THE

RULES AND REGULATIONS

OF THE

EMMA PENDLETON BRADLEY HOSPITAL

MEDICAL STAFF

Effective as of June 20, 2012
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>SECTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preamble</td>
<td>3</td>
</tr>
<tr>
<td>I.  Admission of Patients</td>
<td>3</td>
</tr>
<tr>
<td>II. Transfer of Patients</td>
<td>4</td>
</tr>
<tr>
<td>III. Discharge of Inpatients and Partial Hospital Patients</td>
<td>4</td>
</tr>
<tr>
<td>IV. Criteria for Autopsy</td>
<td>5</td>
</tr>
<tr>
<td>V.  Medical Records</td>
<td>6</td>
</tr>
<tr>
<td>VI. General Conduct of Care</td>
<td>9</td>
</tr>
<tr>
<td>VII. General Rules Regarding Emergency Services</td>
<td>11</td>
</tr>
<tr>
<td>VIII. Miscellaneous</td>
<td>12</td>
</tr>
<tr>
<td>IX. Committees</td>
<td>12</td>
</tr>
</tbody>
</table>
PREAMBLE

The following Rules and Regulations for the Emma Pendleton Bradley Hospital Medical Staff (the “Medical Staff”) describe specific policies and procedures of the Medical Staff and define in greater specificity, provisions of the Medical Staff Bylaws. All members of the Medical Staff are expected to comply with the provisions contained in these Rules and Regulations and to follow the Emma Pendleton Bradley Hospital (the “Hospital”) values of respect for every individual and a commitment to quality services.

These Rules and Regulations of the Medical Staff are designed to augment and/or clarify requirements related to clinical practice at the Hospital. Care is also governed by federal and state statutes and regulations; standards and conditions of accreditation organizations; the Conditions of Participation of the Centers for Medicare and Medicaid Services (CMS); and Hospital policies and procedures. Where conflicts in requirements arise, these Rules and Regulations are superseded by external regulatory requirements. When conflicts exist between regulatory agency requirements, the more stringent requirement is followed. The Rules and Regulations of the Medical Staff must conform to federal and state requirements, but they may also have additional requirements as set forth by the Medical Staff and the Hospital’s Board.

I. ADMISSION OF PATIENTS

1. A patient meeting admission criteria may be admitted to the Hospital by any member of the Medical Staff who has been granted admitting privileges. All practitioners shall be governed by the admitting policies of the Hospital.

2. A member of the Medical Staff or independently licensed allied health professional shall be responsible for the medical care and treatment of each patient in the Hospital. Whenever these responsibilities are transferred to another service, a note covering the transfer of responsibility shall be entered in the patient's medical record. A corresponding order shall also be entered at the time of the transfer.

3. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of any emergency, such statement shall be recorded as soon as possible.

4. The history and physical examination and mental status examination must clearly justify the reason(s) for the patient to be admitted to the Hospital. These findings must be recorded within twenty-four (24) hours of admission.

5. Each practitioner must assure timely, adequate professional care for his/her patients in the Hospital by being available or having pre-arranged coverage available with equivalent clinical privileges. Failure of a practitioner to meet these requirements could result in loss of clinical privileges through the medical staff investigation and intervention process.

6. Patients admitted to the Hospital should be seen and examined by the attending physician as promptly as necessary to ensure that appropriate evaluation and treatment are initiated such that preventable morbidity is avoided. The length of time which can safely elapse between the patient’s admission and the initial exam is dependent on the patient’s diagnosis and condition. It is the attending physician’s responsibility to judge how urgently the patient must be seen or
arrange surrogate care, if necessary, in order to meet care requirements. The attending physician, or his/her designee, must evaluate a newly admitted patient within twenty-four (24) hours of the admission.

II. TRANSFER OF PATIENTS

1. No patient shall be transferred without consultation with and approval by the practitioner responsible for that patient.

2. Patient transfers from another facility will adhere to the following: The physician who accepts a patient in transfer from another institution is responsible for the disposition of the patient upon arrival at the Hospital. Prior to accepting the patient, the physician or designee must determine that a bed is available. If, after evaluation, the accepting physician finds that the patient would be better served on another service, that physician is responsible to arrange for the transfer of care to that service.

3. Patient transfers to another facility will adhere to the following guidelines:
   a. Patients shall be admitted for the treatment of any and all conditions and diseases for which the Hospital has facilities and personnel. When it is determined, based on the patient’s assessed need and the Hospital’s capabilities, that the transfer of a patient to another facility is in the patient’s clinical best interest, or when a request for a transfer arises from a patient or family member’s request, the Hospital and/or the attending physician shall assist the patient in making arrangements for care at another facility as long as the patient is sufficiently stable for transfer.
   b. If the patient is to be transferred to another health care facility, the transferring physician shall enter all pertinent information into the patient’s medical record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has agreed to accept the patient and the patient is considered sufficiently stable for transport. Clinical records of sufficient content to ensure a successful transition of care shall accompany the patient.

III. DISCHARGE OF INPATIENTS AND PARTIAL HOSPITAL PATIENTS

1. Patients shall be discharged only by order of the attending practitioner or Licensed Independent Practitioner designee. Should a patient leave the Hospital against the advice of the attending practitioner, Licensed Independent Practitioner designee, or without proper discharge, a notation of the incident shall be made in the patient’s medical record.

2. The medical staff will actively participate in the discharge planning process.
   a. Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, which includes an assessment of the availability of appropriate services to meet the patient’s needs after hospitalization, shall be documented in the patient’s medical record. The discharge of a patient to another level of care, to different professionals, or to a different setting is based on the patient’s assessed needs and the Hospital’s capabilities. The discharge planning process shall address the reason(s) for admission; the conditions under which discharge can occur; shifting responsibility for a patient’s care from one clinician, organization, or service to another; mechanisms for internal and external transfer; and the accountability
and responsibility for the patient’s safety during transfer of both the organization initiating the transfer and the organization receiving the patient.

b. Discharge planning shall include, but need not be limited to, the following:

i. Appropriate referral and transfer plans;

ii. Methods to facilitate the provision of follow up care including communication of the following to the new organization or provider:

   1. the reason for hospitalization;
   2. the patient’s physical, psychiatric and/or psychosocial status;
   3. a summary of care, treatment, and services provided;
   4. medication reconciliation of the admitting medications with those to be given at discharge; and,
   5. community resources or referrals provided to the patient.

iii. Information to be given to the patient or the patient’s family or other persons involved in the patient’s care on matters such as the patient’s condition; the reason for transfer or discharge; alternatives to transfer, if any; the anticipated need for continued care, treatment, and services after discharge; arrangements for services to meet the patient’s needs after discharge; and written discharge instructions in a form the patient can understand.

IV. CRITERIA FOR AUTOPSY

1. In the event of a death, the patient shall be pronounced dead by a licensed physician. The body shall not be released from the Hospital until an appropriate entry by a licensed physician has been made and signed in the patient’s medical record. Policies with respect to the release of bodies and completion of the tissue/organ permission request form shall conform to Rhode Island law.

2. Criteria for reporting Hospital deaths to the Rhode Island Medical Examiner are determined by state laws, statutes and regulations. These criteria, outlined in Hospital policy and mentioned below, will be followed by all staff members.

3. No autopsies are performed at Bradley Hospital. If an individual’s death is proximal to their care at Bradley Hospital a Staff Member will participate, as appropriate, in attempting to secure consent for an autopsy. Medical-legal deaths require notifying the State Medical Examiner’s Office prior to asking for permission from the family.

   a. It is the attending physician’s responsibility to notify the immediate family when a patient expiration occurs, and to notify the Rhode Island Medical Examiner if indicated according to state law. Such notification must be evidenced by documentation in the progress notes of the medical record.

   b. To assure that the attending pathologist knows of the specific clinical interest and issues for seeking the autopsy, the physician should:

      i. Alert the attending pathologist by writing the specific clinical concerns in the final note of the medical record or by discussing them directly; and
ii. Identify him- or herself and the patient’s attending physician clearly by name and pager number in the medical record or other form of written communication to the attending pathologist to expedite communication.

V. MEDICAL RECORDS

1. The attending physician shall be responsible for the preparation of a timely, accurate, complete and legible medical record for each of his/her patients within thirty (30) calendar days of an inpatient’s, or partial hospital patient’s discharge. Maintenance requirements for medical records of an outpatient are delineated in the applicable Hospital policies. Each health care record shall be pertinent and current, and shall include all items required by state and federal regulations, accreditation organizations and CMS Conditions of Participation and other applicable standards as outlined in Administrative policies.

Individuals completing patient care summaries and similar record entries will utilize the original source electronic and hard copy documents when creating medical record entries to ensure an accurate account of the patient’s care is conveyed.

All clinical entries in the health care record shall be accurately dated, timed and authenticated. “Authenticated” shall mean to confirm authorship by written signature or electronic identification.

2. History and Physical Exam (H&P) and Mental Status Exam: A complete history and physical and mental status examination by an attending physician member of the Medical Staff, resident designee or LIP designee, shall be recorded within twenty-four (24) hours of inpatient and partial hospital admission. The history and physical and mental status examination should include: the chief complaint; details of the present illness; past medical and psychiatric histories; allergies and medications; and an assessment of the patient’s emotional, behavioral, and social status. Relevant social and family history, assessment of clinical risk, as well as a review of body systems, shall be fully documented. Included shall be impressions drawn from the history and physical examination and mental status examination, and a statement of the plan of treatment. If the history and physical and mental status examination are dictated but are not immediately available, a brief summary of the impression and treatment plan shall be placed in the progress notes.

Further clarification of the H&P and mental status examination requirements are managed by the Medical Record Committee and hospital policy.

3. Treatment Plans: A multidisciplinary treatment plan shall be developed for all admitted patients. The plan shall be developed and implemented by the admitting physician at the time of admission and reviewed and revised as needed by the attending physician on the first business day after the patient’s admission.

Review and modifications to the multidisciplinary treatment plan can be made as to treatment or whenever the patient’s condition warrants revision of the plan. At a minimum, the plan is reviewed and revised by the physician led multidisciplinary team fourteen (14) days after admission and every seven (7) days thereafter as required by federal and Rhode Island regulations.

4. Progress Notes: Pertinent progress notes shall be recorded at the time of evaluation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient’s clinical
problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments. Progress notes shall be written by the attending physician or designee as designated by Medical Staff policies. Progress notes should reflect a continuous documentation of the necessity of hospitalization and continuation of care.

5. Discharge Summary: A discharge summary shall be dictated or written for all hospitalized patients at the time of the patient’s discharge from the Hospital. The discharge summary should include the reason(s) for admission, the significant findings, the treatments administered, final diagnosis(es), the condition and disposition of the patient on discharge, the discharge instructions given to the patient and/or family including discharge medications (following medication reconciliation), and provisions for follow up care, including specific pending tests, studies, or results that require further action. All discharge summaries shall be authenticated by the responsible practitioner.

6. Countersignature Requirements: Other providers whose clinical privileges require countersignature will have those designated entries countersigned according to the mechanisms outlined by the applicable policy.

7. Medical Record Deficiencies: Failure to record any of the following within the specified time shall be considered a major deficiency and subject to the suspension policy for delinquent records:
   a. History and physical and mental status examinations, within twenty-four (24) hours of patient admission.
   b. Discharge summary at the time of discharge.
   c. Required record countersignatures within thirty calendar (30) days of patient discharge.

8. Medical Record Completion Process:
   a. All procedures shall be followed to ensure that health care records are fully documented within the above defined parameters and in all cases within thirty calendar (30) days following patient discharge in accordance with the Rules and Regulations, the accreditation organizations, the CMS Conditions of Participation, and policies of the Medical Staff and Health Information Services (HIS).
   b. The practice for completion of Medical Records is outlined in the relevant Hospital Information Services (HIS) or Medical Staff Policies. These policies specify the actions to be taken if practitioners are delinquent in completing the medical record. In addition, these policies allow for serious action to be taken, against health care providers who are delinquent in completing the medical records, up to and including suspension and/or termination.
   c. When an entry in a patient’s medical record is amended or corrected in any way, the editing practitioner shall sign, date and time their entry at the point of amendment.

9. Confidentiality and Security of Patient and Organizational Information:
   a. Password, E-Signature or Other User Identification: No member of the Medical Staff shall provide or allow another individual to use his or her password, E-Signature or other
user identification (hereinafter “password”) whether or not such other individual is an authorized user of the Hospital’s information systems or patient databases (collectively “information systems”). Each member of the Medical Staff acknowledges that his or her password shall constitute his or her legal signature and shall be accountable for all entries of patient information, orders, and data entered into the Hospital’s information systems and all other actions taken as a result of the use of such password. In the event that a member of the Medical Staff reasonably suspects or becomes aware of any unauthorized use or disclosure of his or her password, he/she shall immediately change the password and report such unauthorized use or disclosure to the Hospital’s Information Services Department.

b. Patient Information and Records: Members of the Medical Staff shall access patient information or records through the Hospital’s information systems either on-site or remotely only for the following purposes in accordance with state and federal laws and regulations:

i. providing health care to the patient or coordinating such care with other health care providers;

ii. billing activities and filing claims for reimbursement for patient care;

iii. conducting scientific or statistical research, management or financial audits;

iv. conducting authorized quality assessments and peer reviews; or

v. performing other administrative duties in accordance with these Bylaws.

All such access and use shall be in accordance with state and federal law and regulations and with applicable Hospital and/or Lifespan policy governing patient data use. Each member of the Medical Staff shall be solely responsible for maintaining the confidentiality, security and integrity of all patient information and records acquired by or disclosed to a Medical Staff member through access to the Hospital’s information systems, including without limitation any patient information printed, photocopied, or downloaded to any hard drive, diskette, CD, tape, thumb drive, or other storage device or any portable or wireless devices (smart-phones, electronic notebooks or other electronic devices not yet foreseen).

c. Peer Review Information: Medical Staff members shall exercise appropriate confidentiality and security in the preparation, maintenance and control of credentialing, quality assurance and peer review information and documents to ensure that such information and documents are not distributed to individuals or entities other than those specifically authorized by these Bylaws, Rules and Regulations, Hospital policies, or as may be otherwise indicated by the Hospital or Medical Executive Committee.

d. Proprietary Information: Medical Staff members shall maintain the confidentiality and security of all of the Hospital’s proprietary data, trade secrets, financial information or other confidential information acquired by or disclosed to a staff member in the course of performing his or her obligations pursuant to these Bylaws, Rules and Regulations, or Hospital policies.
e. E-mail and Internet Usage: Medical Staff members and their designees who have authorized access to the Hospital’s e-mail system and/or internet service provider shall abide by the Hospital’s e-mail and internet usage policies.

10. Organized Health Care Arrangement:

a. Medical Staff members acknowledge that Bradley Hospital is a “Covered Entity” as that term is defined by the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-1329d-8; 42 U.S.C. 1320d-2) (“HIPAA”), regulations promulgated there under (“HIPAA Regulations” or the “Privacy Rule” and the “Security Rule”), and Subsection D of the American Recovery and Reinvestment Act (ARRA) of 2009, more commonly referred to as the Health Information Technology for Economic and Clinical Health (HITECH) Act (Public Law 111-5) and that the Medical Staff is an integral component of the Hospital. Medical Staff members further acknowledge that Bradley Hospital is also subject to additional federal and state statutes and regulations relating to, and the provision of, mental health and mental health services.

b. The members of the Medical Staff agree, as may be permitted by HIPAA, HIPAA Regulations, and HITECH, to:

i. use reasonable efforts to preserve the security and confidentiality of Protected Health Information that each receives from the other;

ii. use and disclose such information to the extent necessary to conduct the activities of the Hospital and to the extent required by these Bylaws, Rules and Regulations, applicable State law, and as set out in Rule 14; and,

iii. comply with the terms of the Hospital’s Joint Notice of Privacy Practices, as may be amended from time to time, with respect to the Protected Health Information created or received by each other in the course of participating in Hospital activities.

11. Abbreviations: Official references defining approved abbreviations shall be kept on file in Health Information Services (Medical Records).

An official list of abbreviations, acronyms, and symbols that will not be used in the Hospital has been developed by the Medical Staff and is also available in the appropriate policy.

VI. GENERAL CONDUCT OF CARE

1. Consent for Treatment: The Hospital’s Consent for Treatment form shall be signed by or on behalf of every patient admitted to the Hospital at the time of admission. In addition to obtaining the patient’s general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment shall be separately obtained. Appropriate forms for such consent will be adopted with the advice of legal counsel, risk management, and standardized in the facility for both inpatient and outpatient services.

2. Written Patient Orders:

a. All orders for treatment shall be in writing or entered in the computerized physician order management system in accordance with approved Medical Staff Rules and Regulations.
MEDICAL STAFF RULES AND REGULATIONS

The expectation is that where and when available, the practitioner will enter all orders via computerized order entry.

b. The practitioner’s orders must be written clearly, legibly, and completely. Orders that are illegible or improperly written will not be carried out until rewritten. Where applicable, this shall include a recognizable signature. All orders must be dated and timed.

3. Verbal Patient Orders:

a. Except in urgent/emergent situations, verbal orders should not be utilized if the practitioner is physically present in the Hospital and/or accessible to a computer or like device capable of transmitting an electronic order entry. A verbal order, regardless of the mode of transmission of the order, shall be considered to be in writing if dictated to a duly authorized person functioning within his or her sphere of competence and countersigned by the responsible covering practitioner. The order shall be written or electronically entered upon receipt and shall include the date and the names of the individuals who gave and received it. The qualified personnel taking the verbal order shall read it back aloud to the ordering practitioner in order to verify the verbal order as transcribed in the patient’s record.

b. Only appropriately licensed personnel authorized by state agencies and the Hospital administrative policies may accept verbal orders related to their respective scopes of practice.

c. All verbal orders must be appropriately authenticated by a practitioner involved in the care of the patient no later than the end of the next calendar day. The verbal order may be countersigned by the ordering practitioner, attending, or covering practitioner.

d. Authentication of special verbal orders such as those for the use of restraints, and/or seclusion, shall follow pertinent Hospital policy.

4. Medication Orders:

a. All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, of the National Formulary or of the American Hospital Formulary Service. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles involved in the Use of Investigational Drugs in Hospitals, the Institutional Board, and all regulations of the Federal Drug Administration.

b. A method to control the use of dangerous and toxic drugs shall be developed by the Medical Staff through its Pharmacy and Therapeutics Committee.

c. A method for control of drugs brought into the Hospital by patients shall be established by the Pharmacy and Therapeutics Committee. Dietary supplements provided by families may be continued at Bradley on a case by case basis after therapeutic medications have been ordered by the physician and reviewed by pharmacy.

5. Consultations:

a. Any qualified practitioner with clinical privileges in the Hospital can be called for
consultation within his/her area of expertise.

b. Consistent with Hospital policy, the attending practitioner is primarily responsible for requesting a consultation when indicated and for calling in a qualified consultant through the entry of a valid order and a record of the practitioner to consultant communication. The practitioner to consultant communication and the medical record shall indicate the reason(s) for the request and its urgency.

c. Each consultation report shall contain a written or dictated opinion by the consultant that reflects an actual examination of the patient and review of the patient’s medical record(s). The report shall be made a part of the current medical record.

d. When the consultation report is dictated, a brief summary of the consultant’s impression and recommendations shall be entered in the patient’s medical record to permit ongoing care until the dictated consultation report is available.

6. Electroconvulsive Therapy: Electroconvulsive Therapy is not performed at Bradley Hospital.

VII. GENERAL RULES REGARDING EMERGENCY SERVICES

1. Consistent with local, state and federal requirement the following suspected abuses must be reported immediately:

   a. If a physician suspects that a child has been abused or neglected an immediate verbal report must be made to the Department of Children, Youth and Families.

   b. Suspected abuse of anyone sixty (60) or older must be reported to the Department of Elderly Affairs.

   c. Suspected abuse of any resident of a long term residential care facility, regardless of age, must be reported to the Department of Health.

2. Responsibility of on-call Physicians to respond to consultation requests from the Emergency Department:

   a. Physicians are expected to respond by telephone to pages from the Emergency Department as soon as possible and no later than thirty (30) minutes. Physicians who for legitimate reasons cannot respond at that time must designate a proxy individual to respond.

   b. Physicians who are on-call are expected to stay within a reasonable proximity to the Hospital such that they can be physically present within thirty (30) minutes after responding to a page. See Hospital Policies for on call details for the Emergency Department.

   c. Physicians who request other physicians to assume all or part of their scheduled on-call responsibilities must be certain that the physician has comparable privileges at the Hospital.

   d. Physicians are expected to respond regardless of a patient's financial class or insurance
3. Withholding Resuscitation Services: Bradley Hospital will resuscitate all patients. Patients who require emergency care will receive care through the Emergency Response System, and will be transported via rescue squad to Hasbro Children’s Hospital.

4. Emergency Preparedness: The Medical Staff will support and fully participate in the Hospital’s Emergency Preparedness Plan as delineated in said Plan.

VIII. MISCELLANEOUS

1. Medical Staff Dues and Application Fees: The Medical Executive Committee will determine the annual dues and fees as required during the routine course of Medical Executive Committee business and these will be retained in the associated Credentials Manual.

2. Podiatry: The Chief Medical Officer shall promulgate from time to time as necessary Rules and Regulations pertaining to the practice of Podiatry in the Hospital.

IX. COMMITTEES

1. Bylaws, Rules and Regulations Committee:
   a. The Bylaws, Rules and Regulations Committee shall receive from the Medical Executive Committee all proposed new bylaws, rules, regulations and amendments to existing rules for the purpose of considering, developing and revising the existing bylaws, rules and regulations. It shall maintain an up-to-date copy of all bylaws, rules and regulations in force.
   b. All proposals for new or amended rules and regulations or amendments presented to the Medical Executive Committee shall be transmitted to the Chairman of the Bylaws, Rules and Regulations Committee for the implementation of its duty as set forth in the preceding paragraph.
   c. The Committee shall consist of no less than two (2) physicians appointed by the Medical Executive Committee.

The Committee shall meet as required. The Committee shall meet at least once a year; it shall carefully review the Bylaws, Rules and Regulations and submit a report in writing to the Executive Committee through the President of the Medical Staff of any needed changes.

The members of this Committee shall be the designated members from Bradley Hospital appointed to the System-wide Bylaws Review Committee (“SBRC”) pursuant to that Committee’s composition as outlined in Article IX, Amendments, in the Medical Staff Bylaws.

2. Quality Council (QC): This Committee provides oversight to the Hospital’s quality programs including review of indicators, and quality improvement teams. The CQC assures accountability for the quality programs, monitors departmental and divisional quality programs and indicators, and sets the goals to assure that the Hospital strives to be in the top decile in all measures.

3. Infection Control Committee:
a. The Committee shall work to ensure an acceptably low level of infectious hazard for patients and Hospital personnel through the design, administration, and regular review of a program of infection control.

b. The Committee shall include representative members which should include but not be limited to from the following departments: Pediatrics, Nursing, and Hospital Administration.

c. The Committee shall meet at least quarterly. The Committee reports to the Medical Executive Committee.

4. Medical Records Committee: The Committee sets policy and manages the accountability of the Medical Staff for the medical records of Hospital patients and works with the Health Information Services to insure the integrity of the Medical Record and compliance with policy. The Committee shall meet at least quarterly and more frequently as necessary. The Committee reports to the Medical Executive Committee.

5. Risk Management Committee (RMC): The Committee provides oversight for the Hospital’s safety programs and issues pertaining to the culture of safety, as well as for the Hospital indicators that relate to the safety agenda and their monitoring.

6. Pharmacy & Therapeutics Committee:

   a. The Committee shall be responsible for development and implementation of standards and policies for the medication management process including but not limited to prescribing, dispensing, administering, monitoring, and information exchange.

   b. The Committee shall recommend the adoption or assist in the formulation of professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to medications.

   c. The Committee shall review and recommend or assist in the formulation of new programs and services proposed by the Director of Pharmacy Services, other Hospital personnel or physicians. The Committee shall govern the admission of new drugs to the Hospital Formulary.

   d. The Committee shall meet quarterly. The Committee shall report to the Medical Executive Committee.

7. Physician’s Health Committee:

   a. The Committee shall identify and assist staff members suffering from any illness that may impair a practitioner’s ability to practice within the scope of their privileges; accept referrals in those cases where impaired performance is suspected to be related to a health problem. This in no way will supersede the CMO’s authority and responsibility to suspend privileges in the best interest of patient care; refer practitioners who are identified to have an impairment to the Rhode Island Medical Society's Physician’s Health Committee and other professional review boards as might be applicable for intervention; or monitor the impaired practitioner’s progress.
b. The Committee shall consist of three (3) members of the Medical Staff appointed by the President of the Hospital Medical Staff. If possible, at least one member of the Committee shall also be a member of the Rhode Island Medical Society's Physician’s Health Committee.

c. The Committee shall meet on an as needed basis. The Committee shall report to the Hospital President, President of the Medical Staff, and CMO as necessary.

8. General Applicability to All Committees:

a. The committees will submit minutes to the Medical Executive Committee after each meeting.

b. The committee Chairmanship and membership shall be reviewed by the President of the Medical Executive Committee and the Medical Executive Committee with final recommendations to the Medical Executive Committee at least on an annual basis.

c. The charters, agendas, and membership will be reviewed annually by the committee chairperson and designated membership and reported to the Medical Executive Committee President.

d. Additional Medical Executive Committee committees may be developed during the regular course of business of the Medical Executive Committee as required by the needs of the Medical Executive Committee, Medical Staff, or regulatory requirement (TJC, State or Federal regulations, CMS Conditions of Participation).