



**UNIVERSITY OF MISSISSIPPI MEDICAL CENTER  
GRENADA**

**MEDICAL STAFF**

**ORGANIZATIONAL MANUAL  
(As Amended)**

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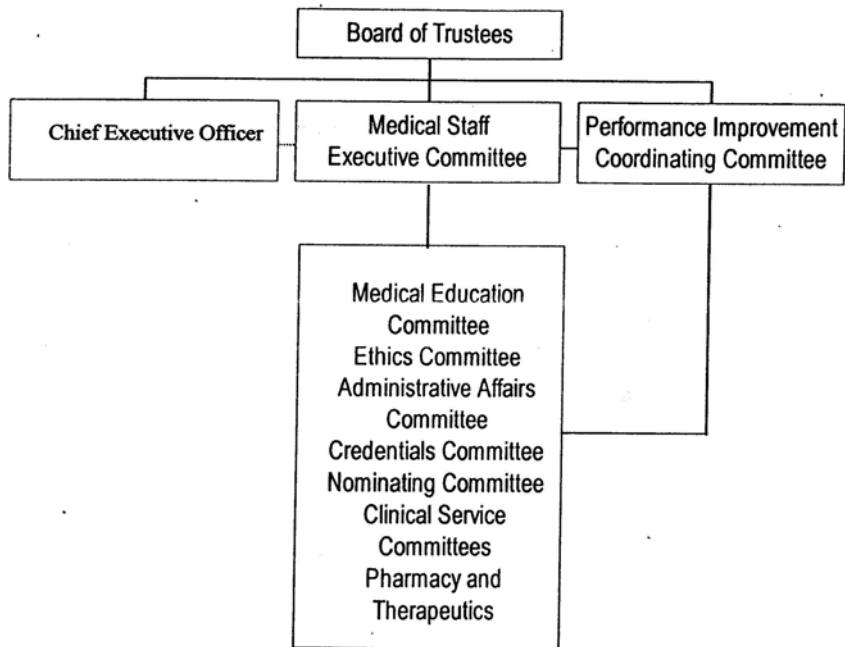
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# ORGANIZATIONAL CHART

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GRENADA LAKE MEDICAL CENTER  
MEDICAL STAFF  
ORGANIZATIONAL CHART



## DEFINITIONS

The following definitions stated in the Medical Staff Bylaws apply to the provisions of this Medical Staff Organizational Manual. The definitions are in alphabetical order.

1. **BOARD OF TRUSTEES** or **BOARD** means the governing body of the hospital, or as appropriate to the context, any committee or individual authorized by the Board to act on its behalf on certain matters.
2. **CHIEF EXECUTIVE OFFICER** or **CEO** means the individual appointed by the Board as the chief executive officer to act on its behalf in the overall executive and administrative management of the hospital. The CEO may, consistent with his responsibilities under the Bylaws of the hospital, designate a representative to perform his responsibilities under the Medical Staff Bylaws and related Manuals.
3. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted by the Board to a practitioner to provide those diagnostic, therapeutic, medical, or surgical services specifically delineated to him.
4. **EX OFFICIO** means service as a member of the body by virtue of office or position held.
5. **HOSPITAL** means University of Mississippi Medical Center of Grenada, Mississippi.
6. **MEDICAL STAFF** or **STAFF** means that component on the hospital chart of organization that stands for all medical physicians and osteopathic physicians who are appointed to membership and are privileged to attend patients or to provide other diagnostic or therapeutic services at the hospital.
7. **MEDICAL STAFF AND BOARD AUTHORITIES OR AUTHORITIES OF THE MEDICAL STAFF AND BOARD** mean any committees, officer, and clinical units of the staff, and the Board and any committees or officers thereof, who have defined responsibilities in effecting the particular function or activity that is the subject of the particular provisions in which the above defined phrase is used.
8. **MEDICAL STAFF MEMBER IN GOOD STANDING** or **MEMBER IN GOOD STANDING** means a practitioner who has been appointed to the member staff or to a particular category of the staff, as the contest requires, and who is not under either a full appointment suspension or a full or partial suspension of voting, office-holding or other prerogatives imposed by operation of any section of the Bylaws or the related manuals or any other policies of the medical staff or the hospital.

9. **MEDICAL STAFF BYLAWS AND RELATED MANUALS** means any one or more of the following documents as appropriate to the context.

- Bylaws of the Medical Staff
- Medical Staff Credentialing Procedures Manual
- Medical Staff Fair Hearing Plan
- Medical Staff Organization Manual
- General Rules and Regulations of the Medical Staff

**MEDICAL STAFF BYLAWS** or **BYLAWS** means only the first document of those listed above.

10. **MEDICAL STAFF YEAR** means the 12-month period commencing on October 1 of each year and ending on September 30 of the next year.

11. **PHYSICIAN** means an individual with an M.D. or D.O. degree, who is licensed to practice medicine.

12. **PRACTITIONER** means, unless otherwise expressly provided, physicians and any individual such as dentist, oral surgeons, podiatrist, or other individuals who either: a) are applying for appointment for clinical privileges, b) currently hold appointment and/or exercises specific delineated clinical privileges; or c) is applying for or is exercising temporary clinical privileges pursuant to Section 5.8 of the Bylaws.

13. **PREROGATIVE** means a participatory right granted, by virtue of staff category or otherwise, to a staff member or allied health professional, and exercisable subject to the ultimate authority of the Board, and to the conditions and limitations imposed in the Bylaws and related manuals and in other hospital and medical staff policies.

14. **SPECIAL NOTICE** means the written notification sent by certified mail, return receipt requested, or by personal delivery service with signed acknowledgement of receipt.

## **PART ONE. RESPONSIBILITIES AND AUTHORITY OF OFFICERS**

### **1.1 RESPONSIBILITIES AND AUTHORITY OF THE CHIEF OF STAFF**

As the primary elected medical staff officer, the chief executive officer of the Staff and the staff's representative in its relationships to others, the chief of the staff has these responsibilities and authority:

#### **1.1-1 AS THE STAFF'S REPRESENTATIVE TO OTHERS**

- (a) Transmit to the board of trustees and to the chief executive officer (CEO) the views and recommendations of the medical staff and the medical staff executive committee (MSEC) on matters of hospital policy, planning, operations, governance, and relationships with external agencies, and transmit the views and decisions of the board and CEO to the MSEC and the medical staff membership.
- (b) Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital operations to the board and CEO.
- (c) Oversee, in conjunction with the hospital's legal counsel, compliance on the part of the applicable medical staff authorities with the procedural safeguards and rights of individual staff members in all stages of the hospital's credentialing processes.

#### **1.1-2 AS THE CHIEF EXECUTIVE OFFICER**

- (a) Direct the operation and organization of the administrative policy-making and representative aspects of the medical staff organization, assist the CEO in coordinating these with administration, nursing, support and other personnel and services, enforce compliance with the provisions of the Bylaws and related manuals, rules, 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 MSEC.
- (c) Unless otherwise provided in the Medical Staff Bylaws or this Manual, appoint, subject to MSEC approval, medical staff members to and the chairmen of staff committees formed to accomplish staff administrative, environmental or representation function.
- (d) Serve as chairman of the MSEC and as an ex-officio member of all other standing staff committees, with vote.



- (e) 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.

**1.1-3 AS THE CHIEF PERFORMANCE IMPROVEMENT OFFICER**

- (a) Direct the development, implementation and day-to-day functioning and organization of the medical staff components of performance improvement, risk management and utilization management, and oversee 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 Medical Staff Bylaws or this manual, appoint, subject to MSEC approval, medical staff members to and the chairmen of committees formed to accomplish staff and education functions.
- (c) Advise the board, CEO, MSEC, 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 board on the findings and results of the performance improvement activities, provide written recommendations for actions that are required, and together with the CEO monitor that the decisions of 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 and assist the CEO in coordinating activities of administration, nursing, support and other personnel and services with medical staff clinical units.
- (b) Advise the board, the CEO and the MSEC on matters impacting on patient care and clinical services, including the need for new or modified programs and services, for recruitment and training of professional and support staff personnel and for staffing patterns.

**1.2 RESPONSIBILITIES AND AUTHORITY OF THE VICE-CHIEF OF THE STAFF**

As the second ranking elected medical staff officer, the vice-chief has these responsibilities and authority:

- (a) Assume all of the duties and responsibilities and exercise all of the authority of the chief of the staff when the latter is temporarily or permanently unable to accomplish.
- (b) Serves as a member of the MSEC and as chair of the Medical Staff function PEER) of the Performance Improvement Coordinating Committee.

NOTE: PICC is now a hospital wide committee and as such may be chaired by any standing member of the committee. It is still preferable that this chair be a physician member of the committee.

- (c) Perform such additional duties and exercise such authority as may be assigned or granted by the medical staff chief, by the MSEC, by the board or in the Medical Staff Bylaws and related manuals or in other staff or hospital policies.

### **1.3 RESPONSIBILITIES AND AUTHORITY OF THE SECRETARY-TREASURER**

The Secretary-Treasurer has these responsibilities and authority:

- (a) Serve as a member of the MSEC and as chairman of the Administrative Affairs Committee.
- (b) Be responsible for reporting on meetings of the medical staff and the MSEC.
- (c) Supervise the collection and accounting for any funds that may be collected in the form of dues, assessments, or otherwise and disburse these funds as directed by the MSEC.
- (d) If funds are collected from dues, assessments, or otherwise, prepare an annual financial report for transmittal to the staff at its annual meeting and to the CEO, and any other interim reports that may be requested by the chief of the staff or the MSEC.
- (e) Perform such additional duties and exercise such authority as may be assigned or granted by the medical staff chief, by the MSEC, by the board, or in the Medical Staff Bylaws and related manuals or in other medical staff or hospital policies.

### **1.4 RESPONSIBILITIES AND AUTHORITY OF THE IMMEDIATE PAST CHIEF**

The immediate past chief has these responsibilities and authority:

- (a) Serve as an ex-officio voting member of the MSEC and as an advisor to the chief of the staff and other officials and committees of the staff and as chairman of the credentials committee.

- (b) Perform such additional duties as may be assigned by the chief of the staff, by the MSEC, by the board, or in the Medical Staff Bylaws and related manuals or other medical staff or hospital policies.
- (c) Serves as chairman of the Credentials Committee. *(Add. 5/8/01)*

## **PART TWO. FUNCTIONS OF THE STAFF**

### **2.1 GENERAL**

The required functions of the medical staff are as described in Section 2.2 below. The staff official(s) and/or organizational component(s) responsible for each of the activities to be carried out in accomplishing a function are identified in Part Four of this Manual.

### **2.2 DESCRIPTION OF FUNCTIONS**

#### **2.2-1 GOVERNANCE, DIRECTION, COORDINATION, AND ACTION**

- (a) Receive, coordinate and act upon as necessary the written reports and recommendations from committees, other groups and officers concerning the function assigned to them and the discharge of their delegated administrative responsibilities.
- (b) Coordinate the activities of and policies adopted by the staff, 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 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.
- (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) Act on all matters of medical staff business, except as otherwise provided in the Medical Staff Bylaws.
- (h) Fulfill the reporting requirements in Section 10.3-3 of the Medical Staff Bylaws and such others as are defined for specific activities in the Medical Staff Bylaws and related manuals.

## **2.2-2 PERFORMANCE IMPROVEMENT PROGRAM ACTIVITIES**

- (a) Adopt and modify, subject to the approval of the MSEC and the board, and supervise the conduct of specific programs and procedures for assessing, maintaining and improving the quality and efficiency of medical care provided in the hospital.
- (b) Implement the procedures required under (a) 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 improvable situations.
- (d) Follow-up on action taken.
- (e) Coordinate the staff's performance improvement activities with those of other health care disciplines.
- (f) Provides reports of findings of performance improvement activities to the Board through oral reports from the Chief of Staff and from presentation, generally quarterly, by the Chief Nursing Officer or others as deemed necessary. (Revised May 2003)
- (g) Participate in annually evaluating the overall performance improvement 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 clinical monitoring activities.
- (b) Conducts ongoing review of mortalities, including analysis of autopsy reports, when available, with a formal assessment report generated no less than quarterly.
- (c) Conducts ongoing 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, with a formal assessment report generated no less than quarterly.
- (d) Conduct ongoing blood usage reviews, including evaluation of appropriateness of transfusions (whole blood and blood components),

review of all confirmed transfusion reactions, and review of ordering practices for blood and blood products (including the amount requested, the amount used and the amount wasted), with a formal assessment report generated no less than quarterly.

- (e) Conduct ongoing review and evaluate drug therapy practices and drug utilization, including review of the appropriateness of empiric and therapeutic use of drugs, with a formal assessment report generated no less than quarterly.
- (f) Deleted
- (g) Review on a continuous basis other general indicators of the quality of care and of clinical performance, including unexpected patient care management events.
- (h) Deleted
- (i) 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 medical staff Performance Improvement Coordinating Committee and for information purposes to any other staff organizational entity or official with an official interest in the activity. The medical staff Performance Improvement Coordinating Committee reports similarly to the MSEC, and for information to any other staff organizational entity or official with an official interest in the activity and to the board. The MSEC reports to the Board by the Chief of Staff through oral and/or written reports given and/or submitted monthly as required.

#### **2.2-4 CASE MANAGEMENT**

- (a) Develop a case management plan for approval by the MSEC, 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 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 case management 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 case management activities, including a determination of their effectiveness in allocating resources.

- (d) Conduct studies, take actions, submit reports and make recommendations as required by the Case Management plan.
- (e) The Case Management Coordinator submits a written report to the Performance Improvement Coordinating Committee on the findings generated from the Case Management plan review in accordance with current Case Management Service (CMS) guidelines. The MSEC through the Chief of Staff reports pertinent findings to the Board.

**2.2-5 SPECIAL STUDIES**

- (a) Conduct any special studies of the inputs, processes or outcomes of care that may be required to determine the appropriateness of clinical performance.
- (b) Those responsible under 2.2-5(a) send written reports as required or requested on the progress and results of such studies to the Medical Staff Performance Improvement Coordinating Committee. The Medical Staff Performance Improvement Coordinating Committee reports to the MSEC. The MSEC through the Chief of Staff reports pertinent findings to the Board.

**2.2-6 SPECIAL HOSPITAL SERVICES REVIEW**

- (a) Develop and implement mechanisms to monitor and evaluate the care provided in or by the intensive care and other special 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) Those responsible for activities under 2.2-6(a) submit written reports at least quarterly on results and progress to the Medical Staff Performance Improvement Coordinating Committee which reports in turn to the MSEC. Responsible entities under (b) report to the Medical Staff Performance Improvement Coordinating Committee for coordination which reports in turn to the MSEC. The MSEC through the Chief of Staff reports pertinent findings to the Board. Other staff or hospital organizational entities or officials with an official interest in any of the activities covered by this section receive reports for informational purposes.

**2.2-7 CREDENTIALS REVIEW**

- (a) Review, evaluate and transmit written reports as required by the Medical Staff Bylaws, Credentialing Procedures Manual or other relevant protocols on initial appointment, concluding or extending the provisional period, reappointments, modifications of appointment,

clinical privileges, and the performance of specified services by allied health professionals.

- (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 staff chief; (2) the MSEC; (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; or (4) the board.
- (c) Submit written reports to the MSEC and the board 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.

#### **2.2-8 EDUCATION**

- (a) Participate in developing, planning, implementing, and evaluating 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 and utilization management findings.
- (b) Coordinate, as necessary, the various education activities.
- (c) Provide medical direction and advice to the hospital's medical library services.
- (d) Maintain a written record of education activities and participation in them.
- (e) Submit written reports at least quarterly to the MSEC.

#### **2.2-9 MEDICAL RECORDS**

- (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; and
  - (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) Submit a written report to the Performance Improvement Coordinating Committee at least quarterly on the progress and results of the activity.

#### **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 pharmacy 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 drug list for use in the hospital, prescribe the necessary operating rules for its use, and assure that said rules are available to and observed by all staff members.
- (e) Develop a mechanism to identify, review and receive reports on all unexpected drug reactions.
- (f) Evaluate clinical data concerning new drugs or preparations requested for use in the hospital.
- (g) Submits written reports to the MSEC concerning drug utilization policies and practices in the hospital. (Revised May 2003; July 2006)

#### **2.2-11 INFECTION CONTROL**

- (a) Maintain surveillance over the hospital infection control program.
- (b) Develop and implement a system for reporting, identifying and analyzing the incidence and cause and reviewing the proper management and epidemic potential of infections among patients.
- (c) Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.



- (d) Develop, evaluate and review preventive, surveillance and control policies and procedures relating to all phases of the hospital's activities, including: operating rooms, delivery rooms, special care units; central service; housekeeping and laundry; sterilization and disinfection procedures by heat, chemicals, or otherwise; isolation procedures, prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment; testing of hospital personnel for carrier status; disposal of infectious material; food sanitation and waste management; and other situations as requested.
- (e) Deleted
- (f) Conduct on a periodic basis statistical/prevalence studies of antibiotic usage and susceptibility/resistance trend studies.
- (g) The Infection Control Surveillance Officer reports to the Infection Control Officer of the Medical Staff any pertinent findings from surveillance activities. Oversight decisions will then be forwarded to the appropriate Service Committee(s) with an overall report being given at least quarterly to the Performance Coordinating Improvement Committee.

#### **2.2-12 EMERGENCY-PREPAREDNESS**

- (a) Participate with the hospital safety committee in developing, periodically reviewing and implementing a fire plan for the hospital and by reporting the plan to the MSEC as it is reviewed annually.
- (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, and report this plan to the MSEC as it is reviewed annually.

#### **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.
- (c) Submit written reports as necessary or required to relevant staff organizational components and to the board or appropriate committees thereof with findings and recommendations for action.

## **2.2-14 BYLAWS REVIEW AND REVISIONS**

- (a) Conduct as necessary but at least every three years a review of the Bylaws and the related manuals and forms promulgated in connection with them.
- (b) Conducts as necessary, but at least every three years a review of all clinical policies and rules.
- (c) Submit written recommendations to the MSEC and to the board for changes in these documents. *(Revised May 2003)*

## **2.2-15 NOMINATING**

Identify nominees for election to general staff or of the appropriate constituent group, Medical Staff Performance Improvement Coordinating Committee, the chief executive officer and the board concerning the qualifications and acceptability of prospective nominees.

# **PART THREE. MEDICAL STAFF COMMITTEES**

## **3.1 DESIGNATION**

There will be a Medical Staff Executive Committee (MSEC) and the following standing committees responsible to the MSEC: Administrative Affairs, Clinical Services(s), Credentials, Ethics, Medical Education, Nominating, and Performance Improvement Coordinating, Pharmacy and Therapeutics. *(Rev. July 2006)*

## **3.2 MEDICAL STAFF EXECUTIVE COMMITTEE**

The composition and duties of the medical staff executive committee are as set forth in Section 10.3 of the Medical Staff Bylaws. Its governance, direction, coordination, action, and reporting functions are as described in Section 2.2 of this Manual. In addition, the MSEC supervises overall medical staff compliance with accreditation and other regulatory requirements applicable to the medical staff or any of its clinical units.

## **3.3 CREDENTIALS COMMITTEE**

### **3.3.1 PURPOSE AND MEETINGS**

- (a) Coordinates the staff credentials function by:
  - (1) Receiving and analyzing applications and recommendations for appointment, conclusion or extension of the provisional period, clinical privileges, and changes therein, and recommending action thereon;
  - (2) Integrating performance improvement, risk management and case management findings, membership and other relevant information into individual credentials files;

- (3) Developing or coordinating, periodically reviewing and making recommendations on the procedures and forms used in connection with each component of the credentialing process and recommending standards for the content and organization and overseeing maintenance of the individual credential files.
- (b) Designs and oversees implementation of the credentialing procedures for allied health professionals (AHP).
- (c) The Credentials Committee meets monthly as necessary and reports to the MSEC. *(Revised May 2003)*

### **3.3-2 COMPOSITION**

The credentials committee includes:

- (a) Immediate past chief of the medical staff, as chairman and with vote;
- (b) At least three staff members selected to be representative of major clinical areas, all with vote;
- (c) Medical staff chief, with vote;
- (d) Chief executive officer or designee, without vote; and
- (e) Representative from medical staff office, as secretary and without vote.

### **3.4 thru 3.4-2 Deleted**

## **3.5 CONTINUING MEDICAL EDUCATION COMMITTEE**

### **3.5-1 PURPOSE AND MEETINGS**

The medical education committee:

- (a) Directs or coordinates the development of and evaluates the effectiveness of continuing medical education programs for the staff that: (1) are responsive to needs identified in case management, risk management and utilization findings and by staff members; (2) are designed to inform the staff of developments in diagnostic and therapeutic aspects of care pertinent to practice at the hospital; and (3) refresh the medical staff in aspects of basic medical education.
- (b) Analyzes the status and needs of, and makes recommendations regarding materials for the hospital's medical library services. The continuing medical education committee meets at least quarterly or more frequently as needed and reports on its activities to the medical staff executive committee.

### **3.5-2 COMPOSITION**

The continuing medical education committee includes:

- (a) A chairman, with vote;
- (b) At least four (4) additional active staff members selected to be representative of the major clinical areas, all with vote;
- (c) Librarian or designated hospital representative, without vote;
- (d) Medical staff chief, with vote; and
- (e) Chief executive officer or designee, without vote.

## **3.6 ADMINISTRATIVE AFFAIRS COMMITTEE**

### **3.6-1 PURPOSE AND MEETINGS**

The administrative affairs committee (AAC) fulfills staff responsibilities relating to review and revision of Medical Staff Bylaws and related manuals and assumes the responsibilities for investigating and providing recommendations on special projects and activities of concern to the staff as are referred by the medical staff executive committee. In conjunction with the hospital administration, it assists in long-range planning and in evaluating the effectiveness of new programs, services, and capital equipment. The AAC meets every other month as need demands and reports to the MSEC.  
*(Rev. 7-11-06)*

- (a) Coordinates the development, review, and any required revisions of and recommends action to the medical staff executive committee and/or hospital administration as appropriate, on hospital and medical staff policies relating to direct patient care, including the clinical policies of the staff, of special clinical units and programs (e.g. total parenteral nutrition, enterostomal therapy, chronic ventilator patients) and of diagnostic and therapeutic support services. *(Rev. May 2003)*
- (b) Serves as a forum for review of the observance of patients' rights.
- (c) Coordinates the staff medical records review function by: 1) serving as a clearing house for requests for changes in medical record forums; 2) acting as a liaison with Health Information Management (HIM) department on matters relating to medical records practices; and, 3) formulating rules and procedures for access to patients' histories, x-rays, and other clinical records for use in publications and/or communications outside the hospital.

- (d) Coordinates the medical staff records review function by: a) developing and reviewing medical staff policies and rules relating to medical records, including medical records completion, forms, formats, filing, indexing, storage, destruction and availability and recommending changes therein, and b) receives performance improvement, risk management and utilization findings suggestive of or requiring changes in any of the above policies and practices responsive to decisions made by utilization findings.

### **3.6-2 COMPOSITION**

The administrative affairs committee includes:

- (a) Secretary-treasurer of the medical staff as chairman, and with vote;
- (b) At least one member from each service committees and others as felt necessary to carry on the work of the committee. *(Rev. May 2003)*
- (c) Medical staff chief, with vote;
- (d) Chief executive officer or designee(s), without vote.

## **3.7 ETHICS COMMITTEE**

### **3.7-1 PURPOSE AND MEETINGS**

The ethics committee acts as an advisory and consulting group to health care professionals, patients, patient representatives, and other interested parties on bio-ethical matters such as the use of extraordinary measures to maintain life functions, refusal of treatment, living wills, and so on. It reviews any medical decision that has ethical implications and develops policies and guidelines on issues in bio-ethics, observing applicable Federal and State requirements. It meets on an as needed basis at the call of the chairman and reports to the medical staff executive committee.

### **3.7-2 COMPOSITION**

The ethics committee includes a chairman who is the immediate past chief of the medical staff and other medical staff members appointed by the incumbent Chief of Staff and in addition, members from: a) nursing, b) social services, c) clergy, d) risk management, e) attorney, f) ombudsman, and g) administration.

## **3.8 NOMINATING COMMITTEE**

### **3.8-1 PURPOSE AND MEETINGS**

The nominating committee shall nominate, when required under the provisions of the Medical Staff Bylaws, one or more qualified candidates for the offices of chief, vice-chief and secretary-treasurer. It shall meet as required under Sections 8.4 of the Medical Staff Bylaws and otherwise as necessary to accomplish its function.

### **3.8-2 COMPOSITION**

The nominating committee shall be composed of:

- (a) medical staff chief, as chairman and with vote; and
- (b) at least four (4) additional active staff members to be representative of the major clinical services, all with vote.

## **3.9 PERFORMANCE IMPROVEMENT COORDINATING COMMITTEE**

### **3.9-1 PURPOSE AND MEETINGS**

The Performance Improvement Coordinating Committee (PICC) is a joint committee with the hospital that coordinates, prioritizes and monitors the medical staff data-gathering and analysis components of the hospital's performance improvement program and coordinates the medical staff's activities in this area with those of the other professional and support services in the hospital. It develops an annual plan, in coordination with the Director of Case Management for the staff's and hospital's PI activities and annually reviews the effectiveness and cost-efficiency of the staff's PI and hospital's activities. It establishes: formats for the aggregation, display and reporting of data and findings; a system for follow-up to determine that action taken results in problem resolution; and formats and schedules for submission of data and findings, committee minutes and special reports. It shall maintain a performance improvement file on each staff member and transmit the pertinent information contained therein to the Credentials Committee and the appropriate service committee chairman for use in the appointment/reappointment process of the staff member.

The PICC will also coordinate and monitor the staff's and hospital's clinical risk management program by implementing a system for screening of unexpected patient care management events and providing a mechanism for review of identified events and claims in anticipation of or preparation for litigation. It will analyze aggregated data on significant events to identify possible patterns and serve as the link to other medical staff and hospital groups with related responsibilities.

The PICC meets monthly and reports to the MSEC. As appropriate and necessary, it transmits findings for information or follow-up to the Credentials Committee, Medical Education Committee, any of its own subcommittees, physician directors of relevant special units of the hospital and to administration when other professional, technical or administrative services are involved.

When performance improvement activities identify possible practitioner performance problems, report shall be made to PICC. PICC shall determine and execute a plan of action which, at this level, shall be limited to efforts to

correct the problem and shall not extend to limitation of privileges or sanctions. These actions, or review of possible practitioner performance problems, are made in a closed session of the medical staff members only. *(Rev. May 2003; July 2006)*

### **3.9-2 COMPOSITION**

The PICC includes:

- (a) a chair for the overall committee, preferably a physician member, but may be any standing member of the committee *(Rev. July 2006)*
- (b) the vice chief of staff as the chair of the PEER function and with vote *(Rev. July 2006)*
- (c) the chairman of each service committee and three to four other representatives as appointed by the Chief of Staff, with vote. *(Rev. Oct. 2000)*
- (d) the medical staff officers (except the secretary/treasurer who serves as chair of AAC), with vote,
- (e) the CEO or designee(s), with vote,
- (f) the Chief Nursing Officer, with vote,
- (g) the performance improvement director, with vote,
- (h) the HIM director, with vote, and
- (i) two (2) representatives designated by the CEO from ancillary hospital departments participatory services, with vote.
- (j) hospital representatives who are designated for any given meeting to give their progress reports, with vote. *(Added July 2006)*

NOTE: The alpha designations between (a) and (j) designate the members of the committee and their voting power. Letters (a) through (g) designate the standing members of the committee and are: all physician members of the committee, the CEO, the CNO, the PI director, and the HIM director. *(Rev. May 2003; July 2006)*

### **3.10 Deleted**

### **3.11 Deleted**

### **3.12 SERVICE COMMITTEES**

### **3.12-1 PURPOSE AND MEETINGS**

The medical staff has designated the following service committees: Medicine Service Committee, Surgery Service Committee and Obstetrics/Gynecology and Pediatrics Service Committee. These service committees meet at least quarterly to formulate recommendations on matters referred by the Medical Staff and other staff or hospital committees or officials. A quorum of service committee members shall be required at the quarterly meeting and at any called meeting where business is to be conducted and vote is expected or required.

#### **Duties and responsibilities of Service Committee Chairmen**

1. To serve as a member in a leadership role on the Performance Improvement Coordinating Committee and the Medical Staff Executive Committee.
2. To participate with the Credentials Committee in the privileging/reappointment process.
3. To call special sessions of the service committee at such times felt necessary and/or pertinent to the practice group.
4. Chair all called meetings and the quarterly meetings.

### **3.12.2 COMPOSITION (Service Committees)**

All active staff members shall be assigned to service committees by the Chief of Staff. Assignment to services shall be reflective of the nature of the individual staff member's practice and may result in a staff member being assigned to more than one service committee.

A chairman shall be elected/reaffirmed by the membership of each service committee at the beginning of each Medical Staff year. *(Rev. July 2006)*

## **3.13 PHARMACY AND THERAPEUTICS**

### **3.13-1 PURPOSE AND MEETING**

The Pharmacy and Therapeutics Committee shall carry out all functions as defined in Section 2.2-10 of this organizational manual. The committee is a joint committee of hospital and medical staff. The committee shall meet quarterly and submit written recommendations to the MSEC. *(Rev. May 2003; Rev. July 2006)*

### **3.13-2 COMPOSITION**

- (a) A chairman appointed by the Chief of Staff, with vote,
- (b) At least two other members of the active staff appointed by the Chief of Staff, with vote,
- (c) The Chief Nursing Officer, with vote,



(d) The Pharmacy Director, as secretary; with vote, and

(e) Administrative support, with vote. *(Rev. March 2013)*

**3.14 TRAUMA COMMITTEE - Deleted**

**3.15 CANCER COMMITTEE - Deleted**

**PART FOUR. ASSIGNMENT OF FUNCTIONS  
(AS DESCRIBED IN PART TWO)**

	A	COS	CRED	P & T	MSEC	CMEC	NOM	PICC	PHY	HOSPITAL DEPT. MANAGER
GOVERNANCE					X					
DIRECTION		X			X					
COORDINATION		X			X					
ACTION		X			X					
PI PROGRAM ACT.		X	X		X			X		
MONITORING ACT.				X				X	X	
CASE MANAGEMENT								X		
SPECIAL STUDIES				X				X		
SPECIAL REVIEWS								X	X	X
CREDENTIALS REV.			X		X			X		
EDUCATION & LIBRARY					X	X		X		
MEDICAL RECORDS				X	X			X		
PHARMACY & THERAPEUTICS				X	X					
INFECTION CONT.				X	X			X		
EMERGENCY PREPAREDNESS					X					
PLANNING	X	X			X				X	
BYLAWS REVIEW AND REVISIONS	X				X					
NOMINATING							X			

**KEY TO ACRONYMS:**

AAC	Administrative Affairs Committee
COS	Chief of Staff
CRED COM	Credentials Committee
P&T	Pharmacy & Therapeutics
MSEC	Medical Staff Executive Committee
CMEC	Continuing Medical Education Committee
NOM COM	Nominating Committee
PICC	Performance Improvement Coordinating Committee

## **PART FIVE: MEETING PROCEDURES**

### **5.1 NOTICE OF MEETINGS**

Monthly calendar of meetings is posted on the first day of every month and each person entitled to be present is made aware of meetings by telephone or written notice prior to each meeting. 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 fifty (50) percent of the active medical staff at any regular or special meeting constitutes a quorum for the transaction of any business under the Medical Staff Bylaws and the related manuals.

#### **5.2-2 COMMITTEE MEETINGS**

Fifty (50) percent of the qualified voting members of a committee, but not less than two members, constitutes a quorum at any meeting of such committee.

### **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 and the chief administrative officer.
- (c) The election of officers and of representatives to staff and hospital committees, when required by the Medical Staff Bylaws.
- (d) Reports by responsible officers and committees and discussion on the overall results of the staff's performance improvement, risk management and case management program activities and on the fulfillment of the other required staff functions.
- (e) New business.

### **5.4 MANNER OF ACTION**

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present is the action of the group. Action may be taken without a meeting by the staff or committee by presentation of the

question to each member eligible to vote, in person or by mail, and each vote cast returned to the chairman of the group or to the chief of staff in the case of a staff vote. Such vote shall be binding so long as the question is voted on by at least the number of voting members of the group that would constitute a quorum.

#### **5.5 MINUTES**

Minutes of all meetings shall be prepared 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, forwarded to the medical staff executive committee or the parent committee in the case of a subcommittee. Minutes shall be made available, upon request to and at the discretion of the chief of the staff, to any member of the staff who functions in an official capacity within the hospital so as to have a legitimate interest in them. When access is approved, it shall be afforded in a manner consistent with confidentiality policies of the hospital concerning medical staff minutes and activities. A permanent file of the minutes of each meeting shall be maintained.

#### **5.6 PROCEDURAL RULES**

Meetings of the staff 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 SIX. AMENDMENT**

#### **6.1 AMENDMENT**

This Medical Staff Organizational Manual may be amended or repealed, in whole or in part, by one of the following mechanisms:

- (a) a resolution of the medical staff executive committee (MSEC) recommended to and adopted by the board; or
- (b) action by the board on its own initiative after notice to the MSEC of its intent and pursuant to the procedures outlined in Article Fourteen of the Medical Staff Bylaws.

#### **6.2 RESPONSIBILITIES AND AUTHORITY**

The procedures outlined in Article Fourteen of the Medical Staff Bylaws shall be followed in the adoption and amendment of this Medical Staff Organizational Manual, provided that the medical staff executive committee may act for the staff in making the necessary recommendations.

**PART SEVEN. ADOPTION**

**7.1 MEDICAL STAFF**

This Medical Staff Organization Manual was adopted and recommended to the board by the medical staff executive committee on \_\_\_\_\_.  
Date

\_\_\_\_\_  
Chief of the Medical Staff

**7.2 BOARD OF TRUSTEES**

This Medical Staff Organizational Manual was approved and adopted by resolution of the board of trustees on \_\_\_\_\_.  
Date

\_\_\_\_\_  
President, Board of Trustees

\_\_\_\_\_  
Chief Executive Officer