procedures that serve as operational guidelines for Surgical Services.

3.N.3. Meetings and Reports:

The Operating Room Committee shall meet every other month and submit reports to the Medical Executive Committee on its activities.

3.O. OPERATING ROOM BLOCK COMMITTEE

3.O. 1. Composition:

(a) The Operating Room Block Committee is a subcommittee of the Operating Room Committee and shall consist of department chairs from; Surgery, Anesthesiology, Obstetrics & Gynecology, Orthopedics, the Medical Staff President and the Chair of the Robotics Committee. The Committee Chair shall be appointed by the President of the Medical Staff in consultation with the Vice President of Medical Affairs.

(b) Non-voting representatives will be included as deemed appropriate by Administration and the Committee Chair.

3.O.2. Duties:

The Operating Room Block Committee shall:

(a) conduct a continuous evaluation of operating room block times to include the institutional needs of block time and reallocating and or removing block time.

3.O.3. Meetings and Reports:

The Operating Room Block Committee shall meet every quarterly and submit reports to the Medical Executive Committee on its activities.

3.P. OPERATIVE AND OTHER INVASIVE PROCEDURES COMMITTEE

3.P. 1. Composition:

(a) The Operative and Other Invasive Procedures Committee, also referred to as the Tissue Committee, shall consist of one (1) Active or Active Community Staff member appointed from each of the Departments of Surgery, Obstetrics and Gynecology, Radiology and Pathology and other departments as necessary.

(b) *Ex officio* members, without vote, shall include representatives from Nursing Services, Surgical Services and the Performance Improvement Department.

3.P.2. Duties:

The Operative and Other Invasive Procedures Committee shall:

(a) review and evaluate procedures performed in the UPMC Pinnacle when there is a disagreement among the preoperative, post-operative, and pathological diagnosis, or where a question of the acceptability of the procedure undertaken has been raised;

(b) study the agreement or disagreement among the pre-operative and post-operative clinical diagnoses and the final pathologic diagnosis based on tissue review, and report instances of infractions and inconsistencies of surgery and pathological diagnoses;

(c) establish a screening mechanism based on predetermined criteria and evaluate those surgical cases in which no pathological specimen was removed; and

(d) refer to the department Quality Committees on those instances which require further evaluation and correlation of the work performed by the surgeon, the pathologist, the radiologist, and any other department of the Hospital where applicability exists.

3.P.3. Meetings and Reports:

The Operative and Other Invasive Procedures Committee shall meet at least once monthly and its reports shall be submitted to the Medical Executive Committee and made available to the Medical CPOE Practice Committee.

3.Q. EXECUTIVE PHARMACY AND THERAPEUTICS COMMITTEE

3.Q. 1. Composition:

(a) The Pharmacy and Therapeutics Committee ("P&T") Committee is an integrated committee of each of the individual participating Medical Staffs of domestic UPMC Hospitals. The Medical Staffs at each participating UPMC Hospital have independently adopted the committee as their own by including it in their respective Medical Staff Bylaws documents, for the purpose of optimizing the quality and efficiency of pharmacy services throughout all of the participating UPMC Hospitals.

(b) Each participating Medical Staff, through its Vice President of Medical Affairs, shall designate one Medical Staff member as a member of the P&T Committee. Representatives shall serve for a term of two years or until a successor has been appointed.

(c) Representatives from the UPMC Pharmacy Service Center, the UPMC Health Services Division and UPMC Physician Services Division shall also serve as members of the P&T Committee. Additional representatives from the following departments, offices and disciplines within UPMC and the UPMC Hospitals may be selected by the Committee Chair or Chairs to serve as members: Regulatory, Quality, Safety; Privacy; Physician; Administration; Nursing; Compliance; Health Plan; and Risk Management/Legal (on an ad hoc basis, at the discretion of the Chair or Chairs).

(d) The Chair or Chairs of the committee shall be designated by the UPMC Chief Medical Officer.

3.Q.2. Duties:

The Pharmacy and Therapeutics Committee shall:

(a) evaluate and recommend procedures and practices concerning drug utilization and administration within each Hospital;

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

(c) recommend standards regarding the use and control of investigational drugs and research in the use of recognized drugs;

(d) evaluate clinical data concerning new drugs or preparations required for use in each Hospital;

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

(f) establish procedures which will present unnecessary duplication in stocking drugs;

(g) make recommendations concerning drugs for which automatic stop drug orders are necessary; and

(h) recommend policies for, and maintain surveillance of, infusion and transfusion practices.

3.Q.3. Meetings and Reports:

(a) The committee shall meet as often as necessary to perform its duties, but at least quarterly.

(b) The committee shall report to the MEC at least annually.

(c) The committee may form subcommittees as necessary.

(d) Minutes of all meetings of the committee or any subcommittee shall be maintained and shall contain information that is specific to each UPMC Hospital. Such minutes shall be made available so that they are accessible onsite at each Hospital.

(e) Because of the systemwide nature of the committee, it may establish additional rules concerning the conduct of meetings and its other activities that may supplement or vary from other rules contained herein applicable to Medical Staff committees generally.

3.R. RADIATION SAFETY COMMITTEE

3.R.1. Composition:

The Radiation Safety Committee shall consist of at least three (3) members. Membership shall include the Radiation Safety Officer, physician experts in nuclear medicine and therapeutic radiology, a person with special competence in radiation safety, a representative from Administration, and a representative from Patient Care Services. The chair will be appointed by the Chair of the Department of Radiology.

3.R.2. Duties:

The Radiation Safety Committee shall:

(a) ensure that all individuals working with or in the vicinity of radioactive materials (including physicians, technologists, physicists and pharmacists) have sufficient training and experience to enable them to perform their duties safely and in accordance with the Nuclear Regulatory Commission (NRC) and Commonwealth of Pennsylvania (PA) regulations and the conditions of such licensure as may be required and maintained as an individual or institutional license;

(b) ensure that all usage of radioactive material is conducted in a safe manner consistent with the institution's As Low As Reasonably Achievable ("ALARA") program;

(c) establish a table of investigational level for individual occupational radiation exposures as part of the institution's ALARA program;

(d) review and approve all requests for use of radioactive material and the use of radiation producing equipment with the institution;

(e) prescribe special conditions that will be required during the use of radioactive materials, such as requirements for bioassays, physical examinations of users, and special monitoring procedures;

(f) annually review the entire safety program, including records, reports from the Radiation Safety Officer, results of the NRC and Commonwealth of PA inspections, written safety procedures and management control systems, and recommend any remedial action to correct deficiencies and report to the Medical Executive Committee;

(g) ensure that the byproduct material license is amended, when necessary, prior to any changes in facilities, equipment, policies, procedures and personnel;

(h) establish an ongoing educational and safety program for all persons whose duties may require them to work in, or to frequent, areas where radioactive materials are used (e.g., patient care services, security and housekeeping personnel);

(i) maintain written records of all committee meetings, actions, recommendations and decisions;

(j) formulate and publish directions, notices, manuals, forms, requisitions and regulations deemed necessary by the Committee for safe handling, use, storage and disposition of radioactive materials, and shall at all times be guided by material provided by the NRC, the American Society of Nuclear Medicine, the American College of Radiology, the International Commission on Radiation Protection, and the International Atomic Energy Agency; and

(k) assure compliance with the laws of Commonwealth of PA and the United States and any local ordinances with regard to the safe use, installation, and registration of any radiation-producing device or material.

3.R.3. Meetings and Reports:

The Radiation Safety Committee shall meet as often as necessary to conduct its business, but not less than once in each calendar quarter, and submit reports to the Medical Executive Committee on its activities.

3.S. Physician Thrive Committee - UPMC Pinnacle

3.S.1. Composition:

The Physician Thrive Committee- UPMC Pinnacle shall consist of members of Physicians, Allied Health Members, and UPMC Pinnacle Hospitals leadership.

The chair and members will be appointed by the President of the Medical Staff for a two (2) year term. Terms may be renewed

3.S.2. Duties:

The Physician Thrive Committee- UPMC Pinnacle shall:

(a) support the medical and allied health staff with resilience measures;

(b) promote regular measurement of burnout.

(c) give direction to the work units to assist them in addressing the identified drivers of burnout.

(d) support policies that cultivate long tenure and low turnover.

(e) provide resources for the promotion of resilience and self-care.

3.S.3. Meetings and Reports:

The Physician Thrive Committee- UPMC Pinnacle shall typically meet monthly, but at a minimum of six (6) times per year.

The Physician Thrive Committee- UPMC Pinnacle will annually submit a report to the Medical Executive Committee on its activities.

3.T. Investigating Committee - To Determine if Corrective Action is Warranted

3.T.1. Composition:

The Investigating Committee shall consist of the Present of at least three (3) members of the Active or Active Community Medical Staff, acting as a Professional Competence Committee. The President of the Medical Staff shall appoint one (1) of the members of the committee to serve as chair. If the President of the Medical Staff is the subject of the investigation then the Organizational VPMAS will chair the committee.

3.T.2. Duties:

The Investigating Committee shall be an ad hoc committee of the Medical Executive Committee and:

(a) support the medical and allied health staff with corrective action reviews and procedures

3.T.3. Meetings and Reports:

The Investigating Committee shall meet on an ad hoc basis and report to the Medical Executive Committee. Outlined in the Medical Staff Credentialing Policy.

3.U. UPMC Pinnacle Health Information Committee Charter

3.U.1. Delegation:

The Medical Staff Executive Committee (MEC) of UPMC Pinnacle Hospitals- Harrisburg, West Shore and Community Osteopathic recognizes the value of having the duties of the Medical Information Committee (Medical Records Committee) performed centrally. The UPMC Pinnacle Hospitals- Harrisburg, West Shore and Community Osteopathic MEC authorizes the UPMC Pinnacle Health Information Management Committee to perform the duties required of a Medical Information (Medical Records) Committee for its medical staff.

3.U.2. Membership:

The President of the Medical Staff will appoint one (1) member of the Active or Active Community Medical Staff to participate and represent UPMC Pinnacle Hospitals- Harrisburg, West Shore and Community Osteopathic on the UPMC Pinnacle Health Information Management Committee.

3.U.3. Reports and Recommended Action Items:

The minutes of the UPMC Pinnacle Health Information Management Committee will be included in the agenda and information for the UPMC Pinnacle Hospitals- Harrisburg, West Shore and Community Osteopathic MEC on a regular basis. Recommendations that require the UPMC Pinnacle Hospitals- Harrisburg, West Shore and Community Osteopathic MEC approval will be discussed and voted upon according to the protocol followed by the UPMC Pinnacle Hospitals- Harrisburg, West Shore and Community Osteopathic MEC.

3.V. Endo/Bronch Block Committee

3.V.1. Composition:

The Endo/Bronch Block Committee shall consist of the Department Chair of Surgery and Anesthesia, and the section chiefs of Gastroenterology and Pulmonary Medicine. The Committee shall include at least one (1) practitioner from each of the following clinical departments/sections of Gastroenterology, General Surgery, and Pulmonary Medicine. The members of the committee, chair and co-chair shall be

appointed by the President of the Medical Staff in consultation with the Vice President of Medical Affairs.

The Senior Director of Operations and Clinical Directors of Surgical Services will serve as ex officio, non-voting members.

3.V.2. Duties:

The Endo/Bronch Block Committee shall:

(a) Conduct a continuous evaluation of Endoscopy and Bronchoscopy suite block scheduling and access.

(b) develop and maintain policies and procedure that serve as operational guidelines to support equal scheduling opportunities for all qualifying Medical staff and outline processes to maximize scheduling access.

3.V.3. Meetings and Reports:

The Endo/Bronch Block Committee shall meet quarterly and submit a report to the Medical Executive Committee on its activities.

3.W. LEADERSHIP COUNCIL

3.W.1. Composition:

The Leadership Council shall be comprised of the following voting members: Medical Staff President, who shall serve as Chair; Medical Staff President-Elect; Secretary/Treasurer of the Medical Staff; Professional Practice Evaluation Committee Chair; Credentials Committee Chair; Immediate Past President of the Medical Staff; and the VPMA as an ex-officio member. Medical Staff Services Specialists shall also serve as non-voting members to facilitate the Leadership Council's activities and to perform functions on behalf of the Council between meetings.

Other appropriate individuals (e.g., Department Chair, other Medical Staff members, Allied Health Professionals, Chief Nursing Officer, other Hospital personnel, Employer representative, etc.) may be invited to attend a particular Leadership Council meeting (as guests, without vote) in order to assist the Leadership Council in its discussions and deliberations regarding 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 Leadership Council review

process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

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

3.W.2. Duties:

The 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 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 Credentials Policy, possesses disciplinary authority. The Leadership Council shall perform the following specific functions:

(a) Establish standard policies and procedures in writing, pertaining to the scope and circumstances of practice for Allied Health Professionals in the medical management of the patient; and

(b) serve as a resource for Department Chairs and other Medical Staff Leaders who are working with colleagues to improve clinical or professionalism performance or manage health issues that may impact the safety and quality of care;

(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) identify and nominate qualified individuals to serve as Department Chairs and Vice Chairs, to be presented to and elected by the relevant departments;

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

(h) review requests for reinstatement from automatic relinquishments and leaves of absence;

(i) 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

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

3.W.3. Meetings and Reports:

The 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 Leadership Council shall make periodic reports to the MEC and the Board. The Leadership Council's reports to the MEC and Board 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.X. Professional Practice Evaluation Committee ("PPEC")

3.X.1. Composition:

The PPEC shall consist of the following voting members: PPEC Chair and Vice Chair; additional Medical Staff members who are: broadly representative of the clinical specialties on the Medical Staff; interested or experienced in PPE/peer review or other Medical Staff affairs; supportive of evidence-based medicine protocols; and consistent with the non-disciplinary nature of the PPEC, generally do not also serve on the MEC.; and VPMA.

In the discretion of the Leadership Council, an Allied Health Professional may also be appointed to the PPEC, with vote.

Medical Staff Services Specialists shall serve as non-voting members to facilitate the PPEC's activities and to perform functions on behalf of the PPEC between meetings.

The Leadership Council shall appoint the PPEC members and shall designate one voting member as PPEC Chair. The PPEC Chair shall then appoint the Vice Chair.

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

Before any PPEC 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 Leadership Council or PPEC.

Other appropriate individuals (e.g., Medical Staff members, Advanced Practice Allied Health Professionals, Chief Nursing Officer, other Hospital personnel, Employer representative, UPMC System PPEC members, etc.) may be invited to attend a particular PPEC meeting (as guests, without vote) in order to assist the PPEC 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 PPEC.

Between meetings of the PPEC, the PPEC Chair, in conjunction with the VPMA or another PPEC member, may take steps as necessary to implement and operationalize the decisions of the PPEC. By way of example and not limitation, this may include providing clarifications to a Practitioner regarding the PPEC'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.X.2. Duties:

The PPEC 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 PPEC 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 Credentials Policy, possesses disciplinary authority. The PPEC shall perform the following specific functions:

(a) oversee the peer review/professional practice evaluation process and ensure that all components of the process receive appropriate training and support;

(b) review reports showing the number of cases being reviewed, 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 the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;

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

(e) review cases referred to it as outlined in the PPE/Peer Review Policy;

(f) develop, when appropriate, Voluntary Enhancement Plans for Practitioners;

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

(h) work with Department Chairs to disseminate educational lessons learned from the review of cases pursuant to the peer review process, either through educational sessions in the department or through some other mechanism;

(i) consult with the UPMC System PPEC or its members to seek assistance or guidance, when helpful; and

(j) perform any additional functions as may be requested by the Leadership Council, the MEC, or the Board.

3.X.3. Meetings and Reports:

The PPEC shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The PPEC shall submit reports of its activities to the MEC and the Board on a regular basis. The PPEC'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. By way of example and not limitation, this may include providing clarifications to a Practitioner regarding the Leadership Council's decisions or expectations, reviewing and approving communications with the Practitioner, and similar matters.

3.Y. Utilization Review Committee

The Utilization Review Committee assures that review of patients, including beneficiaries of Medicare and Medicaid, is conducted with respect to the medical necessity of admissions to the institution, the duration of stays, and professional services furnished, including drugs and biologicals.

3.Y.1. Composition:

The Utilization Review Committee shall consist of the following members Director, Clinical Care Coordination and Discharge Planning (Meeting Lead), Physician Advisor and/or Medical Director (Meeting Lead), Vice President of Medical Affairs, Chief Hospitalist/Chief of Medicine, Chief of Emergency Medicine, Chief of Surgery, Quality Leader, Chief Nursing Officer, Chief Financial Officer, Complex Care Team Representative, Behavioral Health Leader, and Chief of Obstetrics/NICU. Other suggested participants: Lead Allied Health Professionals, Private Physicians Representative, if applicable Other Provider Leaders, Pharmacy Leader, Project Manager or Support Staff, and Inpatient Rehab Leader.

3.Y.2. Duties:

The Utilization Review Committee reviews services furnished by the hospital and by members of its medical staff to patients, including those entitled to benefits under the Medicare and Medicaid programs and works to understand the resource utilization within the hospital and address processes that impact the use of those resources.

3.Y.3. Meetings and Reports:

The Utilization Review Committee shall meet quarterly and submit a report to the Medical Executive Committee on its activities. The Utilization Review Committee reviews professional services that are reasonably assumed outliers based on extraordinarily high costs. The purpose of these reviews is to determine medical necessity and to promote the most efficient use of available health facilities and services. The Committee reviews the plan annually and recommends changes to the Medical Executive Committee.

ARTICLE 4

AMENDMENTS

An amendment to the Medical Staff Organization Manual may be made by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists.

ARTICLE 5

ADOPTION

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

Adopted by the Medical Staff:_____

Approved by the Board:_____

Revised 01/2016

09/2017

01/2018

01/2018

03/2018

10/2018

01/2019

02/2019

04/2019

08/2019

12/2019

6/2020

9/2020

1/2021

4/2021

9/2021

7/2022

10/2022

1/2023

2/2023

6/2023

3/2024

5/2024

6/2024

Last Revisions – 6/20/2024

Reviewed 01/2017