MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF UPMC MEMORIAL

MEDICAL STAFF ORGANIZATION MANUAL

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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 Administrative Leadership, a Medical Staff member, or by a Medical Staff committee, including a Peer Review 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 Privileged 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 an individual assigned a function under this Manual is unavailable or unable to perform that 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 procedures set forth within this Manual do not invalidate any review or action taken.

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 number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in 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:

Anesthesia
Cardiovascular Medicine
Emergency Medicine
Family Practice
Medicine
Obstetrics & Gynecology
Orthopedic Surgery
Radiology
Surgery

2.C. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS

The functions and responsibilities of Departments, Department Chairs, and Department 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. Except as otherwise provided in this Manual, each committee shall meet as often as necessary to fulfill its responsibilities, at times set by the Presiding Officer.

(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. CREDENTIALS COMMITTEE

3.D.1. Composition:

(a) The Credentials Committee shall consist of at least five members of the Medical Staff with preference given to individuals who have served in Medical Staff leadership positions and/or who have a particular interest in the credentialing functions. In the discretion of the Leadership Council, an Allied Health Professional may also be appointed to the committee, with vote.

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

(c) The VPMA and Medical Staff Services Specialists shall serve as *ex officio* members, without vote, to facilitate the Credentials Committee's activities and to perform functions on behalf of the committee between committee meetings.

3.D.2. Duties:

The Credentials Committee shall:

(a) in accordance with the Credentials Policy, review Non-Privileged Information regarding all applicants seeking Medical Staff appointment, reappointment, and/or clinical privileges as well as all applicants seeking to practice as Allied Health Professionals, review the report from the Department Committee regarding the quality and efficiency of services ordered or performed by each applicant, and make written reports of its findings and recommendations; and

(b) 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.E. DEPARTMENT COMMITTEE

3.E.1. Composition:

(a) The Department Committee shall consist of the Department Chair, Vice Chair, and VPMA. Committee members may perform functions on behalf of the committee between committee meetings.

(b) The Medical Staff Services Specialists shall serve as an *ex officio* member, without vote, to facilitate the Department Committee's activities and to perform functions on behalf of the committee between committee meetings.

3.E.2. Duties:

The Department Committee shall:

(a) evaluate the Non-Privileged Information and the Privileged Peer Review Information pertaining to an applicant for appointment, reappointment, and/or clinical privileges, assess the quality and efficiency of services ordered or performed by the applicant, determine whether the applicant satisfies all other

necessary qualifications for appointment and the clinical privileges requested, and prepare a report of its findings to the Credentials Committee and to the Medical Executive Committee;

(b) review cases referred to it and perform other Peer Review functions in accordance with the PPE/Peer Review Policy and report its findings to the Committee for Professional Enhancement; and

(c) meet periodically as needed.

3.F. LEADERSHIP COUNCIL

3.F.1. Composition:

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

(1) Medical Staff President, who shall serve as Chair;

(2) Medical Staff Vice President;

(3) Chair, Committee for Professional Enhancement;

(4) At-large members (2); and

(5) VPMA.

(b) 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.

(c) 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.

(d) 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 Council. 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.F.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) review and address concerns about Practitioners' professional conduct;

(b) review and address possible health issues that may affect a Practitioner's ability to practice safely;

(c) review and address issues regarding Practitioners' clinical practice that may be referred to it by the Committee for Professional Enhancement;

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

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

(f) 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;

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

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

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

(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 MEC or the Board.

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

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.G. MEDICAL EXECUTIVE COMMITTEE

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

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

3.H.1. Composition:

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

(1) CPE Chair and Vice Chair;

(2) additional Medical Staff members who are:

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

(ii) interested or experienced in 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; and

(3) VPMA.

(b) In the discretion of the Leadership Council, an Allied Health Professional may also be appointed to the CPE, with vote.

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

(d) The Leadership Council shall appoint the CPE members and shall designate one voting member as CPE Chair. The CPE Chair shall then appoint the Vice Chair.

(e) 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.

(f) 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 Leadership Council or CPE.

(g) Other appropriate individuals (e.g., Medical Staff members, Allied Health Professionals, Chief Nursing Officer, other Hospital personnel, Employer representative, UPMC System CPE members, 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.

(h) Between meetings of the CPE, the CPE Chair, in conjunction with the VPMA 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.H.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 Credentials Policy, possesses disciplinary authority. The CPE 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) identify performance improvement initiatives as a result of reviews;

(c) 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;

(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 Awareness Letter may be sent to the Practitioner involved in the case;

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

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

(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 peer review process, either through educational sessions in the department or through some other mechanism;

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

(k) review regulatory reporting measures; and

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

3.H.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.I. BYLAWS COMMITTEE

3.I.1. Composition:

(a) The Bylaws Committee shall consist of the President of the Medical Staff and VPMA.

(b) *Ex officio* members shall include representatives from the Medical Staff Services Department.

3.I.2. Duties:

The Bylaws Committee shall perform the following functions:

(a) conduct periodic review of the Medical Staff Bylaws, Rules and Regulations, and related policies at each Hospital at least once every two years; and

(b) review and submit recommendations to the MEC for amendments to the Medical Staff Bylaws, Rules and Regulations, and related policies.

ARTICLE 4

INTEGRATED MEDICAL STAFF COMMITTEES

4.A. GENERAL

(1) The Medical Executive Committees of UPMC Carlisle, UPMC Community Osteopathic, UPMC Hanover, UPMC Harrisburg, UPMC Lititz, UPMC Memorial, and UPMC West Shore recognize the value of having the duties of certain committees performed centrally by integrated committees. The Medical Executive Committee at each Hospital authorizes these integrated committees to perform the duties required of an individual Medical Staff committee by approving this Manual.

(2) Unless otherwise indicated, each individual Medical Staff, through its Medical Staff leadership, shall designate one or more Medical Staff representatives as members of the committees.

(3) Unless otherwise indicated, all of the integrated committees in this Article shall meet as often as necessary to perform their duties. The reports, actions, and recommendations of these committees will be reported to the MECs on a regular basis. Recommendations that require individual MEC approval will be discussed and voted upon according to the procedures followed by the individual MECs.

(4) Because of the integrated nature of these committees, each committee may establish additional rules concerning the conduct of meetings and their activities that may supplement or vary from other rules contained herein that are applicable to Medical Staff committees generally.

4.B. INTEGRATED HEALTH INFORMATION MANAGEMENT (“HIM”) COMMITTEE

4.B.1. Composition:

The Integrated Health Information Management (“HIM”) Committee shall consist of at least one member from the Medical Staff of each Hospital, along with representatives from the following departments, offices and disciplines within UPMC and the UPMC hospitals as needed: Regulatory, Quality, and Safety, Privacy, eRecord Leadership (Physician and Administration), Nursing, Coding/Clinical Documentation Improvement, Compliance, and Risk Management/Legal.

4.B.2. Duties:

The Integrated HIM Committee shall perform the following functions:

(a) help assure that medical records are maintained in compliance with all applicable regulations, accreditation standards, and professional practice standards and that they are completed in a timely fashion;

(b) monitor the conduct of audits regarding timeliness, completeness, and appropriateness of medical record documentation, and help assure that audit findings are reviewed and that follow-up recommendations are made as needed;

(c) track safety and quality data separately for each facility and assure that records are maintained on-site at each Hospital;

(d) make recommendations to the appropriate Medical Staffs for action with respect to Medical Staff members who fail to conform to policies, including policies pertaining to timeliness and completeness of medical records;

(e) evaluate and make recommendations as appropriate regarding policies, rules and regulations relating to medical records; and

(f) partner in strategic planning for management of health information, including electronic medical record systems.

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

The Integrated HIM Committee shall meet as necessary to accomplish its functions, and the minutes of its meetings will be included in the agenda and information of each Hospital's MEC on a regular basis.

4.C. INTEGRATED MEDICAL PRACTICE CPOE COMMITTEE

4.C.1. Composition:

(a) The Integrated Medical Practice CPOE Committee, also referred to as the Medical Care Evaluations Committee, shall consist of representatives from the Medical Staff, Pharmacy, Nursing, Informatics, Quality, and Hospital Administration at each Hospital.

(b) Other members will include the VPMAs, DIO (residency or designated program leadership) and representatives from nursing leadership.

4.C.2. Duties:

The Integrated Medical Practice CPOE Committee shall perform the following functions:

(a) oversee standards of care and clinical practice with the Hospitals;

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

(c) develop and implement clinical standards of care; and

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

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

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

4.D. SYSTEM PHARMACY AND THERAPEUTICS COMMITTEE

4.D.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 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.

4.D.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.

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

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

ARTICLE 5

AMENDMENTS

This Manual may be amended by the process outlined in Article 9 of the Medical Staff Bylaws.

ARTICLE 6

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/MEC: __May 20, 2022; August 25, 2022; March 7, 2023____________

Board of Directors: __May 27, 2022; August 26, 2022; March 24, 2023_______________