MEDICAL STAFF

OFFICERS

&

ORGANIZATION

MANUAL

McLaren
BAY REGION
Medical Staff Services

OFFICERS AND ORGANIZATION OF THE MEDICAL STAFF

TABLE OF CONTENTS

PART III. MEDICAL STAFF COMMITTEES

PART IV. ASSIGNMENT OF FUNCTIONS

PART V. MEETING PROCEDURES

PART VI. AMENDMENT

PART VII. CONCERNS AND CONFLICTS

PART VIII. ADOPTION

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OFFICERS AND ORGANIZATION OF THE MEDICAL STAFF

DEFINITIONS

The following definitions apply to the provision of this officers and organization manual.

1. PROFESSIONAL AFFAIRS COMMITTEE means the Professional Affairs Committee of the Board.

2. EX OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

3. BIMONTHLY means every other month.

4. MAJORITY VOTE means more than one-half of the votes cast by persons legally entitled to vote, excluding blanks in the case of written ballots and abstentions, at any properly called meeting, regular or special, at which a quorum is present. If one-half of the votes cast results in a whole number and a fraction, then the whole number and fraction shall be rounded off to the next higher whole number which shall constitute the required majority of the votes cast.

PART I. RESPONSIBILITIES AND AUTHORITY OF OFFICERS

1.1 RESPONSIBILITIES AND AUTHORITY OF THE CHIEF OF STAFF
As the primary medical staff officer, the chief administrative office of the Staff and the Staff's representative in its relationships to others, the Chief of Staff has these responsibilities and authority:

1.1-1 AS STAFF'S REPRESENTATIVE TO OTHERS

(a) Transmit to the Board or the appropriate committee of the corporation and to the President the views and recommendations of the Medical Staff and the Medical Executive Committee (MEC) on matters of hospital policy, planning, operations, governance, and relationships with external agencies, and transmit the views and decisions of the hospital's Board and President to the MEC and the Medical Staff membership.

(b) Communicate and represent the opinions and concerns of the Medical Staff and its individual matters affecting hospital operations to the Board and the President.

(c) Oversee compliance on the part of the Medical Staff with the procedural safeguards and rights of individual Staff members in all stages of the hospital's credentialing process.

1.1-2 AS THE CHIEF ADMINISTRATIVE OFFICER

(a) Direct the efficient operation and organization of the administrative policy-making and representative aspects of the Medical Staff organization, assist the President in coordinating these with Administration, Nursing, support and other personnel and services, enforce compliance with the provisions of the bylaws, rules, regulations, policies and procedures of the Staff and the hospital related to these matters and with regulatory and accrediting agencies' requirements, and periodically evaluate the effectiveness of the organization.

(b) Preside at, and be responsible for the agenda of, all general and special meetings of the Medical Staff and of the MEC.

(c) Unless otherwise provided in the hospital or Staff Bylaws or this manual, appoint Medical Staff members to, and the chairmen of, staff committees formed to accomplish Staff administrative, environmental or representation functions, and serve as chairman of the MEC, as an ex-officio member without vote of all standing Staff committees, and as a voting member of the Board.

(d) Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the Medical Staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves. In the absence of another practitioner serving as the Chief Quality Management and Clinical Officer (e.g., a Medical

Director), the Chief of Staff also has the following responsibilities and authority:

(e) The Chief of Staff shall have the authority to appoint an interim chairman of any department which has no chairman or vice chairman for any reason. Such interim chairman shall serve until a successor is elected at the next regular meeting of that department, at which time, both a chairman and vice chairman will be elected.

1.1-3 AS CHIEF QUALITY OFFICER

(a) Direct the development, implementation and day-to-day functioning and organization of the Medical Staff components of the Performance Improvement Plan, and assure that they are clinically and professionally sound and accomplishing their objectives and are in compliance with regulatory and accrediting agencies' requirements.

(b) Unless otherwise provided in the hospital or staff bylaws or this manual, appoint Medical Staff members to, and the chairmen of, committees formed to accomplish Staff quality management/peer review, monitoring, education or research functions, and serve as an ex officio member of the Medical Executive Committee and of the Board and as an ex officio member of the Professional Functions Committee.

(c) Advise the Professional Affairs Committee (PAC), President, MEC and other relevant Staff and hospital individuals and groups on the functioning of the Performance Improvement program.

(d) Consult with, and report in writing to, the PAC on the findings and results of Quality Management/Peer Review activities, provide written recommendations for actions that are required, and together with the President assure that the decisions of the PAC and the Board are carried out within the hospital and the Medical Staff.

1.1-4 AS THE CHIEF CLINICAL OFFICER

(a) Supervise the clinical organization of the Staff, coordinate the delivery of services among the clinical services, and assist the President in coordinating activities of Administration, Nursing, support and other personnel and services with Medical Staff clinical units.

(b) Advise the Board, the PAC, the President and the MEC on matters impacting on patient care and clinical service including the need for new or modified programs and services, for recruitment and training of professional and support staff personnel, for staffing patterns and for research.

1.2 RESPONSIBILITIES AND AUTHORITY OF THE VICE CHIEF OF STAFF
As the second ranking Medical Staff Officer, the Vice Chief of Staff has these responsibilities and authority:

(a) Assume all of the duties and responsibilities and exercise all of the authority of the Chief of Staff when the latter is unable, temporarily or permanently, to accomplish the same by reason of illness, absence, other incapacity or unavailability, or refusal.

(b) Serve as an ex officio member of the Medical Executive Committee (MEC).

(c) Perform such additional duties as may be assigned by the Chief of Staff, the MEC or the Board.

1.3 RESPONSIBILITIES AND AUTHORITY OF THE IMMEDIATE PAST CHIEF OF STAFF

The immediate Past Chief of Staff has these responsibilities and authority:

(a) Serve as an ex officio member of the MEC and as an advisor to the Chief of Staff and other officials and committees of the Staff.

(b) Perform such additional duties as may be assigned by the Chief of Staff, the MEC or the Board.

1.4 RESPONSIBILITIES AND AUTHORITY OF THE SECRETARY-TREASURER

The Secretary-Treasurer has these responsibilities and authority:

(a) Serve as an ex officio member of the MEC.

(b) Record and report on meetings of the Medical Staff and of the MEC.

(c) Give proper notice of all Staff meetings on order of the appropriate authority.

(d) Supervise the collection and accounting for any funds that may be collected in the form of Staff dues, assessments, or application fees or otherwise.

(e) Prepare at least an Annual financial report for transmittal to the Staff at its Annual meeting and to the Board and the President, and any other interim reports that may be requested by the Chief of Staff or the President.

(f) Perform such additional duties as may be assigned by the Chief of Staff, the MEC or the Board.

1.5 RESPONSIBILITIES AND AUTHORITY OF DEPARTMENT CHAIRMEN

In assuring the accomplishment of the functions of the departments as provided in the Medical Staff Bylaws and in meeting his responsibility for all professional and administrative activities within the department, a department chairman has these specific responsibilities and authority:

(a) All clinically related activities of the department;

(b) All administratively related activities of the department, unless otherwise provided for by the hospital;

(c) Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;

(d) Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;

(e) Recommending clinical privileges for each member of the department;

(f) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department or the organization.

(g) the integration of the department or service into the primary functions of the organization;

(h) the coordination and integration of interdepartmental and intradepartmental services;

(i) the development and implementation of policies and procedures that guide and support the provision of services;

(j) the recommendations for a sufficient number of qualified and competent persons to provide care or service;

(k) the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care services;

(l) the continuous assessment and improvement of the quality of care and services provided;

(m) the maintenance of quality control programs, as appropriate;

(n) the orientation and continuing education of all persons in the department or service; and

(o) recommendations for space and other resources needed by the department or service.

(p) Communicate and implement within the department actions taken by the Medical Executive Committee (MEC), the Professional Affairs Committee (PAC) and the Board.

(q) He, or his designee, shall serve on the MEC as representative of his department and make specific recommendations and suggestions regarding his department to the MEC, hospital management and the Board.

(r) Enforce the hospital and Medical Staff bylaws, rules, policies, procedures, and regulations within the department, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or sought when necessary.

1.6 MEDICO-ADMINISTRATIVE OFFICERS

1.6-1 DEFINED

A medico-administrative officer is a practitioner engaged by the hospital, either full or part-time, in an administratively responsible capacity, whose activities also include clinical responsibilities, such as direct patient care or supervision of the patient care activities of other practitioners under the officer's direction.

1.6-2 STAFF MEMBERSHIP, CLINICAL PRIVILEGES AND MEMBERSHIP OBLIGATIONS

A medico-administrative officer must achieve and maintain Medical Staff membership and clinical privileges appropriate to his clinical responsibilities, and discharge Staff obligations appropriate to his Staff category, in the same manner applicable to all other Staff members.

1.6-3 EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN MEMBERSHIP STATUS OR CLINICAL PRIVILEGES

(a) The effect of the removal from his medico-administrative office on the officer's Staff membership status and clinical privileges, and the effect of an adverse change in an officer's Staff membership status or clinical privileges on continuance in his medico-administrative office, is governed solely by the terms of the contract between the officer and the hospital. An adverse change in membership status or clinical privileges as defined in the Medical Staff Bylaws that is not triggered by removal from a medico-administrative office entitles the officer to the procedural rights contained in the hospital's Fair Hearing Plan.

(b) In the absence of a contract or where the contract is silent on the matter, removal from office alone will have no effect on membership status or clinical privileges, except the removed officer may not thereafter exercise clinical privileges for which exclusive contractual arrangements have been made; continuance in office following loss of membership is impermissible under Section 1.6-2; and the effect of an adverse change in clinical privileges on continuance in office will be as determined by the Board after soliciting and considering the recommendations of the Staff.

(c) Unless the contract provides otherwise, a practitioner who believes that his removal from a medico-administrative office has, or will have, an adverse effect on his exercise of clinical privileges in any of the respects specified in the Medical Staff Bylaws is entitled to the procedural rights contained in the hospital's Fair Hearing Plan.

PART II. FUNCTIONS OF THE STAFF

2.1 GENERALLY

The required functions of the Medical Staff are as specified in Article Ten of the Medical Staff Bylaws and as more fully described in Section 2.2 below. Part IV of this manual lists the Staff official or component responsible for each of the activities to be carried out in accomplishing a function.

2.2 DESCRIPTION OF FUNCTIONS

2.2-1 GOVERNANCE, DIRECTION, COORDINATION AND ACTION (EXECUTIVE)

(a) Receive, coordinate and act upon the written reports and recommendations from departments, committees, other assigned activity groups and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities.

(b) Coordinate the activities of, and policies adopted by, the Staff, departments, other clinical units and committees.

(c) Account to the Board and to the Staff by written reports for the overall quality and efficiency of patient care in the hospital.

(d) Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Staff members, including initiating investigations and initiating and pursuing corrective action, when warranted.

(e) Make recommendations on medico-administrative and hospital management matters.

(f) Inform the Medical Staff of the accreditation program and the accreditation status of the hospital.

(g) Represent and act on behalf of the Staff, subject to such limitations as may be imposed by the Staff.

(h) Meet at least quarterly with a permanent record kept of the proceedings and actions.

(i) Prepare at least a quarterly written summary report of its discussions and actions for the Staff, the Board and the Administration.

(i) Communicate with the Quality Council through the Medical Executive Committee

2.2-2 QUALITY MANAGEMENT/PEER REVIEW PROGRAM

(a) Adopt and modify, subject to the approval of the Medical Executive Committee and the Professional Affairs Committee, and supervise the conduct of specific programs and procedures for assessing and improving the effectiveness and efficiency of medical care provided in the hospital and participate in quality management/peer review activities of the Medical Staff.

(b) Implement the programs and procedures required under (a).

(c) Formulate recommendations for action to correct identified problems.

(d) Act upon recommendations to correct problems.

(e) Follow-up on action taken.

(f) Coordinate the Staff's Quality Management activities with those of other health care disciplines.

(g) Send written reports to the next higher authority in the organizational structure on the results and progress of the Quality Management activities.

(h) Participate in ongoing evaluation of the overall Quality Management Program for its comprehensiveness, integration, effectiveness and cost efficiency.

2.2-3 MONITORING ACTIVITIES

(a) Adopt, modify, supervise and coordinate the conduct and findings of the patient care monitoring activities.

(b) Conduct monthly review of mortalities, including analysis of autopsy reports when available.

(c) Conduct monthly surgical case review, including tissue review, evaluation and comparison of preoperative and postoperative diagnosis, indications for surgery, actual diagnosis of tissue removed, and situations in which no tissue was removed.

(d) Conduct blood utilization studies at least quarterly, including comparisons of the use of whole blood versus blood components, review of each actual or suspected transfusion reaction, and review of the amount of blood requested, the amount used and the amount of wastage.

(e) Review and evaluate the clinical (prophylactic and therapeutic) use of antibiotics in the hospital on at least a quarterly basis.

(f) Review on a continuous basis and enforce or coordinate compliance with consultation requirements and other established policies and protocols relating to clinical practice in the hospital.

(g) Those responsible for conducting any of these monitoring activities shall submit written reports of results and progress as required by the frequency of the activity to the Quality Council, to the Chief of Staff, to any other Staff organizational entity or official with an official interest in the activity, and to the PAC.

2.2-4 UTILIZATION REVIEW

(a) Develop a Utilization Review Plan for approval by the Medical Staff, hospital Administration and the Board. The plan must apply to all patients regardless of payment source, outline the confidentiality and conflict of interest policy, and include provision for at least: (1) review of the appropriateness and medical necessity of admissions, continued hospital stays and supportive services; (2) discharge planning; (3) data collection and reporting; (4) use of written, objective, measurable criteria in conducting the reviews.

(b) Review and monitor that the Utilization Review Plan is in effect, known to Staff members and functioning at all times.

(c) Prepare written evaluations of the Utilization Review activities on a continuous basis, including a determination of their effectiveness in allocating resources.

(d) Conduct studies, take actions, submit reports and make recommendations as required by the Utilization Review Plan.

(e) Submit reports to the MEC and to the PAC of specific recommendations resulting from, the program.

2.2-5 SPECIAL STUDIES

(a) Participate in any special studies of the inputs, processes or outcomes of care that may be required to determine the appropriateness of practitioner performance in the hospital.

2.2-6 SPECIAL HOSPITAL SERVICES REVIEW

(a) Implement mechanisms to monitor and evaluate the care provided in or by the medical-surgical intensive care units, the operating and recovery rooms, emergency room, and hospital patient care support (diagnostic and therapeutic) services.

(b) Develop and coordinate, or participate in developing and coordinating, and enforce clinical policies and procedures for those same areas and services.

(c) Submit reports on results and progress to the MEC and to any other Staff or hospital organizational entity or official with an official interest in the activity, and to the PAC.

2.2-7 CREDENTIALS REVIEW

(a) Review, evaluate and transmit written reports as required by the Medical Staff Bylaws and Credentialing Procedures Manual on the qualifications of each applicant or member for appointment, provisional period conclusion or

extension, reappointment, or modification of appointment and for clinical privileges, and of each allied health professional for the performance of specified services.

(b) Initiate, investigate, review and report on corrective action matters and on any other matters involving the clinical, ethical or professional conduct of any practitioner assigned or referred by: (1) the Chief of Staff (2) the MEC (3) those responsible for the functions described in Sections 2.2-2, 2.2-3, 2.2-4, 2.2-5, 2.2-6, 2.2-8, 2.2-9 and 2.2-10; (4) the PAC or (5) the Board.

(c) Submit written reports every two months to the MEC and the PAC on the status of pending applications or other credentials matters, including the specific reasons for any inordinate delay in their processing.

(d) Maintain a credentials file for each member of the Staff, including records of participation in Staff activities and results of Quality Management/Peer Review activities.

2.2-8 EDUCATION AND RESEARCH

(a) Participate in implementation and evaluation of programs of, and requirements for, continuing education that are relevant to the type and scope of patient care services delivered in the hospital, designed to keep the Medical Staff informed of significant new developments and new skills in medicine, and responsive to Quality Management findings.

(b) Participate in supervision and evaluation of research projects and clinical investigations.

(c) Participate in supervision of the hospital's medical library services.

(d) Maintain a written record of education activities and participation in them.

2.2-9 MEDICAL RECORDS

(a) Develop a medical record review program for the review, approval and adoption by the Medical Center's Board of Directors, Medical Staff, and Administration. Review and evaluate medical records to determine that they: (1) properly describe the condition and progress of the patient, the therapy and tests provided, the results thereof, and the identification of responsibility for all actions taken; and (2) are sufficiently complete, are legible and adequate as a medico-legal document, at all times so as to facilitate continuity of care and communications between all those providing patient care services in the hospital.

(b) Develop, review, enforce and maintain surveillance over enforcement of Staff and hospital policies, rules and regulations relating to medical records, including

medical records completion, preparation, forms, formats, filing, indexing, storage, destruction and availability and recommend methods of enforcement thereof and changes therein.

(c) Provide liaison with hospital Administration, Nursing Service and Medical Records professionals in the employ of the hospital on matters relating to medical records practices.

2.2-10 PHARMACY AND THERAPEUTICS

(a) Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital.

(b) Advise the Medical Staff and the hospital's Pharmaceutical Department on matters pertaining to the choice of available drugs.

(c) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

(d) Develop and review periodically a formulary for use in the hospital, prescribe the necessary operating rules and regulations for its use, and assure that said rules and regulations are available to, and observed by, all Staff members.

(e) Review all unexpected drug reactions.

(f) Evaluate clinical data concerning new drugs or preparations requested for use in the hospital.

(g) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(h) Coordinate action on findings from the Medical Staff’s review of the clinical use of antibiotics.

(i) Conduct on a periodic basis statistical/prevalence studies of antibiotic usage and susceptibility/resistance trend studies.

2.2-11 INFECTION CONTROL

When indicated, work with infection control and the Infection Control Committee to develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.

2.2-12 DISASTER-PREPAREDNESS

(a) Assist in developing and periodically reviewing, in cooperation with the hospital Administration, a written plan that is designed to safeguard patients at the time of disaster.

(b) Assist in developing and periodically reviewing, in cooperation with the hospital Administration, a written plan for the care, reception and evacuation of mass casualties that is coordinated with the inpatient and outpatient services of the hospital, that adequately relates to other available resources in the community and coordinates the hospital's role with other agencies in the event of disasters in the hospital's or nearby communities, and that is rehearsed by all personnel involved at least twice yearly.

2.2-13 PLANNING

(a) Participate in evaluating on an annual basis 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 assess the relative priorities of services and needs and allocation of present and future resources.

2.2-14 BYLAWS REVIEW AND REVISION

(a) Conduct a review for possible revision at least every two (2) years of the bylaws and rules, regulations, procedure manuals, and forms promulgated in connection with them.

(b) Conduct a review for possible revision at least every two (2) years of the clinical policies, rules and regulations.

(c) Submit written recommendations to the MEC and to the PAC regarding revision of any documents mentioned in this Section 2.2-14.

2.2-15 NOMINATING

(a) Identify nominees for election to general Staff offices or to other elected positions in the Staff organizational structure.

(b) In accomplishing (a), consult with members of the Staff or of the appropriate constituent group and the Administration concerning the qualifications and acceptability of prospective nominees.

2.2-16 RISK REVIEW

(a) Participate in planning for management of risk factors, recognizing that certain activities can prevent the occurrence of accidents in the hospital.

(b) Participate in performance improvement activities related to prevention and/or management of incidents that occur in the hospital.

PART III.

3.1 DESIGNATION

To accomplish the functions of the Medical Staff as described in Part II of the Officers and Organization Manual, the committee structure is segregated into (1) Medical Staff Committees (2) Medical Staff-Institutional Committees and (3) Liaison Committees.

3.1-1 MEDICAL STAFF COMMITTEES

The following committees are designated Medical Staff Committees and as such, only Medical Staff members are accorded voting prerogatives as designated by their Staff category.

Committee	Reports to
Medical Executive	Medical Staff and Board
Professional Functions (includes the bylaws, credentialing and nominating functions of existing or future standing and ad hoc committees)	MEC
Practitioner Excellence	MEC
Professional Relations	MEC
Critical Care	MEC
Medical Education & Training	MEC
Pharmacy & Therapeutics	MEC
Surgical Services	MEC
Patient Blood Management Committee	MEC
Utilization & Record Management	MEC

Quality monitoring and quality improvement functions shall also be reported to the Quality Council.

3.1-2 MEDICAL STAFF-INSTITUTIONAL COMMITTEES

(a) The following committees are designated Medical Staff-Institutional committees with voting prerogatives determined by the functions and purposes of the committee as described in this section or as established at the time the committee is formed.

(b) All committees shall report their recommendations or policy decisions using quality monitoring techniques and shall report as needed to the Medical Executive Committee and the Quality Council.

Committees

Infection Control

Voting prerogatives are described in the appropriate committee description in this Manual and are not necessarily restricted to Medical Staff members.

3.1-3 LIAISON COMMITTEES

The primary function of the Joint Conference Committee is to establish and maintain understanding, communications, and effective working relationships among the Medical Staff, Board and Administration:

Committees	Reports to
Joint Conference	Boards and Medical Staff

3.2 MEDICAL EXECUTIVE COMMITTEE

The purpose and composition of the Medical Executive Committee (MEC) are as set forth in the Medical Staff Bylaws, Article 10.3. Its governance, direction, coordination and action functions are as described in Section 2.2-1 of this manual.

3.3 CRITICAL CARE COMMITTEE

3.3-1 PURPOSE AND MEETINGS

The Critical Care Committee has the following responsibilities:

(a) Develop, monitor and implement patient care policies, procedures, and practices in the intensive care, coronary care, and neurointensive care units.

(b) Develop, monitor and implement patient care policies, procedures, and practices relating to Code Blue. Review Code Blue calls and recommend improvements when indicated.

(c) Appoint qualified physician supervisors/directors for special care units, subject to approval by the MEC, who shall be responsible for the day-to-day medical direction of the unit including:

- coordination of the units with other patient services;
- assistance in evaluating new or replacement equipment in the units.

(d) Develop criteria for ICU/CCU/NICU admission, discharge, and triage; transfer and discharge in the event of conflicts and when the unit is at patient capacity; triage in general.

(e) Monitor and evaluate patient care rendered in the unit and recommend changes based upon established criteria.

(f) Assure that the quality, safety and appropriateness of patient care services provided within the unit are reviewed and evaluated on a regular basis, and that appropriate action is taken based on the findings.

(g) May recommend criteria for critical care privileges to the appropriate medical staff department.

Decisions, policies and procedures are recommended to the MEC, Administration, and the Board. For those changes recommended by the committee that affect other services, the committee must seek consultation and agreement from those affected services prior to implementing the change.

The committee shall meet as often as is necessary, but not less than quarterly and shall report to the Medical Executive Committee and to the Quality Council regarding its monitoring functions.

3.3-2 COMPOSITION AND VOTING

The Critical Care Committee shall be composed of the following:

(a) Active/Emeritus Medical Staff members representing General Internal Medicine, Pulmonary Medicine/Intensivist, General Surgery, Anesthesiology, Cardiology, Cardiothoracic Surgery, Neurosurgery, Neurology, Family Practice and Emergency Services, Infectious Diseases, the Trauma Medical Director and;

(b) ICU nurse manager, staff nurse, and a representative from pharmacy, dietary, respiratory care, enterostomal therapy, quality management, infection control, Director of Patient Care Services and Chief Medical Officer.

The Chief of Staff shall appoint the Active/Emeritus Medical Staff members. This committee shall elect a chairman and vice-chairman by majority vote. All Medical Staff members shall have the right to vote, unless otherwise specified; provided, the chairman shall only vote in cases where the vote of the Chair will affect the result. Members who are not Medical Staff will serve as ex-officio without vote. A quorum shall consist of voting members present. Decisions of this committee shall be made by a majority vote.

3.4 INFECTION CONTROL COMMITTEE

3.4-1 PURPOSE AND MEETINGS

The Infection Control Committee is responsible for the development, implementation, monitoring, recommending improvements in and following up on recommendations relating to the Infection Control Program. The objective of the program is to develop effective measures to prevent, identify and control infections from any source that might be a hazard to patients, personnel, and visitors. While the Infection Control Program is primarily a hospital wide multidisciplinary committee, the role of the Medical Staff is to provide direction and to strengthen the clinical aspects of the program. The Infection Control Committee has the authority, through its physician members, to institute any appropriate control measures or studies when it is reasonably considered to be a danger to any patient, personnel, or visitor.

The Infection Control Committee shall determine the type of surveillance and reporting programs to be used; provide standard criteria for reporting all types of infections; review and make recommendations concerning policies and procedures relating to infection control; assure that the program meets licensing and accreditation agency standards; review and monitor the results of surveillance and reporting mechanisms and initiate corrective actions for breach of policies relating to the Infection Control Program.

The committee shall meet quarterly or more often if necessary upon the call of the chairman. This committee reports as provided in Section 3.1-2.

3.4-2 COMPOSITION AND VOTING

The Infection Control Committee shall be composed of Medical Staff members who have knowledge of, or experience in, infection control, representing the Departments of Surgery, and Medicine; a Pathologist and an Infectious Disease physician. Other members of this Committee shall be composed of hospital members representing Hospital Administration, Nursing Administration, Pharmacy, Bacteriology, Occupational Health Supervisor, Nursing Director of Surgical Services, OB/Women's Health, Nurse Manager of Operating Room, Manager of Sterile Processing, Manager of Environmental Services, Director of Quality & Resource Management, the Infection Preventionist(s); and, a staff nurse knowledgeable regarding quality issues appointed to serve as liaison between the Infection Control Committee and the nursing staff.

Ex-officio members from other departments will be invited to meetings when appropriate. The chairman shall be appointed by the Chief of Staff. The chairman shall appoint a vice chairman. The chairman shall be an individual whose credentials include knowledge of, or experience in, infection control. Such credentials must be documented. All medical staff members of this committee shall have the right to vote. Other members of this committee with a right to vote include the Infection Preventionist(s) and a Pharmacist. The chairman shall only vote in cases where the vote of the Chair will affect the result. A quorum shall consist of voting members present. Decisions of this committee shall be made by a majority vote.

3.5 JOINT CONFERENCE COMMITTEE

3.5-1 FUNCTIONS

The functions of the Joint Conference Committee are to:

(a) conduct itself as a forum for the discussion of matters of administrative and medical policies and procedures requiring agreement among the Board, Medical Staff and Administration;

(b) perform such other duties as assigned by the Chief of Staff or the Chairman of the Board of Directors.

3.5-2 COMPOSITION AND VOTING

The Joint Conference Committee shall be composed of sixteen (16) members. Eight (8) members shall be members of the Governing Body and eight members shall be active members of

the Medical Staff. The Governing Body shall be represented by the chairman and at least two other officers of the Board of Directors, the President and four other members of the Board of Directors. The Medical Staff shall be represented by the Chief of Staff, the Vice Chief of Staff, and the immediate Past Chief of Staff, Secretary-Treasurer of the Staff and four other members of the Medical Executive Committee of the Medical Staff.

The committee may extend its membership to include ex-officio members. The Chief of the Medical Staff and the Chairman of the Board of Directors shall function as co-chairmen of this committee with the Chief of the Medical Staff acting as the presiding officer. In the absence of the Chief of Staff, the Chairman of the Board of Directors shall serve as the presiding officer. In the absence of both the Chief of Staff and the Chairman of the Board of Directors, the committee shall select a chairman pro-tem. All members shall have the right to vote, except ex-officio members, who shall **not** have the right to vote. The co-chairmen shall only vote in cases where the vote of the co-chairmen will affect the result. A quorum shall consist of at least nine (9) voting members. Decisions of this committee shall be made by a majority vote.

3.5-3 MEETINGS

Meetings of the Joint Conference Committee shall be held as needed if requested by the President, the Chief of Staff or the Chairman of the Governing Body.

3.6 GRADUATE MEDICAL EDUCATION COMMITTEE

The Graduate Medical Education Committee shall be a standing committee whose general purpose is to supervise the training of externs, interns, and residents in the hospital.

3.6-1 SPECIFIC PURPOSE AND MEETINGS

To formulate and maintain guidelines for externs, interns, and residents training in the hospital, including guidelines for all medical documents utilized by trainees during their training period.

Guidelines for medical documents shall include a description of the particular medical documents, the requirements for signatures and co-signatures, and definition of time frames.

This committee shall meet at least monthly and shall report to the Medical Executive Committee.

3.6-2 COMPOSITION AND VOTING

The Graduate Medical Education Committee shall consist of twelve (12) physician members with at least one representative from Family Practice, Internal Medicine, Surgery, Pediatrics, Obstetrics & Gynecology, and Anesthesiology. All physician members of this committee shall have the right to vote. The Director of Medical Education and the Vice President of Medical Affairs shall serve as ex-officio members without vote. The Chief of Staff shall appoint members of this committee for a term of (1) year. The committee, by majority vote, shall vote for a chairman. The chairman shall appoint a vice-chairman. The chairman shall only vote in cases where

the vote of the chair will affect the result. A quorum shall consist of voting members present. Decisions of this committee shall be made by a majority vote.

3.7 PHARMACY AND THERAPEUTICS COMMITTEE

3.7-1 PURPOSE AND MEETINGS

The Pharmacy and Therapeutics Committee fulfills the Staff functions of antibiotic and other drug use reviews, drug utilization policies and practices, including establishing criteria for the prophylactic and therapeutic use of antibiotics based upon documented studies; maintains a current hospital formulary; and monitors drug policies and practices for compliance with licensing, accreditation, and regulatory agencies. It shall establish policies, procedures, and practices in conjunction and cooperation with Administration and monitor the operation of the poison control functions and the nutritional support program of the hospital. The committee meets as often as necessary but not less than quarterly. It reports as provided in Section 3.1-1.

Decisions, policies and procedures, and physician standing orders enacted by this committee may be implemented but are subject to ratification by the Medical Staff Executive Committee and the Professional Affairs Committee of the Board. For those changes recommended by the committee that affect other services, the committee must seek consultation and agreement from those affected services prior to implementing the change.

3.7-2 COMPOSITION AND VOTING

The Pharmacy and Therapeutics Committee is composed of ten (10) Active/Emeritus Medical Staff representatives of various clinical services, the Administrative Director of Nursing or designee, the Administrative Director of Professional Services or designee, the chief pharmacist and ad hoc representatives as needed. The Chief of Staff shall appoint the ten (10) Active Medical Staff members and shall appoint one of those ten to serve as chairman of the committee. Ad hoc members may be appointed as needed by the chairman. All Medical Staff members of this committee shall have the right to vote; provided, the chairman shall only vote in cases where the vote of the Chair will affect the result. To inform the organization of potential or real conflicts that could occur as a result of members' business or personal relationships, all physicians appointed to the Pharmacy and Therapeutics Committee must complete and sign a conflict of interest (COI) statement on an annual basis. The COI statement will be maintained as a document in the physician's credentials file in the Medical Staff Office. A quorum shall consist of voting members present. Decisions of this committee shall be made by a majority.

3.8 PRACTITIONER EXCELLENCE COMMITTEE

3.8-1 PURPOSE AND MEETINGS

To establish a centralized, multi-specialty approach for the Medical Staff to evaluate practitioner performance on an individual and aggregate level and help create a positive culture for peer review.

Scope

- The PEC will be responsible for measuring and evaluating all areas of practitioner competency for care provided at McLaren Bay Region and its facilities under the responsibilities of the Medical Staff unless otherwise indicated in this charter.
- Although the PEC will be a source of competency data, credentialing and privileging decisions are the responsibility of the department chairs, the Credentials Committees, the Professional Functions Committee and the MEC.
- Performance measurement and evaluation for hospital systems and processes are the responsibility of the appropriate hospital committee or department.

Responsibilities

The primary responsibilities of the PEC are:

1. Measurement System Management
2. Evaluation of Practitioner Performance
3. Improvement Opportunity Accountability
4. Oversight of Other Medical Staff Practitioner Performance Evaluation Committees including the Department Quality Committees (DQC)
5. Perform Case Review for those Departments electing not to do their own review and for those Departments not adequately fulfilling their responsibilities to do case review.

Meetings

The PEC will meet at least 10 times per year. A quorum for purposes of making final determinations or recommendations for individual case reviews or improvement opportunities based on aggregate data will require the presence of 50% of the voting PEC members at a regularly scheduled meeting. A majority will consist of a majority of voting PEC members present.

PEC members will be expected to attend at least two thirds of the scheduled PEC meetings over a twelve month period and perform assigned case reviews according to PEC policies to maintain membership. If a member fails to fulfill their responsibilities, they will be replaced by the process used for initial appointment to the PEC. PEC members will be expected to participate in appropriate educational programs provided by the Hospital or Medical Staff to increase their knowledge and skills in performing PEC responsibilities.

If a member of the medical staff who is not a PEC member is requested to perform a case review, it is that individual’s responsibility to perform that review in a timely manner according to PEC policies.

PEC Oversight

The PEC reports to the MEC. No changes can be made to the PEC charter and policies without MEC approval. The PEC Chair will provide a report to the MEC for each PEC meeting.

3.8-2 COMPOSITION AND VOTING

The PEC will be comprised of not less than ten voting members who are Active/Emeritus members of the medical staff with a balanced representation of the main specialties areas of the hospital. Practitioners from other specialties may be invited to the meeting as needed.

Current department chairs and voting MEC members are not eligible to be PEC members unless no one else is available and with the approval of the MEC.

Ex-Officio Members

The VPMA, the CNO, the director of Quality Management and the quality and medical staff support staff as determined by the Chair are ex-officio members of the PEC.

Appointment and Terms

The voting PEC members will be appointed by the Chief of Staff based on the recommendations from the department chairs and the PEC Chair and approved by the MEC.

Voting members will be appointed for a three year term except for initial committee members who will have staggered terms to initiate the process (i.e. 4 for 4 years), 3 for 2 years and 3 for 3 years).

Voting members may serve up to two consecutive terms and are eligible for reappointment to the committee after one year after their last term is completed. However, voting members may serve more than two consecutive terms with the approval of the MEC for each additional term.

The PEC Chair will be elected by the Committee from its current members based on majority vote and approved by the Chief of Staff. If no single member receives a majority of the votes, a run-off election will be held for the two members with the highest number of votes on the initial ballot.

To be eligible for appointment as Chair, the individual must be a current voting PEC member and have served as a voting PEC member at some point in time for at least one year. The Chair will serve for a term of one year and may have an unlimited number of consecutive terms as long as the chair is eligible to be PEC member. The PEC Chair will be an ex-officio member of the MEC without vote.

3.9 PROFESSIONAL FUNCTIONS COMMITTEE

3.9-1 PURPOSE AND MEETINGS

The Professional Functions Committee performs the following functions:

(a) Coordinates the Staff credentials functions by receiving and analyzing applications and recommendations for appointment, provisional period conclusion or extension, reappointment, clinical privileges, and changes therein, corrective action and recommending action thereon.

(b) Fulfills Staff responsibilities, via the Medical

Executive Committee, relating to revision of Medical Staff Bylaws and the accompanying procedure manuals and forms.

(c) Fulfills the responsibilities of preparing a slate of candidates for all elected officers, as described in Article 7.3, 7.4, 7.5, and 7.6 of these Bylaws, and committees not otherwise appointed by the Chief of Staff or designated in these Bylaws and manuals.

The Professional Functions Committee shall meet every two months or more frequently, as need requires, and is responsible to the Medical Executive Committee.

3.9-2 COMPOSITION AND VOTING

The Professional Functions Committee shall be composed of ten (10) voting members.

(1) The Vice Chief of Staff who shall serve as chairman

(2) The Secretary-Treasurer who shall serve as vice chairman

(3) Six (6) elected members of the Active/Emeritus Medical Staff, serving three (3) year staggered terms with two (2) members elected each year at the Quarterly Staff meeting prior to the Annual Medical Staff meeting

(4) The Chief of Staff

(5) The Immediate Past Chief of Staff

Initially, the members were elected by the Medical Staff for staggered terms; two for 3-year terms, two for 2-year terms, and two for a 1-year term.

The chairman shall vote only in cases where the vote of the Chair will affect the result. A quorum shall consist of fifty (50) percent of the qualified voting members. Decisions of this committee shall be made by a majority of the voting members present at the time of the vote.

3.10 PROFESSIONAL RELATIONS COMMITTEE

3.10-1 PURPOSE AND MEETINGS

The Medical Staff Professional Relations Committee will be a standing committee whose primary purpose is to maintain the highest possible reputation, integrity, fraternity and ethics of the Medical Staff. To this end, the Committee will review and attempt to resolve disputes among, and complaints against, members of the Medical Staff in their hospital activities and functions, and shall report its findings and make recommendations, when appropriate, to both the Professional Functions Committee and the Executive Committee of the Medical Staff. This review would include, but not necessarily be limited to, the following:

(1) disputes between individual members of the Medical Staff. These would include such diverse areas as complaints about fee schedules, interpersonal and professional relationships, physician impairment and personality conflicts.

(2) summary reports of complaints against Medical Staff members resolved by the Chief of Staff and/or Administrator.

(3) complaints against individual Staff members by hospital employees, patients, patients' families and insurers.

The committee shall meet as necessary at the request of the Board of Directors, the Medical Executive Committee or the Vice President of Medical Affairs.

3.10-2 COMPOSITION AND VOTING

The Professional Relations Committee shall be composed of six (6) members of the Active/Emeritus Medical Staff and four ex officio members, who shall be the Chief of Staff, the President, the Vice President for Medical Affairs, and the Chairman of the Professional Functions Committee or his designee. The chairman and vice chairman of this committee shall be elected by the committee members at the beginning of each Staff year. In case of the need for the Committee to meet in Executive session, the vice chairman will serve as recording secretary.

The six members of the Active/Emeritus Medical Staff shall be elected at the Quarterly Staff meeting prior to the Annual Medical Staff meeting. The elected members of this Committee shall serve three (3) year, staggered terms, with two (2) members elected each year. Initially, the members will be appointed by the Chief of Staff, two for three year terms, two for two year terms, and two for one year terms. Medical Staff members serving on the Hospital Board are not eligible for nomination to the Professional Relations Committee. The six elected members shall have the right to vote and the ex officio members shall **not** have the right to vote. The chairman shall vote only in cases where the vote of the Chair will affect the result. A quorum shall consist of voting members present. Decisions of this committee shall be made by a majority.

3.11 QUALITY COUNCIL

3.11-1 PURPOSE AND MEETINGS

The Quality Council shall:

(a) Report to the Board of Directors through the Professional Affairs Committee

(b) Communicate with the MEC

(c) Recommend priorities for organizational-wide improvement consistent with strategic initiatives

(d) Establish, schedule, and charter Performance Improvement Teams

(e) Coordinate the activities of Performance Improvement Teams

(f) Act as the committee to review sentinel events and to determine appropriate responses

(g) Submit a report to the Professional Affairs Committee at

least quarterly which contains an overview of Performance Improvement activities

(h) Refer Medical Staff peer review functions/concerns to the appropriate Medical Staff Department and/or the Medical Executive Committee

The Quality Council shall meet as often as necessary, but not less than quarterly. A quorum shall consist of fifty (50) percent of the voting members.

3.11-2 COMPOSITION AND VOTING

The Quality Council shall be composed of eleven (11) voting members and ex-officio members without vote. The Chairman of the Quality Council shall be a physician appointed by the Chief of Staff from among the voting members of the Quality Council.

(a) The following shall be voting members:

(1) The Vice Chief of Staff

(2) Two (2) members of McLaren Bay Region's Board of Directors

(3) Five (5) Physician members, broadly representing the Active/Emeritus Medical Staff, serving three (3) year staggered terms appointed by the Chief of Staff

(4) The Chief Financial Officer

(5) The Vice President of Patient Care Services

(6) President, McLaren Bay Region

(b) The following shall be ex-officio members, without vote:

(1) The Vice President of Medical Affairs

(2) The Chief of Staff

(3) The Director of Quality & Resource Management Services

(4) Director of Patient Care Services

(5) Director of Health Information Services

(c) The Quality Council may call upon any other person to attend its meetings for consultation and/or input as it may deem necessary or desirable from time to time.

3.11-3 RESPONSIBILITIES

The responsibilities of the Quality Council shall be to:

(a) Establish and monitor organizational priorities based on Strategic Plan goals and objectives

(b) Select key functions for organizational monitoring and evaluation

(c) identify the objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring and evaluation and improvement activities on a hospital-wide basis

(d) Ensure appropriate patient outcomes, service levels, productivity, and patient satisfaction through assessment of patient care and integration with the interdisciplinary teams.

(e) Utilize the basic principles and methodology of Continuous Quality Improvement

(f) Make recommendations based upon the findings of monitoring and evaluation to continuously improve patient outcomes and to incorporate their findings into strategic planning

(g) Identify Performance Improvement Teams as indicated

(h) Ensure that corrective actions have impact on Strategic Goals and Objectives.

(i) Determine time frames for trend analysis

(j) Ensure interaction between work groups

(k) Design, manage, and evaluate the mechanism for quality control indicators and facilitate flow of information throughout the organization

(l) Evaluate work group performance against identified performance expectations

(m) Identify measurable, reproducible indicators based on our values, that let the organization know that it is functioning in an appropriate, efficient, and effective manner (e.g. licensure, Joint Commission accreditation, patient satisfaction)

3.12 SURGICAL SERVICES COMMITTEE

3.12-1 PURPOSE, MEETINGS AND REPORTING

The Surgical Services Committee is responsible for formulating policies and making decisions in conjunction and cooperation with Administration that will facilitate efficient and proper use of the facilities, personnel, and equipment in the surgical suite, including the Recovery Room. It also serves as a central Medical Staff planning and budget development body for surgical services. Problems relating to the surgical suite shall initially be brought to this committee for resolution or, if deemed more appropriate, then referred to the chief or chairman of the clinical department involved. Decisions, policies and procedures enacted by this committee may be implemented but are subject to ratification by the Medical Executive Committee, the Chief of Staff and Administrator. For those changes recommended by the committee that affect other services, the committee must seek consultation and agreement from these affected services prior to implementing the change.

The committee meets monthly and reports to the Medical Executive Committee.

3.12-2 COMPOSITION AND VOTING

The Surgical Services Committee shall consist of physicians on Active/Emeritus Staff. The Surgical Services Committee shall be composed of the following members: the chairman or vice-chairman of each surgical department, as well as other members sufficient to assure representation of all surgical specialties practiced in the hospital that have recognized boards, including but not limited to Obstetrics & Gynecology, Ophthalmology, Otolaryngology, Orthopedics, Neurosurgery, Oral & Maxillofacial Surgery, Plastic Surgery, General Surgery, Thoracic Surgery, urology, and Anesthesiology. In addition, the Vice President of Patient Care Services or designee, Nurse Director of Surgery, and the Nurse Manager of PACU shall also be members of this committee. The chairman and vice-chairman shall be Active Medical Staff members elected by the Surgical Services Committee members for a two-year term and with the concurrence of the officers of the Medical Staff. All Medical Staff members of the committee shall have the right to vote; provided, the chairman shall only vote in cases where the vote of the Chair will affect the result. A quorum shall consist of voting members present. Decisions of this committee shall be made by a majority vote.

3.13 PATIENT BLOOD MANAGEMENT COMMITTEE

3.13-1 PURPOSE AND MEETINGS

The Patient Blood Management Committee is responsible for the review, evaluation, and recommendations relating to the proper utilization of blood and blood components including investigation of suspected reactions, amounts of blood requested, used, and blood wastage. It meets quarterly or more often as indicated and is responsible to the Medical Executive Committee.

3.13-2 COMPOSITION AND VOTING

The Patient Blood Management Committee shall be composed of the following:

Eleven (11) voting members representing Pathology, General Surgery, Cardiothoracic Surgery, Vascular Surgery, Hematology/Oncology, Pulmonology/Critical Care, Internal Medicine or Family Practice, Orthopedic Surgery, Anesthesiology, OB/Gynecology, Emergency Medicine; and,

Ex-officio members: medical director of quality, patient care services director of Surgical Services, transfusion safety officer, laboratory representative from the Blood Bank, floor/front line nurse; and, vice president of medical affairs.

The Committee shall elect a chairman. A quorum shall consist of voting members present. Decisions of this committee shall be made by a majority vote.

3.14 UTILIZATION AND RECORD MANAGEMENT COMMITTEE

3.14-1 PURPOSES AND MEETINGS

The functions of this Committee include:

(a) the review and monitoring of medical records, practices,

policies and procedures, including receiving reports on medical records accuracy and completeness and following up on deficiencies identified through other review and monitoring activities. It evaluates records, including outpatient and emergency records, it reviews and evaluates records for timely completion, clinical pertinence and overall adequacy for Quality Management activities. It evaluates records, when necessary, as a medico-legal document. This Committee shall endeavor to assure that the records reflect the condition and progress of the patient, including results of all tests and therapy given. This Committee also ensures that appropriate information regarding patient care is exchanged when patients are admitted, referred, transferred, or discharged. This Committee is responsible for preparation and review (at least annually) of a Medical Record Review Plan. The Medical Record Review Plan shall meet the accrediting agency standards and shall govern the Committee's activities and shall be approved and implemented by the MEC.

(b) the preparation of a Utilization Review Program. This program shall endeavor to assure appropriate allocation of the hospital's resources in striving to provide prompt, high quality care to patients in a cost-effective manner. The program shall address overutilization, underutilization, and inefficient scheduling of resources. The Utilization Review Plan, as approved and implemented by the MEC, shall be monitored and reviewed at least annually and revised to reflect the findings of utilization review activities. The Utilization Review Plan, shall meet the accrediting agency standards and shall govern the Committee's activities.

(c) The Committee shall meet as often as is necessary, but not less than bi-monthly. This Committee shall be responsible to and shall submit recommendations to the Medical Executive Committee.

(d) Credentialing Functions
The Credentialing function of this Committee is to refer its findings to the Professional Functions Committee for their evaluation for purposes of reappointment and the granting or renewal of clinical privileges.

3.14-2 COMPOSITION AND VOTING
The Chief of Staff shall appoint not less than seven (7) Medical Staff members to serve on this Committee. The Chief of Staff shall appoint a chairman of the Committee. The Committee chairman shall appoint a vice chairman. All Medical Staff members of this Committee shall have the right to vote, including the Chief of Staff who is the ex-officio member.

Representatives of various clinical and support services including but not limited to a member of the MRB Board, Vice President of Medical Affairs, Director of Health Information Management, Director of Quality and Resource Management (Patient Care Services), Chief Financial Officer, Vice President of Patient Care Services, Medical Director of Quality Management, Medical Director of Utilization & Resource Management, Utilization Review Specialist, and

Compliance Officer shall serve on this Committee without a right to vote. Ad hoc representatives as needed shall also serve on this Committee without a right to vote and shall be appointed by the Committee chairperson.

The chairperson shall only vote in cases where the vote of the chair will affect the result. A quorum shall consist of voting members present. Decisions of this Committee shall be made by a majority vote. Each member of the Committee (Medical Staff, clinical and support services) shall have the privilege of designating a substitute member.

PART IV. ASSIGNMENT OF FUNCTIONS

4.1 PARTICIPATION IN CERTAIN REQUIRED HOSPITAL FUNCTIONS

Medical Staff responsibilities relating to the following hospital or corporate functions are discharged as indicated:

FUNCTION	
(a) Liaison with the Board	Functions of various Staff Officers
	Hospital President or designees on MEC and other Staff committees
	Chairman of Professional Affairs Committee on Quality Council and Joint Conference Committee
	Hospital President or designees attend Staff/Department meetings
	Chief of Staff and Vice Chief of Staff on Board of Directors
(b) Hospital accreditation	Chief of Staff MEC
(c) Institutional and financial planning	Functions of various Staff officers and MEC
	Medical Staff members on Board's Institutional Planning Committee
(d) Functional and physical plant safety	Functions of department chairmen and physician heads of special units
	Medical Staff member on hospital's Safety Committee

4.2 SPECIFIC CLINICAL DEPARTMENT DUTIES

4.2-1 SPECIFIED DUTIES

The functions of all clinical departments are contained in Article 8.3 of the Bylaws and the responsibilities and authority of the clinical department chairmen are contained in Article 1.5 of the Officers and Organization Manual. While the majority of the Quality Management duties have been assigned to standing committees of the Medical Staff, the following specified duties are reserved for assessment directly by the departments:

(a) Tissue Review: Review of surgical cases in which tissue was removed as well as for those cases where no specimen was removed shall be performed on a monthly basis. The review shall include the indications for surgery and all

cases where there is a major discrepancy between the preoperative and postoperative (including pathologic) diagnosis. Screening methods may be developed and approved by the department involved. Written reports shall be maintained that reflect the results of all evaluations and the actions taken.

(b) Mortality and Autopsy Review: Each clinical department shall review and analyze all deaths occurring in that department to determine if the deaths were inevitable and whether the facilities were overused or underused. Autopsy reports shall be reviewed for agreement or justification of disagreement between the clinical and pathological cause of death and for noting cases of unusual interest.

4.2-2 ANESTHESIOLOGY AND RECOVERY ROOM REVIEW

In addition to the above duties (4.2-1a and 4.2-1b), the Anesthesiology Department shall review and analyze all clinical occurrences relating to anesthesia cases in which there is a question of a deviation from adopted rules and regulations relating to pre-anesthetic evaluation, anesthesia administration, post-anesthetic care, follow-up and complications, including infections, that may be attributed or suspected as resulting from the administration of anesthesia or from anesthesia equipment. Recovery room review includes the review of the basis for discharge of the patient from the unit based upon adopted discharge criteria, complications occurring in the unit, follow-up visits and care provided during the post recovery period. Review shall also include the services of Cardiopulmonary Resuscitation and Respiratory Therapy. The quality and appropriateness of the anesthesia services provided shall be reviewed and evaluated as often as necessary, but no less than quarterly.

4.2-3 TELEMETRY UNIT, 4 EAST and 4 WEST

The Internal Medicine Department, with input from the Family Practice Department, is responsible for developing and/or making changes regarding policies, procedures, and practices involving patients on the 4th Floor Progressive Unit and Medical/Telemetry Unit.

4.2-4 MANNER OF ACTING

The above duties may be performed by a department acting as a committee of the whole or by a subcommittee within the department that reports to the chairman of the department. The decision as to which method to use by a department is at the discretion of the chairman of the department considering the size of the membership of the department, the amount of materials, i.e., medical records, data, and reports from the Quality Management office, reports and referred recommendations from the Professional Affairs Committee, Medical Executive Committee, Quality Council or one of the subcommittees of Medicine, Surgery, Obstetrics & Gynecology or Pediatrics.

PART V. MEETING PROCEDURES

5.1 NOTICE OF MEETINGS

Written notice of any regular general staff meetings, or of any regular committee, department meeting not held pursuant to resolution, must be delivered personally or by mail to each person entitled to be present thereat not less than 5 days nor more than 15 days before the date of such meeting and must be posted. Notice of any special meeting of the staff, a department, or a committee must be given orally or in writing at least 72 hours prior to the meeting and must be posted. Personal attendance at a meeting constitutes a waiver of notice of such meeting, except when a person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting was not duly called or convened. No business shall be transacted at any special meeting except that stated in the meeting notice.

5.2 QUORUM

5.2-1 GENERAL STAFF MEETINGS

The presence of qualified voting members of the Active Medical Staff at any regular or special meeting constitutes a quorum for the transaction of any business under these bylaws.

5.2-2 DEPARTMENTS, OTHER CLINICAL UNITS AND COMMITTEE MEETINGS

Fifty (50) percent of the qualified voting members of the Medical Executive Committee, or the Quality Council constitutes a quorum at any meeting of such body.

Qualified voting members present at a Department or committee meeting (excluding the Medical Executive Committee and Quality Council) shall constitute a quorum.

5.3 ORDER OF BUSINESS AT REGULAR STAFF MEETINGS

The order of business at a regular staff meeting is determined by the Chief of Staff. The agenda includes at least:

(a) Acceptance of the minutes of the last regular and all special meetings held since the last regular meeting.

(b) Administrative reports from the Chief of Staff, the chairmen of departments, and the President.

(c) The election of officers and of representatives to Staff and hospital committees, when required by these bylaws.

(d) Reports by responsible officers, departments, and committees and discussion on the overall results of the Staff's Quality Management/Peer Review Program activities and on the fulfillment of the other required Staff functions.

(e) New business

(f) Recommendations for improving patient care within the hospital.

5.4 MANNER OF ACTION

In all cases, the action of all staff committees occurs at any properly called meeting, regular or special, when a quorum is present and a resolution or motion is passed by a "majority vote" as defined in DEFINITIONS. Action may be taken without a meeting by a department or committee by written document, setting forth the action so taken, which shall be forwarded to each member entitled to vote and shall be signed by a majority of the members entitled to vote on the action so taken. If the vote of any staff committee is by secret ballot, then the chairman may vote by ballot along with the other members of the committee.

5.5 MINUTES

Minutes of all meetings are prepared by the secretary of the meeting and include a record of attendance and the vote taken on each matter. Copies of said minutes must be signed by the presiding officer, approved by the attendees and made available to any member of the Staff upon request. A file of the minutes of each meeting shall be maintained in accordance with the Corporate Record Retention Policy.

5.6 PROCEDURAL RULES

Meetings of the Staff, departments, and committees will be conducted according to the then current edition of Roberts' Rules of Order. In the event of conflict between said Rules and any provision of the Medical Staff Bylaws or any of its related manuals, the latter are controlling.

PART VI. AMENDMENT

6.1 AMENDMENT

The Officers and Organization Manual may be amended or replaced in whole or in part only by the same mechanism as the Medical Staff Bylaws. This procedure is spelled out in Article 16 of the Medical Staff Bylaws. "In general terms" means that recommendation for change will be processed through the Medical Executive Committee, the Medical Staff as a body, the Professional Affairs Committee, the Joint Conference Committee, and the Governing Body.

PART VII. CONCERNS AND CONFLICTS

7.1 SPECIAL PAC CONCERNS

If the PAC determines that its recommendations to the Board of Directors is in any conflict in any material way with the position of the MEC, prior to referral of the matter to the Board of Directors, it shall refer the matter to the Joint Conference Committee with notice of such referral given to the MEC.

7.2 ACTION IN CASE OF CONFLICT

If all conflicts are resolved in the Joint Conference Committee, the matter shall be recommended to the Board of Directors on the recommendation of the PAC. If all conflicts are not resolved, the Board of Directors shall be so advised and the matter shall be brought to the Board of Directors for resolution after notice to the MEC.

7.3 RESPONSIBILITIES AND AUTHORITY

The procedures outlined in the Medical Staff and hospital corporate bylaws regarding Medical Staff responsibility and authority to formulate, adopt and recommend Medical Staff bylaws and amendments thereto and the circumstances under which the Professional Affairs Committee may resort to its own initiative in accomplishing those functions apply as well as to the formulation, adoption and amendment of this Officers and Organization Manual.

PART VIII. ADOPTION

8.1 MEDICAL STAFF

This Medical Staff Officers and Organization Manual was adopted and recommended to the Professional Affairs Committee by the Medical Executive Committee in accordance with and subject to the Medical Staff Bylaws.

ADOPTED by the MEDICAL STAFF on December 13, 1995
Date

8.2 BOARD

This Medical Staff Officers and Organization Manual was approved by resolution of the Professional Affairs Committee after considering the Medical Executive Committee's recommendations and in accordance with and subject to the hospital corporate bylaws.

APPROVED by the PROFESSIONAL AFFAIRS COMMITTEE OF THE BOARD on:

February 5, 1996
Date

Revisions:		
	06/24/96	05/02/05
	10/06/97	04/24/06
	02/02/98	06/26/06
	10/05/98	10/23/06
	02/01/99	12/18/06
	06/21/99	06/25/07
	02/07/00	06/23/08
	10/02/00	04/27/09
	04/23/01	06/21/10
	06/25/01	10/18/10
	10/17/01	02/28/11
	12/17/01	04/30/12
	04/22/02	10/22/12
	12/16/02	10/28/13
	03/03/03	04/28/14
	06/23/03	08/25/14
	08/25/03	04/27/15
	10/27/03	11/16/15
	03/01/04	04/25/16
	12/20/04	06/20/16
		04/24/17

S. M. Vandenbelt, M.D.
Chief of Staff

G. Bosco, Chairperson
Professional Affairs Committee