HOMESTEAD HOSPITAL

ORGANIZATION AND FUNCTIONS 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 Credentials Policy.

1.B. DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more qualified designees.
ARTICLE 2

ORGANIZATION OF THE MEDICAL STAFF

The Medical Staff of Homestead Hospital shall be organized as a non-departmental staff. The current Clinical Services organized by the Medical Staff and formally recognized by the MEC are as follows: Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, Hospitalists, Emergency Services Department and Pulmonary On-Call.
ARTICLE 3

FUNCTIONS

3.A RESPONSIBILITIES FOR MEDICAL STAFF FUNCTIONS

The MEC is responsible for the Medical Staff functions set forth in Section 3.B of this Manual. The Medical Staff Officers, Clinical Service Chiefs, and Hospital and Medical Staff committee chairs must work together collaboratively to carry out these functions and maintain effective mechanisms for communication through the creation of periodic reports to the MEC or the appropriate clinical service or committee. Issues of concern should be reported to the MEC as needed to ensure adherence to regulatory requirements, accreditation standards, and appropriate standards of medical care.

Additionally, the MEC may recommend to the Board of Directors, and the Board of Directors may appoint, designated physician leaders to help fulfill Medical Staff functions and identify other medical and administrative resources needed to adequately fulfill these functions.

3.B. DESCRIPTION OF MEDICAL STAFF FUNCTIONS

3.B.1 Governance, Direction, Coordination and Action

(a) Receive, coordinate and act upon, as necessary, the reports and recommendations from clinical services, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

(b) Account to the Board and to the Medical Staff, by written recommendation, for the overall quality and efficiency of patient care at the Hospital;

(c) Take reasonable steps to ensure professional and ethical conduct, and initiate investigations and pursue corrective action of Medical Staff Members, when warranted;
(d) Make recommendations on medico-administrative, and Hospital clinical and operational matters;

(e) Inform the Medical Staff Members of the accreditation requirements, and the accreditation and State licensure status of the Hospital;

(f) Act on all matters of Medical Staff business, and fulfill any State and/or Federal reporting requirements;

(g) Oversee, develop, and plan Continuing Medical Education programs and activities that are designed to keep the Medical Staff Members informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities (this education function is coordinated through Baptist Health South Florida);

(h) Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur, in order to facilitate and provide a process for conflict resolution (this education function, as well as the recommendation of ethics policies and procedures, is coordinated through Baptist Health South Florida);

(i) Provide oversight concerning the quality of care provided by residents, interns, students (if applicable) who rotate through the Hospital facility, and ensure that the same act within approved guidelines established by the Medical Staff and Board; and

(j) Ensure effective, timely and adequately comprehensive communication between the Members of the Medical Staff and Medical Staff leaders, as well as among Medical Staff leaders and Hospital Administration and the Board.

3.B.2 Medical Care Evaluation / Performance Improvement / Patient Safety Activities

(a) Set expectations, develop plans, educate Members, and manage processes to measure, assess, and improve the quality of clinical activities;
(b) Understand the adopted approach to and methods of performance improvement;

(c) Ensure that important processes and activities are measured, assessed, and improved systematically across all disciplines throughout the Hospital;

(d) Communicate findings, conclusions, recommendations, and actions to improve performance to appropriate Members and the Board and define in writing responsibility for acting on recommendations for improvement;

(e) Participate in ensuring that the processes are defined and implemented for identifying and managing sentinel events and events that warrant intensive analysis;

(f) Ensure that an ongoing, proactive program for identifying risks to patient safety and reducing medical/health care errors are defined and implemented;

(g) Provide for mechanisms to measure, analyze, and manage variation in the performance of defined processes that affect patient safety; and

(h) Measure and assess the effectiveness of contributions to improving performance and patient safety.

3.B.3 Monitoring Activities

(a) Findings of the assessment process that are relevant to an individual's performance (the MEC provides leadership for measuring, assessing and improving processes that primarily depend on the activities of one or more members);

(b) Medical assessment and treatment of patients;

(c) Use of medications;

(d) Use of information, in the credentialing process, regarding adverse privileging decisions;

(e) Use of blood and blood components;

(f) Use of operative and other procedures;
(g) Appropriateness of clinical practice patterns;

(h) Education of patients and families;

(i) Coordination of care with other Members and Hospital personnel;

(j) Accurate, timely, and legible completion of patients' medical records;

(k) Significant departures from established patterns of clinical practice;

(l) Use of developed criteria for autopsies;

(m) Sentinel event data;

(n) Patient Safety Data;

(o) Coordination of care, treatment, and services with other Members and Hospital personnel, as relevant to the care, treatment, and services of an individual patient;

and

(p) Use of clinical guidelines and evidence based order sets that promote evidence based medicine.

3.B.4 Credentials and Privilege Review

(a) Review the credentials of all applicants for appointment and reappointment to the Medical Staff and the Allied Health Staff, and clinical privileges, conduct a thorough review of these applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) Review all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Staff 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, clinical privileges for new procedures and clinical privileges that cross specialty lines.

3.B.5 Health Information Management

(a) Review and evaluate medical records to determine that they:

- Properly describe the condition and progress of the patient, the therapy, the tests provided and the results thereof, and the identification of responsibility for all actions taken; and

- Are sufficiently complete and legible at all times so as to facilitate continuity of care and communication between all those providing patient care services in the Hospital;

(b) Review, enforce, and maintain surveillance over enforcement of Medical Staff and Hospital policies and rules relating to medical record including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein; and

(c) Provide liaison with Hospital Administration, nursing service, and medical records professionals and other employees of the Hospital on matters relating to medical records practices and information management planning.

3.B.6 Emergency Preparedness

Assist the Hospital’s Administration in developing, periodically reviewing, and implementing an emergency operations plan that addresses disasters both external and internal to the Hospital.
3.B.7  Planning

(a) Participate in evaluating existing programs, services, and facilities of the Hospital and Medical Staff; and recommend continuation, expansion, abridgment, or termination of each;

(b) Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and

(c) Communicate strategic, operational, capital, personnel, information management, and corporate compliance plans to Medical Staff members.

3.B.8  Bylaws Review

(a) Conduct periodic review of the Medical Staff Bylaws, Medical Staff manuals, and Medical Staff Rules and Regulations;

(b) Conduct periodic review of the clinical policies and rules; and

(c) Submit written recommendations to the Board for amendments to the Medical Staff Bylaws, Medical Staff manuals, and the rules & regulations.

3.B.9  Nominating

Nominating Committee will nominate candidate(s) for the offices of the President of the Medical Staff, the President Elect and the At-Large Members of the MEC.

3.B.10  Infection Control Oversight
(a) The Medical Staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;

(b) Develop and approve policies describing the type and scope of infection control surveillance activities;

(c) Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

(d) Evaluate and revise the type and scope of surveillance annually;

(e) Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;

(f) Ensure reporting of nosocomial infection findings on a timely basis to the attending physician and appropriate clinical or administrative leader; and

(g) Review all policies and procedures on infection prevention, surveillance, and control at least every two (2) years through the Infection Control Committee.
ARTICLE 4

MEDICAL STAFF COMMITTEES

4.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Manual outlines the Medical Staff committees of the Hospital that carry out ongoing and focused professional practice evaluations, 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.

4.B. MEETINGS, REPORTS AND RECOMMENDATIONS; CONFLICTS OF INTEREST

(1) Unless otherwise indicated, each committee described in this Manual will meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions.

(2) Each committee will 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) If a member participating on a Medical Staff committee has an actual or potential conflict of interest regarding any item(s) to be discussed and/or voted on by such committee, then that member is expected to disclose such conflict to that committee.

4.C. STANDING COMMITTEES

The Standing Committees of the Medical Staff are:

(1) Medical Executive Committee (MEC);
4.D. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the MEC are set forth in Section 5.2 of the Medical Staff Bylaws.

4.E. CREDENTIALS COMMITTEE

4.E.1. Composition:

(a) As set forth in the Credentials Manual, the Credentials Committee will consist of at least five Active Staff members and one Allied Health Professional selected for their knowledge, experience, and/or commitment to credentialing and quality improvement processes. Members of the Credentials Committee will be either former leaders who have demonstrated interest to learn about this function, or who have demonstrated
leadership experience. The Credentials Committee shall include the President Elect and the Immediate Past President.

(b) Service on this committee shall be considered the primary Medical Staff obligation of each committee member.

4.E.2. Duties:

The Credentials Committee will:

(a) Review the credentials of all applicants for appointment and reappointment to the Medical Staff and the Allied Health Staff, and clinical privileges, conduct a thorough review of these applications, interview such applicants as may be necessary, and submit its recommendations to the MEC.

(b) Review, as may be requested by the MEC, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Staff and, as a result of such review, make a written report of its findings and recommendations to the MEC.

(c) Review and make recommendations to the MEC regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital including, specifically, clinical privileges for new procedures and clinical privileges that cross specialty lines. Clinical Services will make recommendations to the Credentials Committee regarding the eligibility criteria for clinical privileges that concern their respective Clinical Service.

4.F MEDICAL STAFF QUALITY COMMITTEE (MSQC)

4.F.1 Composition

The Medical Staff Quality Committee (MSQC) will be comprised of eleven members of the Active Medical Staff including but not limited to a representative member from each of the following specialties:

(a) Internal Medicine or Family Practice
(b) Cardiovascular
(c) General Surgery
(d) OB/GYN/Pediatrics
(e) Orthopedics
(f) Emergency Medicine
(g) Anesthesiology
(h) Radiology.

The President of the Medical Staff and President Elect of the Medical Staff are non-voting members of the Committee. The presence of at least 50% of the voting committee members will constitute a quorum.

4.F.2 Duties

The MSQC is responsible for evaluating and improving physician performance in the areas of clinical quality, physician responsiveness, documentation issues and clinical resource use related to physician patterns and retrospective review of unusual or complex specific cases.

The following areas are considered outside the MSQC’s scope:

(a) Routine concurrent aspects of physician resource use will be managed through Utilization Review/Care Coordination.

(b) Routine review of pathology reports will be managed through a separate process.

(c) Routine review of infections will be managed through the Infection Control Committee

(d) Physician performance issues regarding physician behavior will be the responsibility of the Practitioner Review Committee.

(e) Policies requiring medical staff approval for Blood Use or Medical Records will be handled directly by the MEC.
(f) Formulary and medication policy issues requiring medical staff approval will be addressed by the Infection Control Committee and/or Pharmacy and Therapeutics Committee.

4.G PRACTITIONER REVIEW COMMITTEE (PRC)

4.G.1. Composition:

The Practitioner Review Committee will consist of three members of the Medical Staff. Members of the Practitioner Review Committee should not also be serving as an officer of the Medical Staff.

4.G.2. Duties:

The Practitioner Review Committee will:

(a) Function in accordance with the relevant policies.

(b) Review, evaluate, address and, if appropriate, make recommendations to the MEC regarding conduct (including, but not limited to, disruptive behavior and professionalism) by any Member.

(c) Handle conduct and/or impairment matters in a confidential fashion and keep the President of the Medical Staff and the Chief Executive Officer apprised of the matters under review.

4.H HEALTH INFORMATION MANAGEMENT COMMITTEE

4.H.1 Composition

The Health Information Management Committee shall consist of at least four (4) Active Staff members of the Medical Staff, and there shall be no more than one (1) member from any particular Clinical Service. This Committee shall include one (1) representative from BHSF Health Information Management Department, one (1) representative from Performance
Improvement Department, one (1) representative from Nursing Administration, and one (1) representative from the Hospital’s Administration.

4.2 Duties

The Health Information Management Committee will:

(a) Review and evaluate medical records to determine that they:

• Properly describe the condition and progress of the patient, the therapy, the tests provided and the results thereof, and the identification of responsibility for all actions taken; and

• Are sufficiently complete and legible at all times so as to facilitate continuity of care and communication between all those providing patient care services in the Hospital.

(b) Review, enforce, and maintain surveillance at least quarterly over enforcement of Medical Staff and Hospital policies and rules relating to medical record including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein.

(c) Serve as a liaison with Hospital Administration, nursing service, and medical records professionals and other employees of the Hospital on matters relating to medical records practices and information management planning.

(d) Meets at least quarterly.

4.1 PHARMACY & THERAPEUTICS COMMITTEE

4.1.1 Composition:

The Pharmacy and Therapeutics Committee shall consist of at least fourteen (14) members: at least four (4) from the Medical Staff; four (4) from the Pharmacy Department; and one (1) each
from Nursing Administration, Nutritional Services, Respiratory Therapy, Laboratory, Infection Control and Clinical Nursing.

A representative from the Hospital’s Pharmacy and Therapeutics Committee is a member of the Baptist Health South Florida’s Pharmacy & Therapeutics Committee ("BHSF P&T Committee").

4.1.2 Duties

The Pharmacy & Therapeutics Committee will:

(a) The BHSF P&T Committee maintains a formulary of drugs approved for use by the System. Entity-specific formulary items are maintained through the entity-level committee.

(b) Create treatment guidelines and protocols in cooperation with the applicable Members and nursing staff.

(c) Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, and pharmacist interventions).

(d) Perform drug/medication usage evaluation (DUE/MUE) studies on selected topics and present findings.

(e) Approve policies and procedures related to: total parenteral nutrition; pain management; medication and therapeutics’ procurement; storage; preparation and dispensing; use; safety procedures; and other matters relating to medication use.

(f) Serve as an advisory group to the Medical Staff in connection with drug recalls and the choice of available medications including, but not limited to, formulary review for safety and effectiveness.
(g) Submit reports of its recommendations to the MEC, and if indicated, to the CEO and the BHSF P&T Committee.

(h) Meet at least quarterly.

4. J  INFECTION CONTROL COMMITTEE

4. J. 1. Composition

The Infection Control Committee is a Hospital multidisciplinary committee which oversees the program for surveillance, prevention, and control of infection. The committee shall be composed of at least four (4) members of the Medical Staff. The Infection Control Committee membership shall also include representatives from the Nursing Administration, the Infection Control Practitioners, Facilities Management, Laboratory/Microbiology, Perioperative Services, Supply Chain Management, Environmental Services, Pharmacy, Endoscopy, Dialysis, and Employee Health Service.

4. J. 2. Duties

The Infection Control Committee will:

(a) Develop the scope of surveillance activities.

(b) Develop actions to prevent or control infection based on an evaluation of the surveillance reports of infections and of the infection potential among patients, health care workers, visitors, volunteers and students.

(c) Develop written policies and procedures which define types of isolation precautions that are in compliance with regulatory agency standards and guidelines.

(d) Supervise infection control process in all phases of the Hospital, including:
- Role and scope of participation of each department/service in infection control and prevention activities. Maintain a current and active program of surveillance of all Hospital services.

- Transmission-based 2-tiered isolation precautions/procedures.

- Standard Precautions.

- Other situations as requested by the MEC

(e) Maintain a permanent record of all activities relating to Infection Control & Prevention.

(f) Provide educational and consultative role regarding infection control practices/measures.

(g) Implement strategies to reduce risk for, and/or prevent nosocomial infections.

(h) Institute any infection control surveillance, prevention, or control measure(s) or studies when there is a reason to believe that any patient or personnel may be in danger. This shall include, but not be limited to, the initiation of isolation precautions.

(i) Support the enforcement procedures for occupation exposure to bloodborne pathogens (29 C.F.R. 1910.1030).

(j) Meet at least quarterly.

4.K **CRITICAL CARE / ICU COMMITTEE**

4.K.1 **Composition**

The Critical Care/ICU Committee shall consist of at least five (5) physicians with representation from the following specialties: Anesthesiology, Cardiology, Hospitalist, and Pulmonary. Additional members of the Committee shall be the Nurse Manager of the Critical Care Unit (or designee), and a representative from the Hospital’s Administration. The Chairman of the Critical Care / ICU Committee shall be the Medical Director of Intensive Care Services.
4.K.2 Duties

The Critical Care / ICU Committee will:

(a) Develop and enforce policies governing conduct and procedures in the Critical Care Unit, including patient eligibility requirements, consultation requirements, protocols, etc.

(b) Meet at least quarterly.

4.L CLINICAL ETHICS COMMITTEE

4.L.1 Composition

The Clinical Ethics Committee is a sub-committee of Baptist Health South Florida’s Bioethics Committee ("BHSF Bioethics Committee"). The Hospital’s Clinical Ethics Committee reports to the BHSF Bioethics Committee in matters related to policy development and clinical ethics consultation. The Clinical Ethics Committee shall consist of representatives from the following areas: Medical Staff; Nursing; Care Coordination / Social Work; Respiratory Therapy; Rehabilitation; Pastoral Care; Risk Management; Performance Improvement; Nursing Administration; and the Hospital’s Administration. The Hospital attorney may be added to the committee as deemed appropriate.

4.L.2 Duties

(a) The Clinical Ethics Committee has three primary duties: providing clinical consultation services; collaborating to develop and harmonize institutional policies (via the BHSF Bioethics Committee); and local coordination of educational activities, as appropriate.

(b) The Clinical Ethics Committee is expected to develop institutionally appropriate mechanisms for providing ethics consultations. The Clinical Ethics Committee serves as an in-house resource to physicians, employees, and patients and their family members.

(c) Meets at least quarterly.
4.M  BYLAWS COMMITTEE

4.M.1. Composition:

The Bylaws Committee will consist of at least three Active Staff members of the Medical Staff.

4.M.2. Duties:

The Bylaws Committee will meet as needed and perform the following duties:

(a) Review and make recommendations for revisions to the Medical Staff Bylaws, the Medical Staff manuals, and other related documents, including, but not limited to, the Medical Staff Rules and Regulations, to reflect the Hospital’s current practices with respect to Medical Staff organization and functions.

(b) Comply with the provisions of the Medical Staff Bylaws regarding changes or amendments.

(c) Forward any proposed changes or amendments to the MEC for its comments and recommendations, and final approval by the Board of Directors.

4.N. NOMINATING COMMITTEE

The composition and duties of the Nominating Committee are set forth in Section 3 of the Medical Staff Bylaws.

4.O. Allied Health Professionals Committee

4.O.1 Composition

The Chairperson of the Allied Health Professionals Committee shall be appointed by the President of the Medical Staff. The Allied Health Professionals Committee shall be composed of AHPs and other members deemed appropriate by the Chairperson. The members of this
committee shall serve for a two (2) year term. Appointments may include Associate AHPs, Assistant AHPs, the Chief Nursing Officer or designee and any others as deemed appropriate.

4.O.2 Duties

The Allied Health Professionals Committee shall:

(a) Evaluate and make recommendations to the MEC and Board regarding the need for services that could be provided by classes of AHPs that are not currently permitted to practice in the Hospital.

(b) Develop and recommend policies and privileges for each class of AHP permitted by the Board to practice in the Hospital.

(c) Meet at least twice per year.
ARTICLE 5

AMENDMENTS

This Manual may be amended as set forth in Article 8 of the Medical Staff Bylaws.
ARTICLE 6
ADOPTION

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

Originally adopted on 27/MAS 2015 and amendments subsequently adopted.

[Signature]

Jorge Mejia, MD,
President, Medical Staff

05/04/2015

[Signature]

William Duquette

CEO, Homestead Hospital

05/27/2015

[Signature]

William Chambers, III

Chairperson, Board of Directors

05/27/2015