AHMC ANAHEIM REGIONAL MEDICAL CENTER

MEDICAL STAFF ORGANIZATION and FUNCTIONS MANUAL

Adopted by the Medical Staff: March 28, 2011
Adopted by the Board of Directors: April 20, 2011
AHMC ANAHEIM REGIONAL MEDICAL CENTER
ORGANIZATION AND FUNCTIONS MANUAL
TABLE OF CONTENTS

AHMC ANAHEIM REGIONAL MEDICAL CENTER ............................................. 1
ORGANIZATION AND FUNCTIONS MANUAL .............................................. 1
TABLE OF CONTENTS ............................................................................... 1

ARTICLE I: ORGANIZATION AND FUNCTIONS ........................................ 3
1.1 ORGANIZATION OF CLINICAL DEPARTMENTS & SUB-SECTIONS ........ 3
  1.1.1 CLINICAL DEPARTMENTS: ............................................................ 3
  1.1.2 ESTABLISHING CLINICAL SUB-SECTIONS .................................. 3
  1.1.3 CLINICAL DEPARTMENT SUBSECTIONS ...................................... 3
1.2 DEPARTMENT MEETINGS ................................................................. 3
  1.2.1 REGULAR MEETINGS: ................................................................. 3
  1.2.2 SUB-SECTION MEETINGS ............................................................ 4
  1.2.3 DEPARTMENTAL RECOMMENDATIONS: ...................................... 4
  1.2.4 SPECIAL MEETINGS: ................................................................. 4
  1.2.5 MANNER OF ACTION: ................................................................. 4
  1.2.6 EXECUTIVE SESSION: ............................................................... 4
1.3 ELECTION OF DEPARTMENT AND/OR SUB-SECTION CHAIRS .......... 4
  1.3.1 QUALIFICATIONS ...................................................................... 4
  1.3.2 NOMINATION (Department and Sub-Section Chairs) ..................... 5
  1.3.3 ELECTION (Department and Sub-Section Chairs) ......................... 5
  1.3.4 DEPARTMENT/SUBSECTION VICE CHAIR .................................... 5
  1.3.5 TERM OF OFFICE .................................................................... 5
  1.3.6 REMOVAL OR RESIGNATION OF ELECTED CHAIR ..................... 5
1.4 RESPONSIBILITIES OF DEPARTMENT CHAIR .................................. 5
1.5 RESPONSIBILITIES OF SUB/SECTION CHAIR .................................... 6

ARTICLE II: MEDICAL STAFF OFFICERS ................................................. 6
2.1 ELECTED MEDICAL STAFF OFFICERS ........................................... 6
  2.1.1 CHIEF OF STAFF ...................................................................... 6
  2.1.2 CHIEF OF STAFF ELECT ........................................................... 7
  2.1.3 SECRETARY/TREASURER ........................................................... 8
  2.1.4 ORDER OF AUTHORITY ............................................................ 8

ARTICLE III: FUNCTIONS OF MEDICAL STAFF .................................... 9
3.1 DESCRIPTION OF FUNCTIONS OF THE MEDICAL STAFF ............... 9
  3.1.1 GOVERNANCE, DIRECTION, COORDINATION AND ACTION ....... 9
  3.1.2 PERFORMANCE IMPROVEMENT ACTIVITIES ................................ 9
  3.1.3 MONITORING AND EVALUATION ACTIVITIES ........................... 9
  3.1.4 UTILIZATION MANAGEMENT FUNCTION: .................................. 10
  3.1.5 CREDENTIALS REVIEW FUNCTION .......................................... 10
  3.1.6 MEDICAL RECORDS FUNCTION: .............................................. 10
  3.1.7 EMERGENCY-PREPAREDNESS FUNCTION .................................. 11
  3.1.8 PLANNING FUNCTION: ............................................................ 11
  3.1.9 CONTRACT EVALUATION FUNCTION ....................................... 11
  3.1.10 BYLAWS REVIEW AND REVISION ......................................... 11
  3.1.11 PHARMACY AND THERAPEUTICS FUNCTION ........................... 12
  3.1.12 INFECTION CONTROL FUNCTION ........................................... 12
  3.1.13 NOMINATING FUNCTION ....................................................... 12
3.2 REPORTS ON FUNCTIONS ......................................................... 12

ARTICLE IV: PROFESSIONAL STAFF COMMITTEES .................................. 13

4.1 PROFESSIONAL STAFF COMMITTEES: ........................................... 13
  4.1.1 BYLAWS COMMITTEE ....................................................... 13
  4.1.2 CANCER COMMITTEE ...................................................... 13
  4.1.3 CONTINUING MEDICAL EDUCATION / LIBRARY COMMITTEE ............ 13
  4.1.4 CREDENTIALS COMMITTEE .............................................. 14
  4.1.5 BIOETHICS COMMITTEE .................................................. 14
  4.1.6 MEDICAL EXECUTIVE COMMITTEE ....................................... 15
  4.1.7 PHARMACY AND THERAPEUTICS COMMITTEE ................................ 15
  4.1.8 PERFORMANCE IMPROVEMENT/PATIENT SAFETY COMMITTEE ............. 15
  4.1.9 PHYSICIAN’S WELL-BEING COMMITTEE ..................................... 16
  4.1.10 INTERDISCIPLINARY PRACTICE COMMITTEE ................................ 16
  4.1.11 INFECTION CONTROL COMMITTEE ....................................... 17
  4.1.12 MEDICAL RECORDS COMMITTEE .......................................... 17
  4.1.13 UTILIZATION MANAGEMENT COMMITTEE ................................... 17
  4.1.14 INTENSIVE ASSESSMENT COMMITTEE ...................................... 17
  4.1.15 CONTRACT PHYSICIAN PERFORMANCE EVALUATION COMMITTEE ........ 18
  4.1.16 NOMINATING COMMITTEE .................................................... 18
  4.1.17 PROJECT EVALUATION COMMITTEE (PEC) (IRB) .......................... 18
  4.1.18 ENDOVASCULAR COMMITTEE ............................................. 19
  4.1.19 PHYSICIAN INFORMATICS COMMITTEE (PIC) ................................ 19

4.2 QUORUM REQUIREMENTS .......................................................... 20

ARTICLE V: AMENDMENTS ............................................................. 21

5.1 BIENNIAL REVIEW ........................................................................ 21

5.2 AMENDMENTS ............................................................................. 21
ARTICLE I: ORGANIZATION AND FUNCTIONS

1.1 ORGANIZATION OF CLINICAL DEPARTMENTS & SUB-SECTIONS

1.1.1 CLINICAL DEPARTMENTS:

Clinical Departments: The medical staff is organized into four service departments.

Department of Medical Services: The Department of medical services shall include, but not necessarily be limited to, practitioners practicing in internal medicine, family practice, emergency medicine, radiology, radiation therapy and other medical specialties such as pulmonary, gastroenterology, endocrinology, neurology, psychiatry, dermatology, hematology, oncology and other subspecialties excluding Cardiology and Invasive Interventional Cardiology.

Department of Surgical Services: The Department of Surgical Services shall include, but not necessarily be limited to, practitioners practicing general surgery, neurological surgery, cardiothoracic surgery, vascular surgery, proctology, urology, orthopedics, podiatry, plastic surgery, ophthalmology, otorhinolaryngology, dental surgery, anesthesiology, pathology, and other surgical specialties/subspecialties.

Department of Women's and Children's Services: The Department of Women's & Children's Services shall include, but not necessarily be limited to, practitioners practicing obstetrics/gynecology, pediatrics, perinatology, neonatology, and other Women's and Children's specialties and subspecialties.

Department of Cardiology Services: The Department of Cardiology Services shall include, but not necessarily be limited to, practitioners practicing cardiology, invasive or interventional cardiology.

1.1.2 ESTABLISHING CLINICAL SUB-SECTIONS

Upon approval of the Medical Executive Committee, Clinical Departments may be divided into clinical sub-sections, representing members practicing in the same specialty. Each sub-section shall be directly responsible to the clinical Department within which it functions. The head of a Sub-section shall have the title of Chair.

1.1.3 CLINICAL DEPARTMENT SUBSECTIONS

A. Department of Medical Services
   Emergency Department Section
   Radiology Section

B. Department of Surgical Services
   Anesthesia Section
   Cardiothoracic Section
   Pathology Section

C. Department of Women's and Children's Services
   Pediatric Medicine Section

D. Department of Cardiology Services
   Invasive/Interventional Section (ad hoc if needed)

1.2 DEPARTMENT MEETINGS

1.2.1 REGULAR MEETINGS:

Each Department shall meet at least four (4) times per year, or more often as determined by Chair of that Department, for the purpose of receiving reports or other Department and staff functions, including review, evaluation or other monitoring activities. A representative from Emergency Services, Radiology and Pathology may attend all such Department meetings.
1.2.2 SUB-SECTION MEETINGS
Sub-sections will meet on an Ad-Hoc basis and may schedule regular meetings, if needed. Minutes of meetings will be taken if required for reference and follow-up.

1.2.3 DEPARTMENTAL RECOMMENDATIONS:
Regular reports shall be submitted to the Medical Executive Committee including information on any matter of interest and recommendations for action on specific items. Such recommendations shall be considered by the Medical Executive Committee for submission to the Board of Directors for subsequent consideration.

1.2.4 SPECIAL MEETINGS:
A special Departmental meeting may be called by the Department Chair, by the Chief of Staff or by the Membership as outlined in the Medical Staff Bylaws.

1.2.5 MANNER OF ACTION:
A. The action of a majority of the Members present at a Department meeting at which a quorum is present shall be the action of the Department. Action also may be taken without a meeting by a written consent, signed by each member entitled to vote.
B. Effective peer review, the consideration of the qualifications of Medical Staff members to perform specific procedures and evaluation and improvement of the quality of care rendered in the hospital, must be based on free and candid discussion. Any breach of confidentiality of the discussion, or deliberations of the Medical Staff departments or sub-committees is outside appropriate conduct for the Medical Staff and will be deemed disruptive to the operations of the hospital.
C. For the purpose of inter-professional resolution of matters bearing on professional competency, the chair shall ensure that decorum is maintained. The chair shall also act to ensure that all participants present at the committee/department have a reasonable opportunity to be heard, and to present, as appropriate, oral or documented clinical practice guidelines and references to medical literature as appropriate.
D. Although the ultimate goal for peer review includes physician education and performance improvement, for an effective peer review to be accomplished, the processes must be separate and the practitioner excused during peer deliberation. A practitioner who has been requested to appear before a committee/department responsible for the evaluation of patient care shall be so notified in writing of issues involved and time and place of meeting. Following his/her case presentation and discussion, the practitioner should be excused to allow appropriate deliberation and case conclusion. Feedback on findings and/or recommendations and reasons for the final disposition will be sent in writing to the practitioner.

1.2.6 EXECUTIVE SESSION:
Executive session is a meeting of a Medical Staff Committee/Department which only voting Medical Staff members may attend, unless others are expressly requested by the committee/department chair to attend. Executive sessions may be called by the presiding officer pursuant to a duly adopted motion. Executive sessions may be called to discuss peer review issues, personnel issues or other sensitive issues requiring confidentiality. The results of executive sessions shall be reported to the MEC and if appropriate to the Governing Board. Results of MEC executive sessions should be reported to the Board or Administration, whichever is appropriate.

1.3 ELECTION OF DEPARTMENT AND/OR SUB-SECTION CHAIRS
1.3.1 QUALIFICATIONS
Each Department/Sub-section Chair shall be a member in good standing of the Active Category of the Medical Staff, qualified by training, experience, and demonstrated clinical and administrative competence, and with sufficient time and interest to carry out the duties of the office. He/she shall be Board certified or have the equivalent qualifications as determined by the Medical Executive Committee.
1.3.2 NOMINATION (Department and Sub-Section Chairs)

Nominations for the Department and Sub-section Chair will be by the voting Members of the Department or Sub-section made at a Department or Sub-section meeting or by mail ballot (at the discretion of the Department) at the end of the term of office or upon a vacancy in office.

1.3.3 ELECTION (Department and Sub-Section Chairs)

Each chair shall be elected by a majority (50% +1) vote of active Members present at the meeting of the Department or Sub-section concerned, or valid ballots returned by mail (at the discretion of the department).

The Medical Executive Committee shall approve the Department and Sub-section Chairs for recommendation to and appointment by the Board of Directors.

The Department or Sub-Section Chair may be re-nominated and re-elected, but only after re-evaluation by the Medical Executive Committee of performance in his/her position at the end of his/her term.

1.3.4 DEPARTMENT/SUBSECTION VICE CHAIR

Each Department/Sub-Section Chair shall appoint a Department/Sub-Section Vice-Chair upon the ratification of the Department/Sub-Section.

1.3.5 TERM OF OFFICE

As stated in Article VI, Section 6.2-D of the Medical Staff Bylaws.

1.3.6 REMOVAL OR RESIGNATION OF ELECTED CHAIR

Removal of a Department or Sub-section Chair during his/her term of office is as stated in the Article VI, Section 6.2-C of the Medical Staff Bylaws. (See also Article V, Section 5.7 of the Medical Staff Bylaws) If a Department or Sub-section Chair resigns or is removed from office prior to the expiration of his/her term the Medical Executive Committee will appoint a replacement to serve until the next election.

1.4 RESPONSIBILITIES OF DEPARTMENT CHAIR

A Department Chair will be elected by the Voting Members of each Department. Anyone who is an active physician member of the Medical Staff and meets the qualifications as stated in Article VI, Section 6.2-A of the Medical Staff Bylaws may be nominated. The responsibilities of the Department Chair will be as follows:

A. Be accountable to the Medical Executive Committee for all professional, clinical and administrative activities within the Department.

B. Be a member or designate his/her designee to be a member of the Medical Executive Committee giving guidance on the overall medical policies of the Hospital and making specific recommendations regarding the Department relating to : (1) the coordination and integration of inter and intra-departmental services, (2) integration of the department into the overall functioning of the organization, (3) development and implementation of policies and procedures that guide and support the provision of services of the department.

C. The Department Chair shall make recommendations for clinical privileges of members in the department both for initial appointment and re-appointment.

D. Maintain surveillance of the professional performance of all practitioners with clinical privileges in the Department and report to the Medical Executive Committee when necessary.

E. Enforcement of the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations and policies & procedures within the Department that guide and support provision of services.

F. Be responsible for implementation within the Department of actions taken by the Medical Executive Committee or the Medical Staff.

G. Assure that the quality and appropriateness of patient care provided in the Department are monitored and evaluated, and be responsible for implementing action following review and recommendations by the Performance Improvement/Patient Safety (PIPS) Committee.

H. Be responsible for the teaching, orientation, and continued education for the Department.
I. Participate in every phase of administration of the Department through cooperation with nursing services and Hospital administration in matters affecting patient care including, but not limited to, assessment and recommending to the relevant hospital authority, off-site sources for needed patient care services not provided by the department or organization.

J. Assist in the preparation of the capital budget for the Department and makes recommendations for space and other resources needed by the department or service.

K. Promote effective practitioner/Hospital relationships.

L. Recommends to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department/sub-sections in recommending clinical privileges for each member.

M. Assist in the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care services.

N. Recommend sufficient number of qualified and competent persons to provide care and service.

O. Conduct ongoing review and continuing surveillance of the professional performance of practitioners with clinical privileges in the department and report regularly thereon to the MEC.

P. Be responsible for the continuous assessment and improvement of the quality of care and services provided and the maintenance of quality control programs as appropriate to be reported to Performance Improvement/Patient Safety (PIPS) Committee on a quarterly basis.

1.5 RESPONSIBILITIES OF SUB/SECTION CHAIR

Each Sub-section Chair shall be a member of the Active Medical Staff, shall be willing and able to discharge the functions of his/her office as defined in the Organizations and Functions Manual and shall be either board certified or shall have been determined to possess equivalent qualifications by the Medical Executive Committee. Additionally, he/she shall possess the qualifications to fulfill the responsibilities specified in the Organizations and Functions Manual.

The duties of the Sub-Section Chair shall include, but not be limited to:

A. Act as chair at Sub-section meetings;

B. Assist in the development and implementation, in cooperation with the appropriate Department Chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to his/her Sub-section;

C. Evaluate the clinical work performed in his/her Sub-section;

D. Conduct investigations and submit reports and recommendations to the appropriate Department Chair regarding the clinical privileges to be exercised within his/her Sub-section by members of, or applicants to, the Medical Staff;

E. Perform such other duties commensurate with the office as may from time to time be reasonably requested by the appropriate Department Chair, Chief of Staff, or Medical Executive Committee.

ARTICLE II: MEDICAL STAFF OFFICERS

2.1. ELECTED MEDICAL STAFF OFFICERS

2.1.1 CHIEF OF STAFF

2.1.1.1 DUTIES AND RESPONSIBILITIES OF CHIEF OF STAFF

The Chief of Staff must be a member of the Active Medical Staff, in good standing, at the time of nomination and election, and must remain a member in good standing during the office term. He/she must be a member of the Medical Staff for at least three (3) years and an Active member in the preceding two (2) years.

The Chief of Staff shall serve as the chief elected officer of the Medical Staff and will fulfill those duties specified in the Medical Staff Bylaws, the Credentials Manual, the Organization and Functions Manual, or assigned by the Medical Staff, or by the Medical Executive Committee.

The duties of the Chief of Staff shall include, but not be limited to:

A. Enforcing the Medical Staff Bylaws, Credentials Manual, Organization and Functions Manual and General Medical Staff Rules & Regulations, etc.
B. Serving as Medical Executive Committee Chair.
C. Serving as Chair (or providing a designee) of the Medical Staff Nominating Committee;
D. Calling, presiding at, and being responsible for the agenda of Special Meetings of the Medical Staff as necessary;
E. Serving as Chair of the Semi-Annual Meetings of the Medical Staff;
F. Serving as Chair (or providing a designee) of the Bylaws Committee;
G. Serving as an ex-officio member of all other Medical Staff committees without vote unless his or her membership in a particular department or committee is required;
H. Appointing, in consultation with the Medical Executive Committee, Medical Staff Committee chairs and members of all standing and special Medical Staff, liaison, or multidisciplinary committees, except where otherwise provided by the Bylaws and, Organization and Functions Manual;
I. Representing the views and policies of the Medical Staff to the Board of Directors and to the Chief Executive Officer;
J. Interacting with the Chief Executive Officer and the Board of Directors in all matters of mutual concern within the Hospital;
K. Serving on liaison committees with the Board of Directors and the Hospital management, as well as outside licensing or accreditation agencies;
L. Serving as an ex-officio member of the Board of Directors;
M. Implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
N. Accounting to the Board of Directors, in conjunction with the Medical Executive Committee and the respective Departments, for the quality, efficiency, and performance of patient care services within the Hospital, and for the effectiveness of the patient care safety and other quality maintenance functions delegated to the Medical Staff; and initiating where appropriate, corrective action against Medical Staff members;
O. Being a spokesperson for the Medical Staff in external professional and public relations.

2.1.1.2 ELECTION
The Chief of Staff Elect shall succeed to the Office of Chief of Staff and be installed at the Annual meeting of the Medical Staff in accordance with the Medical Staff Bylaws Article V.

2.1.1.3 VACANCY IN OFFICE
If there is a vacancy in the office of the Chief of Staff, the Chief of Staff Elect shall serve the remainder of the term.

2.1.1.4 TERM OF OFFICE
The Chief of Staff shall serve a term of two years and shall take office on the first day of the medical staff year following the completion of his/her term as Chief of Staff Elect and installation at the Annual Medical Staff Meeting.

2.1.1.5 REMOVAL FROM OFFICE
Refer to Medical Staff Bylaws Article V, Section 5.7

2.1.2 CHIEF OF STAFF ELECT
2.1.2.1 DUTIES/RESPONSIBILITIES OF CHIEF OF STAFF ELECT
The Chief of Staff Elect must be a member of the Active Medical Staff, in good standing, at the time of nomination and election, and must remain a member in good standing during the office term. He/she must be a member of the Medical Staff for at least three (3) years and an Active member in the preceding two (2) years.

In the absence of the Chief of Staff, the Chief of Staff Elect shall assume all the duties and have the authority of the Chief of Staff (see Duties and Responsibilities of Chief of Staff, outlined herein.).

The duties of the Chief of Staff Elect shall include, but not be limited to:
A. Perform such duties as may be assigned to him/her by the Chief of Staff or Medical Executive Committee;
B. Chair the Performance Improvement/Patient Safety (PIPS) Committee.
2.1.2.2 ELECTION
The Chief of Staff Elect shall be elected every two years by written ballot and installed at a meeting of the Medical Staff in accordance with Medical Staff Bylaws, Article V.

2.1.2.3 VACANCY IN OFFICE
If there is a vacancy in the office of the Chief of Staff Elect, the vacancy will be filled by the Medical Executive Committee for the remainder of the term.

2.1.2.4 TERM OF OFFICE
The Chief of Staff Elect shall serve a term of two years and shall take office on the first day of the medical staff year following his/her election by written ballot and installation at the Annual Medical Staff Meeting.

2.1.2.5 REMOVAL FROM OFFICE
Refer to Medical Staff Bylaws Article V, Section 5.7

2.1.3 SECRETARY/TREASURER

2.1.3.1 DUTIES/RESPONSIBILITIES OF SECRETARY/TREASURER.
The Secretary/Treasurer shall be a member of the Medical Executive Committee and an ex-officio member of all other Medical Staff committees without vote, unless his or her membership on a particular department or committee is required:

The duties of the Secretary/Treasurer shall be to:
A. Cause proper notice of all staff meetings on order of the appropriate authority.
B. Cause to have prepared accurate and complete minutes for all meetings.
C. Supervise the collection and accounting for any funds, assessments, application fees and dues.
D. Perform such other duties as ordinarily pertain to the office or as assigned by the Chief of Staff or Medical Executive Committee.

2.1.3.2 ELECTION
The Secretary/Treasurer of Staff shall be elected every two years by written mail ballot and installed at the Annual meeting of the Medical Staff in accordance with Medical Staff Bylaws, Article V.

2.1.3.3 VACANCY IN OFFICE
If there is a vacancy in the office of the Secretary/Treasurer, the vacancy will be filled by the Medical Executive Committee for the remaining term.

2.1.3.4 TERM OF OFFICE
The Secretary/Treasurer shall serve a term of two years and shall take office on the first day of the medical staff year following his/her election by written ballot and installation at the Annual Medical Staff Meeting. He/she may be re-elected to two terms, not to exceed four consecutive years in this particular office.

2.1.3.5 REMOVAL FROM OFFICE
Refer to Medical Staff Bylaws Article V, Section 5.7

2.1.4 ORDER OF AUTHORITY
In the event of the absence or unavailability of the Chief of Staff, the following persons shall have the authority to act in his/her behalf in the following order: (1) The Chief of Staff Elect, (2) The Immediate Past Chief of Staff, (3) the Secretary/Treasurer, and (4) an Active Medical Staff member designated by the Chief of Staff to act in his/her absence. If all the aforementioned persons are absent or unavailable, the Executive Committee shall meet to designate an Acting Chief of Staff.
ARTICLE III: FUNCTIONS OF MEDICAL STAFF

3.1 DESCRIPTION OF FUNCTIONS OF THE MEDICAL STAFF

3.1.1 GOVERNANCE, DIRECTION, COORDINATION AND ACTION
(See Medical Executive Committee under Professional Staff Committees)

A. Receive, coordinate and act upon as necessary the written reports and recommendations from Departments, Committees, other groups and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities.

B. Account to the Board of Directors and to the Staff by written reports for the overall quality and efficiency of patient care in the Hospital.

C. Take reasonable steps to obtain professionally ethical conduct and competent clinical performance on the part of Staff Members, including initiating investigations and initiating and pursuing corrective action, when warranted.

D. Make recommendations on medico-administrative and Hospital management matters.

E. Inform the Medical Staff of the accreditation program and the accreditation and licensure status of the Hospital.

F. Act on all matters of Medical Staff business, except as otherwise provided in the Medical Staff Bylaws.

3.1.2 PERFORMANCE IMPROVEMENT ACTIVITIES
(See Performance Improvement/Patient Safety (PIPS) Committee under Professional Staff Committees)

A. Adopt and modify, subject to the approval of the Medical Executive Committee and the Board of Directors, a quality improvement plan which sets forth specific programs and procedures for reviewing, evaluating and maintaining the quality and efficiency of patient care within the Hospital, on a hospital-wide basis. The plan may include mechanisms for:
   1) establishing objective criteria
   2) measuring actual practice against the criteria
   3) analyzing practice variations from criteria by peers
   4) taking appropriate action to correct identified problems
   5) following up on action taken
   6) reporting the findings and results of the audit activity to the MEC, the CEO and the Board of Directors.

B. Implement the procedures required under Section 3.1.1 A of this manual by developing criteria and identifying data needs for the various activities, by identifying patterns of performance within or outside the acceptable range, by receiving and evaluating explanations for patterns significantly different from the norm, and by reporting these findings and explanations.

C. Formulate and act upon specific recommendations to correct identified situations.

D. Follow-up on action taken. (For monitoring impact of change, entities identified under Section 3.1.2 B above, for further action, those under Section 3.1.2 C above.

E. Coordinate the Staff's quality review activities with those of other health care disciplines as outlined in the Hospital Quality Improvement Plan.

F. Submit quarterly reports to the MEC on the overall quality and efficiency of medical care provided in the Hospital in conjunction with the corresponding monthly function of the committee.

G. Participate in annually evaluating the performance improvement plan for its comprehensiveness, integration, effectiveness and cost efficiency.

3.1.3 MONITORING AND EVALUATION ACTIVITIES
(See Performance Improvement/Patient Safety (PIPS) Committee under Professional Staff Committees)

A. Adopt, modify, supervise and coordinate the conduct and findings of the patient care monitoring activities.

B. Conduct 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.

C. Conduct periodic blood usage reviews, including evaluation of appropriateness of all transfusions (whole blood and blood components), review of all confirmed transfusion reactions, and review of ordering practices for blood and blood products.

D. Periodically review and evaluate drug therapy practices and drug utilization including review of the appropriateness of empirical and therapeutic use of drugs.

E. Review and evaluate on an ongoing basis the appropriateness, safety, and effectiveness of the prophylactic, empirical, and therapeutic use of antibiotics in the Hospital, reporting conclusions, recommendations, actions taken, and action results.

F. Review on a continuous basis other general indicators of the quality of care and of clinical performance, including unexpected patient care management events.

3.1.4 UTILIZATION MANAGEMENT FUNCTION:
(See Utilization Review Committee under Professional Staff Committees)

A. Develop a utilization management plan for approval by the Medical Executive Committee, Hospital Administration, and the Board of Directors. 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 the use of clinical support services;
   (2) Discharge planning;
   (3) Data collection and reporting requirements; and
   (4) Use of written, objective, measurable criteria in conducting the reviews.

B. Review and monitor that the plan is in effect, known to the Staff Members and functioning at all times.

C. Analyze utilization profiles on a periodic basis and prepare written evaluations of the utilization review and management activities on a continuous basis, including a determination of their effectiveness in allocating resource.

D. Conduct studies, take actions, submit reports and make recommendations as required by the plan.

E. The Utilization Management Committee submits a written report at least four times per year, including at least a summary of the findings of and specific recommendations resulting from the program, to the Medical Executive Committee and for information on utilization patterns to departments/sections, as appropriate, and to Performance Improvement/Patient Safety (PIPS) Committee and any other Staff organizational entity or official with a need to know.

3.1.5 CREDENTIALS REVIEW FUNCTION
(See Credentials Committee under Professional Staff Committees)

A. Review, evaluate and transmit written reports as required by the Medical Staff Bylaws, Credentialing Procedures Manual or other policies on initial appointments, concluding or extending the observation period, re-appointments, modifications of appointment and/or clinical privileges.

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.

C. Submit written reports at the regularly scheduled meetings of the Medical Executive Committee and to the Board of Directors on the status of pending applications or other credentials matters, including the specific reasons for any inordinate delay in their processing.

D. Supervise maintenance of a credentials file for each member of the Staff, including records of participation in Staff activities and results of quality improvement, monitoring and utilization activities.

E. In addition to the biennial reappointment review, appraisals will be conducted periodically on all information available regarding the competencies of medical staff members and as a result of such review, appropriate recommendations made.

3.1.6 MEDICAL RECORDS FUNCTION:
(See Medical Records Committee under Professional Staff Committees)
A. 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;
   (2) Are sufficiently complete 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 and rules 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.
D. Maintain a record of activities and findings and submit reports and recommendations, in writing to
   the Performance Improvement/Patient Safety (PIPS) Committee.

3.1.7 EMERGENCY-PREPAREDNESS FUNCTION:
   (See Medical Executive Committee under Professional Staff Committees and the Bylaws)
   A. Participate in developing, periodically reviewing, and implementing a fire plan for the Hospital.
   B. Assist the Hospital administration in developing, periodically reviewing and implementing an
      emergency preparedness plan that addresses disasters both external and internal to the Hospital.
   C. Participate in emergency response operation as determined by the Incident Commander (see
      Emergency Operations Plan for roles of medical staff, and to whom he or she reports when a
      response to an emergency is required).

3.1.8 PLANNING FUNCTION:
   (See Medical Executive Committee under Professional Staff Committees and Bylaws)
   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.
   C. Submit written reports as necessary or required to relevant staff organizational components and to
      the Board of Directors or appropriate Committees thereof through the Chief of Staff with findings
      and recommendations for action.

3.1.9 CONTRACT EVALUATION FUNCTION
   (See Contract Evaluation Committee under Professional Staff Committees in this Manual)
   The functions of this Committee shall be to review and evaluate the professional performance of
   physicians who are either full-time or part-time hospital-based and who are under contract for their
   services to the Hospital. These shall include but not be limited to, the Hospital Radiologists,
   Pathologist, Medical Directors of Acute Care Center, Respiratory Services, Emergency Department,
   Transitional Care Unit, Perinatal Services, Non-Invasive Cardio/Cardiac Rehab, and Cardiology
   Services.
   The Committee shall meet as necessary prior to the time of renewal of such contracts between the
   physician and the Hospital in order to render a recommendation regarding renewal to the Medical
   Executive Committee. Recommendations shall be based on professional performance, ethics,
   competence and ability of such contract physicians to relate to members of the Medical Staff and to
   practice their profession in a manner, which is commensurate with quality medical practice and patient
   care.

3.1.10 BYLAWS REVIEW AND REVISION
   (See Bylaws Committee under Professional Staff Committees in this Manual)
   The function of this Committee shall be to:
   A. Conduct periodic review of the Bylaws and the related manuals and forms promulgated in
connection with them.
B. Conduct periodic review of the clinical policies and rules.
C. Submit written recommendations to the Medical Executive Committee and to the Board of Directors for changes in these documents.

3.1.11 PHARMACY AND THERAPEUTICS FUNCTION
(See Pharmacy and Therapeutics Committee under Professional Staff Committees in this Manual)

The functions of the Pharmacy and Therapeutics committee shall be:
A. Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use and safety procedures 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 a formulary or drug list for use in the hospital.
E. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.
F. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized.
G. Review of antibiotic usage and untoward drug reactions on a regular basis.
H. Maintain a record of activities relating to the P&T function and submit reports and recommendations to the Performance Improvement/Patient Safety (PIPS) Committee, in writing, concerning drug utilization policies and practices in the Hospital.

3.1.12 INFECTION CONTROL FUNCTION
(See Infection Control Committee under Professional Staff Committees in this Manual)

The Infection control function shall be conducted by a multidisciplinary committee which shall be responsible to the Medical Staff. The duties of the committee are to:
A. Develop a system of reporting, identifying and analyzing the incidence of and the causes of infections.
B. Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.
C. Develop, evaluate and revise preventive surveillance and control.
D. Provide current, updated information on infection control policy and procedures for the Hospital.
E. Advise on all proposed construction.
F. Maintain a record of activities and findings and submit reports and recommendations, in writing to the Performance Improvement/Patient Safety (PIPS) Committee.

3.1.13 NOMINATING FUNCTION
(See Nominating Committee under Professional Staff Committees)

The Nominating Function shall be to:
A. Identify nominees for election to general Staff offices and to other elected positions in the Staff organizational structure.
B. In accomplishing Section 3.1.13, above, consult with Members of the Staff or of the appropriate constituent group, the Medical Executive Committee and Administration concerning the qualifications and acceptability of prospective nominees.

3.2 REPORTS ON FUNCTIONS
Reports of activities and recommendations related to these functions shall be made to the Performance Improvement/Patient Safety (PIPS) Committee as indicated or the Medical Executive Committee and Board of Directors as frequently as necessary, but at least quarterly.
ARTICLE IV: PROFESSIONAL STAFF COMMITTEES

4.1 PROFESSIONAL STAFF COMMITTEES:
There will be a Medical Executive Committee with the following standing Committees which are responsible to the Medical Executive Committee either directly or through the Performance Improvement/Patient Safety (PIPS) Committee: Credentials Committee (see Credentials Policy and Procedure manual), Performance Improvement/Patient Safety (PIPS) Committee, Infection Control Committee, Bylaws Committee, Cancer Committee, CME/Library Committee, Bioethics Committee, Medical Records Committee, Utilization Review Committee, Interdisciplinary Practice Committee, Pharmacy and Therapeutics Committee, Endovascular Committee, Project Evaluation Committee, Physician’s Well-Being Committee, an Intensive Assessment Committee, Contract Evaluation Committee and Nominating Committee.

4.1.1 BYLAWS COMMITTEE
Membership: The voting Members of the Committee shall be appointed by the Chief of Staff. The Committee shall consist of at least five (5) active Members of the medical staff, selected on a basis that will insure representation of the major clinical specialties. The Chief of Staff or his designee shall be the chair.

Purpose and Responsibilities: The Committee shall review the Bylaws, accompanying Manuals, and Rules and Regulations of the Medical Staff as necessary, but at least every two years, and make recommendations to the Medical Executive Committee for changes in these documents.

The Committee shall also review accreditation standards within the Hospital. It shall keep abreast of the accreditation standards of the Joint Commission, Center for Medicare and Medicaid Services (CMS), and California Department of Public Health (CDPH) to on to identify areas of suspected noncompliance with said standards and make recommendations to the Medical Executive Committee for appropriate action.

Frequency of Meetings: The Bylaws Committee shall meet as often as necessary but at least annually.

4.1.2 CANCER COMMITTEE
Membership: The Chair and members of the Cancer Committee shall be appointed by the Chief of Staff. The committee’s composition must include at least one board certified physician representative from surgery, medical oncology, radiation oncology, diagnostic radiology, pathology and the cancer liaison physician. Non-physician members must include administration, nursing, social services, cancer registry and quality improvement.

Purpose and Responsibilities: The Cancer Committee shall be responsible for annual goals, a functioning Cancer Registry which provides periodic reports to the Hospital staff, organizing and conducting multi-disciplinary educational cancer conferences, including the Cancer Clinical Conference, providing consultation services (Tumor Board); and maintaining a system of quality of care evaluation with documentation of its operation.

Frequency of Meetings: The Cancer Committee shall meet as often as necessary but at least quarterly and report to the Medical Executive Committee.

4.1.3 CONTINUING MEDICAL EDUCATION / LIBRARY COMMITTEE
Membership: The CME/Library Committee shall be made up of members of the Medical Staff appointed by the Chief of Staff and the terms for members shall be staggered. The Committee shall include representation from each of the four departments. Other members should include representatives from Quality Improvement, Nursing, Administration, Education, Infection Control, Library, Pharmacy and any other related services. These members shall be ex-officio without vote, except for Nurse Director of Quality, a designated Pharmacist member, and Director of Nursing Education, who shall be granted voting privileges. A quorum for voting however must include a minimum of two (2) voting physician members. A vice Chair shall be selected by the Committee
members and should be considered the Chair-elect subject to confirmation by the incoming Chief of Staff.

**Purpose and Responsibilities:** The purpose of the Committee is to improve patient care through educational programs for Medical Staff and allied health professionals. The Committee will provide comprehensive educational goals and plans for CME, as well as oversee the annual budget. The program shall be in accord with the accreditation requirements of the California Medical Association. Educational programs shall be designed to keep all staff Members informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care, and review various aspects of their basic medical education. The program shall include Hospital sponsored elements on a regular basis and shall be relevant to the type of patient care delivered in the Hospital, in part, oriented to special needs for education as identified by the findings of concurrent and retrospective patient care evaluation studies. The participation of each staff member shall be documented. The Committee shall also oversee the Medical Library and shall approve policies for its use. The Committee shall act as an advisor to the Librarian and to the Chief Executive Officer on the conduct of the Library for the best interest of the Hospital and the Medical Staff. The Committee shall review and make recommendations on all requests for new texts and journals and all requests to discard existing texts/journals.

**Frequency of Meetings:** The Committee shall meet as often as necessary but at least three (3) times per year and report to the Medical Executive Committee.

### 4.1.4 CREDENTIALS COMMITTEE

**Purpose and Responsibilities:** The Credentials Committee shall coordinate all of the credentialing among the four Departments including:

A. the review and evaluation of qualifications, and recommendations for all initial appointments and re-appointments. This shall include evaluation and direct observation, granting or modifications of clinical privileges and the performance of specific services by allied health professionals;

B. recommendations for the development and review of criteria for granting of clinical privileges;

C. the initiation, investigation, and review on matters of corrective action and any other matters involving the clinical, ethical or professional conduct of any medical staff member and/or practitioner with temporary privileges;

D. the development, review, and enforcement of medical staff and Hospital policies and rules and regulations;

E. provide a system for evaluation of new applicants to the medical staff. Provisions shall include direct observation of selected procedures, minimum number of cases to be observed, chart review, and a system for assigning observers;

F. following the policies and procedures established in Credentials Policy and Procedure Manual.

The Committee shall act as the fact-finding and issue resolving body of the four Departments and shall report directly to the Medical Executive Committee.

**Membership:** The voting Members of the Committee shall consist of, but not be limited to, nine Members of the Active staff including two representatives from the Medical Services, two Members from the Surgical Services, two Members from the Women's and Children's Services and two members from the Cardiology Services each of whom shall be recommended by their respective department. The Chair shall be appointed by the Chief of Staff.

**Frequency of Meetings:**
The Credentials Committee shall meet as often as necessary but at least quarterly and make its recommendations to the Medical Executive Committee.

### 4.1.5 BIOETHICS COMMITTEE

**Membership:** Membership of the Bioethics Committee shall include adequate representation from medical staff, nursing, administration, appropriate ancillary hospital staff, a representative from the community and the clergy. The chair will be appointed by the Chief of Staff.

**Purpose and Responsibilities:** The Bioethics Committee shall develop guidelines for consideration
of special problems having ethical implications; implement procedures for the review of special cases; review institutional policies regarding care and treatment of such cases; consult with parties to facilitate communication; educate Medical Staff; and consult with practitioners in matters of their ethical behavior as it relates to their peers and/or patients.

**Frequency of Meetings:** The Bioethics Committee shall meet as often as necessary but at least twice a year and report to the Medical Executive Committee.

4.1.6 **MEDICAL EXECUTIVE COMMITTEE**

The composition, purposes and responsibilities of the Medical Executive Committee are as set forth in Article VII of the Medical Staff Bylaws. The Chief of Staff may appoint non-voting members to the Executive Committee to represent Clinical or Hospital Departments not otherwise represented. The Medical Executive Committee acts on behalf of the Medical Staff between Medical Staff meetings.

4.1.7 **PHARMACY AND THERAPEUTICS COMMITTEE**

**Membership:** The voting Members of the Pharmacy and Therapeutics Committee shall include at least five Members of the Medical Staff, the Director of Pharmacy Services, and at least one representative from the nursing staff and the Hospital administration. The chair shall be appointed by the Chief of Staff.

**Purpose and Responsibilities:** The Committee shall advise on the development and surveillance of drug utilization policies and practices within the Hospital, in order to provide optimal clinical results and a minimal potential for hazard.

The Committee shall serve as an advisory group to the Medical Staff and the Pharmacy on matters pertaining to the choice of available drugs; make recommendations concerning drugs to be stocked on the nursing units and by other services; and develop and review periodically a formulary or drug list for use in the Hospital.

The Committee shall develop written policies and procedures for the establishment of safe and effective systems for procurement, storage, distribution, dispensing and use of drugs and chemicals. The Committee shall evaluate clinical data concerning new drugs or preparations requested for use in the Hospital and establish standards concerning the use and control of investigational drugs, and of research in the use of recognized drugs.

**Frequency of Meetings:** The Committee shall meet as often as necessary but at least quarterly and make its report to the MEC. Any Corrective Action Plans for regulatory agencies (i.e., MERP Audit) will be presented as Action Items following P&T Committee approval but prior to presentation to the MEC. Performance Improvement/Patient Safety Data will be presented concurrently to PIPS as information.

4.1.8 **PERFORMANCE IMPROVEMENT/PATIENT SAFETY COMMITTEE**

**Membership:** The Chair of the Performance Improvement/Patient Safety (PIPS) Committee shall be the Chief of Staff Elect. The Committee shall include at least one or two representatives from each of the four Departments, other members should include representatives from Quality Services, Nursing, Ancillary Services, Administration, Pharmacy, Patient Safety/Risk Management and other related services.

**Purpose and Responsibilities:** The Performance Improvement and Patient Safety Committee shall develop and implement an annual plan for the coordination of quality and performance improvement activities. Said plan and activities shall be subject to the review and approval by the Medical Executive Committee and the Board of Directors. The Committee shall also coordinate organization-wide patient safety and risk management activities through the development and implementation of an annual plan. The Committee shall establish measurable objectives for improving patient safety and reducing medical errors, and. The Committee shall also be responsible for the review of all Sentinel Events, including the oversight of a thorough and credible root cause analysis, appropriate plan of action, risk reduction strategies (including outcomes), and follow-up plan.

The Performance Improvement/Patient Safety Committee will receive reports, and make
recommendations, from Pharmacy regarding medication safety, Medical Records Committee, Infection Control Committee, Utilization Review Committee, and review reports and recommendations regarding National Patient Safety Goals, hospital acquired infections, sedation and pain management and restraint use and other appropriate hospital clinical services. The Committee shall maintain a permanent record of its proceedings and submit written reports of its activities and recommendations to the Medical Executive Committee and the Board of Directors.

**Frequency of Meetings:** The Performance Improvement/Patient Safety Committee shall meet as often as necessary but at least six (6) times per year and make written reports to the Medical Executive Committee.

4.1.9 PHYSICIAN’S WELL-BEING COMMITTEE  
**Membership:** The Medical Executive Committee shall establish a Medical Staff Well-Being Committee comprised of not less than five (5) active Members of the Medical Staff. Each member shall serve a term of two (2) years minimum, and the term shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity. Insofar as possible, Members of this Committee shall not serve as active participants on other peer review or quality improvement committees while serving on the Well-Being Committee.

**Purpose and Responsibilities:** The Well Being Committee may receive reports related to the health, well-being or impairment of Medical Staff members by either self-referral or by referral from others (with informant confidentiality maintained) and, as it deems appropriate, may investigate such reports. With respect to matters involving individual Medical Staff members, the Committee shall evaluate the credibility of the complaint, allegation or concern, including such investigation as reasonably deemed necessary. The Committee will also monitor the affected practitioner and the safety of patients and other individuals until the rehabilitation or any corrective action process is complete; and in the event the member fails to complete a required rehabilitation program, informs the Medical Executive Committee so that any need for other appropriate actions may be assessed. The Committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the Committee clearly demonstrates that the health or known impairment of a Medical Staff member poses an unreasonable risk of harm to any individual in the Hospital including but not limited to patients, Medical Staff members, employees, independent contractors and visitors, that information shall be referred to the Chief of Staff who will determine whether corrective action is necessary to protect an individual. The Committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the Medical Executive Committee, develop educational programs or related activities. It shall maintain only such record of its proceedings as it deems advisable, and shall transmit reports of its activities on a routine basis to the Medical Executive Committee.

**Frequency of Meetings:** The Well Being Committee shall meet as often as necessary and provide reports to the Medical Executive Committee.

4.1.10 INTERDISCIPLINARY PRACTICE COMMITTEE  
**Membership:** The voting Members of the Committee shall consist of: 1) equal numbers of Medical Staff members appointed by the Chief of Staff and registered nurses appointed by the Chief Nursing Officer, 2) other licensed or certified health professionals who perform functions requiring standardized procedures or privileges, appointed by the Chief Nursing Officer, 3) the Chief Nursing Officer and 4) a representative from Administration.

**Purpose and Responsibilities:** The Committee, after obtaining recommendations from members of the Medical and nursing Staffs in the appropriate medical specialties shall be responsible for:

A. recommending policies and standardized procedures allowing registered nurses and other health care professionals to provide for the assessment, planning and direction of the diagnostic and therapeutic care of a patient in the Hospital; The Committee shall also determine the nature and scope of review and/or supervision required for the performance of such standardized procedures. The Nursing Service will maintain a current list of those individuals who are competent to perform each standardized procedure,

B. determining the performance of standardized procedures;
C. making recommendations for the granting and rescinding of clinical privileges for allied health professionals;
D. making recommendations of the re-credentialing of allied health professionals.
E. providing for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the medical staff for medical services.

These recommendations shall be made to the Credentials Committee for forwarding to the Medical Executive Committee and Board. The Committee shall conduct its activities in accordance with Title 22, California Administrative Code, Sections 70706-70706.2 and Business & Professions Code, Section 2725.

**Frequency of Meetings:** The Committee shall meet as often as necessary but at least annually and make its recommendations to the Credentials Committee.

4.1.11 INFECTION CONTROL COMMITTEE

**Membership:** The Infection Control Committee shall include representation from the Medical Staff, Hospital Administration, Quality Services, Nursing Services and the person(s) responsible for management of the infection surveillance, prevention and control program. Representation from housekeeping, central services, laundry, the dietetic department, the engineering and maintenance department, pharmacy and the operating suit is available on at least a consultative basis. It is recommended there be representatives from each of the Medical Staff department.

**Purpose and Responsibilities:** See Medical Staff Functions.

**Frequency of Meetings:** The Infection Control Committee shall meet as often as necessary but at least quarterly and report semiannually to the MEC. The Annual Infection Control Plan and the Evaluation of the previous year’s plan and any Corrective Action Plan for regulatory agencies will be forwarded to PIPS as Action Items following Infection Control Committee approval but prior to presentation to the MEC. Performance Improvement/Patient Safety Data will be presented concurrently to PIPS as information.

4.1.12 MEDICAL RECORDS COMMITTEE

**Membership:** The Medical Records Committee shall include representation from the Medical Staff, Hospital Administration, Nursing Services and Medical Records. It is recommended there be representatives from each of the Medical Staff departments.

**Purpose and Responsibilities:** See Medical Records Functions.

**Frequency of Meetings:** The Medical Records Committee shall meet as necessary but at least two times a year and report to the PIPS Committee.

4.1.13 UTILIZATION MANAGEMENT COMMITTEE

**Membership:** The Utilization Management Committee shall include representation from the Medical Staff, Hospital Administration, Nursing Services and Case Management. It is recommended there be representatives from each of the Medical Staff departments.

**Purpose and Responsibilities:** See Utilization Management Function.

**Frequency of Meetings:** The Utilization Management Committee shall meet as often as necessary but at least quarterly and report annually to the MEC. The Annual Utilization Management Plan and the Evaluation of the previous year’s plan will be forwarded to PIPS as Action Items following Utilization Management Committee approval but prior to presentation to the MEC. Performance Improvement/Patient Safety Data will be presented concurrently to PIPS as information.

4.1.14 INTENSIVE ASSESSMENT COMMITTEE

**Membership:** The Intensive Assessment Committee shall be composed of physicians appointed by the Chief of Staff, representatives from Administration, Quality Improvement, Medical Staff
Performance Improvement, Nursing, Risk Management and other appropriate personnel at the discretion of the Chief of Staff.

**Purpose and Responsibilities:** This Committee will be responsible for reviewing any unexpected occurrence involving death or serious physical or psychological injury, or risk thereof in accordance with the Joint Commission and other accrediting agencies standards.

**Frequency of Meetings:** The Intensive Assessment Committee shall meet as necessary and shall report to the Performance Improvement/Patient Safety (PIPS) Committee and MEC.

4.1.15 **CONTRACT PHYSICIAN PERFORMANCE EVALUATION COMMITTEE**

**Membership:** The chair and membership of this Committee shall be appointed as needed by the Chief of Staff and shall consist of at least five (5) members of the Active Medical Staff, one from each Department plus the Chair. No more than two may have existing or pending contact arrangements with the Hospital and cannot be involved in evaluating their own contract.

**Purpose and Responsibilities:** The functions of this Committee shall be to review and evaluate the professional performance of physicians who are either full-time or part-time hospital based or who are under contract for their services to the Hospital.

**Frequency of Meetings:** The Committee shall meet as necessary prior to the time of annual renewal of such contracts between the physician and the Hospital in order to render recommendations regarding renewal to the Medical Executive Committee.

The Medical Executive Committee, at its discretion and at the discretion of the Chief of Staff, may act as the “Contract Evaluation Committee” where appropriate.

4.1.16 **NOMINATING COMMITTEE**

**Membership:** The Nominating Committee shall be appointed by the Medical Executive Committee and may include members of the Medical Executive Committee.

**Purpose and Responsibilities:** The Committee shall offer one or more nominees for each elected Medical Staff Officer. Nominations will be announced and the names of the nominees distributed to all voting members of the Medical Staff not less than thirty (30) days prior to the Annual Meeting of the Medical Staff. Ballots will be sent to the Active Medical staff not less than fifteen (15) days prior to the Annual Meeting.

Nominations may also be made for any elected office by any voting member of the Medical Staff. The name of the candidate must be in writing to the Chair of the Nominating Committee, be endorsed by at least 10 members of the Active Staff, bear the candidate's written consent and delivered to the Medical Staff Office no less than 20 days prior to the Annual Meeting. Candidates nominated under this paragraph will be listed on the final ballot sent 15 days prior to the Annual Meeting.

A nominee for Chief of Staff Elect and Treasurer shall be elected upon receiving a majority (50% +1) of the valid votes cast by written secret ballot. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. In the event of a tie, the majority vote of the MEC, at its next meeting or at a special meeting called for that purpose, shall decide the election. This vote shall be by secret ballot. The three candidates receiving the most votes will be elected to the Member-At-Large position.

**Frequency of Meetings:** The Nominating Committee shall meet when necessary but at least when the terms of the Medical Staff Officers are expiring.

4.1.17 **PROJECT EVALUATION COMMITTEE (PEC) (IRB)**

**Membership:** The PEC shall consist of at least seven members, including a representative from each Medical Staff Clinical Department and Administration. The PEC shall not consist entirely of men nor of women, or of members of one profession. The Chair shall be appointed by the Chief of Staff and approved by the MEC.
**Purpose and Responsibilities:** The PEC shall:

A. Conduct a thorough review of all research proposals including: scientific merits, budget, facilities, and experience of investigators;

B. Conduct meritorious evaluation of the project.

C. Make recommendations to the MEC and Board regarding research projects.

D. Report to the Performance Improvement/Patient Safety (PIPS) Committee on a quarterly basis:
   1) The number of and disposition of research projects presented to the PEC.

**Frequency of meetings:** Meetings will be held as needed. Special meetings may be called for urgent review needs. A quorum is needed to approve projects; the quorum shall consist of at least three (3) voting members. The presence of the principal investigator or one of the co-investigators is mandatory when his/her project is reviewed.

Members with a conflict of interest shall not vote nor be present during the voting procedure in the review of any research project where the conflict exists.

4.1.8 ENDOVASCULAR COMMITTEE

There shall be an Endovascular Committee, which shall report its findings to the Medical Executive Committee.

**Membership**

The Committee shall be composed of vascular surgeons, cardiologists and interventional radiologists and others at the discretion of the Chief of Staff. Chair will be named by the Chief of Staff and members to include all physicians with Endovascular privileges.

**Duties and Authority**

The Committee shall have the following duties:

A. Review of interesting or unsuccessful cases, and any other cases designated by the Chair or Chief of Staff.

B. Monitor and evaluate care provided in the performance of multidisciplinary endovascular procedures in accordance with established policies and procedures and make recommendations to the physician’s department.

C. Review of applicants for Category IA or I privileges in percutaneous transluminal peripheral angioplasty and other peripheral vascular interventions.

D. At the suggestion of the Chair, a member of the Committee or of the Chief of Staff, the committee shall review and make recommendations for approval or denial of any new interventional devices.

**Frequency of Meetings:** The Committee shall meet as often as necessary and make its report to the appropriate entity, including but not limited to: Credentials Committee, appropriate department or MEC.

4.1.19 PHYSICIAN INFORMATICS COMMITTEE (PIC)

**Goals:**

Overall, the goals and objectives for the IT service provided to physicians follow the informatics approach of aligning information management with current and future physician practice trends to achieve improved efficiency, lower costs and enhance the quality of patient care. Focused IT service to physicians will increase direct physician utilization ARMC computer systems, facilitate the prioritization and processing of physician information management needs and provide education to physicians on technology trends and available products and applications which support physician IT needs.

**Objectives:**

Coordination and prioritization of physician requests and concerns will be necessary in order to provide focused IT service, which meets the needs of most physicians and complies with Medical Staff and ARMC policy and strategic direction. Following, are the roles for achieving this goal.

A. Role of PIC
1. Physician Informatics Committee members will be comprised of medical staff who are interested in providing leadership to other physicians in the area of information technology. Members would represent both functional patient care areas and ARMC care lines. Membership will include at least one (1) member from each Department.

2. The role of the council will be approving and prioritizing the use of IS resources based on physician need. The council, with the assistance of designated IS personnel will establish criteria for completing basic service requests based on physician agreement and in keeping with the objectives and the ARMC operational plan.

3. The council will act as advisors to IS on behalf of the ARMC medical staff on global physician IT needs and current practice trends.

4. Council members will provide leadership to other physicians in increasing direct utilization of ARMC computer systems and supporting established ARMC information technology standards by positively supporting and communicating council decisions and initiatives.

B. Role of Information Services

1. IS will act as consultants to the Physician Informatics Committee to provide the best information technology solutions in keeping with established IT standards.

2. IS will facilitate system design and issue resolution between departments and physicians to enhance clinician patient care collaboration.

3. IS will facilitate physician input in the acquisition of department based computer systems when determined appropriate by ARMC.

4. IS will provide education and support to physicians within the hospital and at physician offices off site. Education and support for designated staff will also be provided. IS will coordinate system design and support so as to maximize reimbursement and timely billing.

5. IS will provide all IT services as aligned with approved projects and within budgets. Specific IT services include project management, process improvement and system re-engineering, optimization of workflow within the physical environment and multidisciplinary clinician collaboration as it related to information management.

6. IS will provide physicians with information on new products, applications, industry trends, services, interactive user groups and system developments at other healthcare facilities. IS will facilitate physician participation in local, national and international healthcare computing user groups, which provide value to physicians and ARMC.

7. IS will act as the primary liaison for physicians with IT vendors to acquire knowledge regarding new technology solutions, current industry standards and for access to industry research and development initiatives.

8. IS will facilitate the standardization of physician IT procedures, application design, education and system usage. Standardization efforts include Internet access, security and confidentiality procedures, system sign on codes, password maintenance and screen design for like systems.

9. Regularly scheduled education sessions, with CME credits provided when possible, will be coordinated by IS as related to information technology.

10. IS will coordinate programs and initiatives designed to promote IT as a tool to decrease risk potential in physician practice. For example, in partnership with Risk Management groups, IS will coordinate order entry error reduction with medical staff and hospital departments.

**Frequency of Meetings:** The Committee shall meet as often as necessary and report to the MEC.

**4.2 QUORUM REQUIREMENTS**

Refer to Article 8.4 of the Medical Staff Bylaws.
ARTICLE V: AMENDMENTS

5.1 BIENNIAL REVIEW
This Manual will be reviewed on a biennial basis by the Bylaws Committee.

5.2 AMENDMENTS
This Medical Staff Organization and Functions Manual may be amended or repealed, in whole or in part, by resolution of the Medical Executive Committee, recommended to and adopted by the Board of Directors.

APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE: 28 March 2011
Chief of Staff: Mark Miller, MD

APPROVED AND ADOPTED BY THE BOARD OF DIRECTORS: 20 April 2011
Chief Executive Officer: Donald Lorack, CEO