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MEDICAL STAFF BYLAWS

PART III ORGANIZATION AND FUNCTIONS MANUAL

Davis Memorial Hospital

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PART III. ORGANIZATION AND FUNCTIONS MANUAL

SECTION 1: FUNCTIONS OF THE STAFF

1.1 Generally:

1.1.1 The required functions of the staff are as described in Section 1.2 below. The Medical Staff Officers, Service Chiefs, or Committee Chairs responsible for each of the activities to be carried out in accomplishing a function are identified in parentheses following the description of the activity

1.1.2 The medical staff of Davis Memorial Hospital shall be organized into two services: the Services of Medicine and Surgery. Each Service shall be directed by a Service Chief who will be responsible for the overall supervision and satisfactory discharge of assigned functions under the MEC.

1.2 Description of medical staff functions:

1.2.1 Governance, direction, coordination, and action:

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

1.2.1.2 Account to the Board of Trustees and to the staff by written recommendations for the overall quality and efficiency of patient care at Davis Memorial Hospital, (President and MEC);

1.2.1.3 Take reasonable steps to obtain professional and ethical conduct and initiate investigations, and pursue corrective action of medical staff members, when warranted, (President and MEC);

1.2.1.4 Make recommendations on medico-administrative and hospital clinical and operational matters, (President and MEC);

1.2.1.5 Inform the medical staff of the accreditation program and the accreditation and state licensure status of the hospital, (President and MEC); and

1.2.1.6 Act on all matters of medical staff business, and fulfill any state and federal reporting requirements, (MEC and certain staff committees).

1.2.1.7 Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities (CME committee);

1.2.1.8 Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications,

1.2.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities (medical staff quality committee)

1.2.2.1 Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when appropriate based on the general competencies defined by the medical staff;

1.2.2.2 Set expectations for competency, define both individual and aggregate measures to assess competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;

1.2.2.3 Understand the medical staff's and administration's approach to and methods of performance improvement;

1.2.2.4 Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;

1.2.2.5 Communicate findings, conclusions, recommendations, and actions to improve the performance of physicians to medical staff leaders and the governing body, and define in writing the responsibility for acting on recommendations for practitioner improvement;

1.2.2.6 Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis;

1.2.2.7 Participate as requested in the hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.2.3 Monitoring activities should include, but not be limited to the following:

1.2.3.1 Medical assessment and treatment of patients;

1.2.3.2 Use of medications;

1.2.3.3 Use of blood and blood components;

1.2.3.4 Use of operative and other procedures;

1.2.3.5 Education of patients and families;

1.2.3.6 Coordination of care with other practitioners and hospital personnel; and

1.2.3.7 Accurate, timely, and legible completion of patients' medical records.

1.2.4 Utilization management activities should include, but not be limited to the following:

1.2.4.1 Efficiency of clinical practice patterns; and

1.2.4.2 Significant departures from established patterns of clinical practice.

1.2.5 Credentials review (see Part II. Credentials Procedure Manual)

1.2.6 Information management (MEC and Quality Medical Management Committee):

1.2.6.1 Review and evaluate medical records to determine that they:

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

1.2.6.1.2 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.

1.2.6.2 Develop, review, enforce, and maintain surveillance at least quarterly over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein. (Quality Medical Management Committee for review and enforcement of timeliness rules, forms, and policy, etc.)

1.2.6.3 Provide liaison with hospital administration, nursing service, and medical records professionals in the employ of the hospital on matters relating to medical records practices and information management planning.

1.2.7 Emergency preparedness: Assist the hospital administration in developing, periodically reviewing, and implementing a crisis management manual that addresses disasters both external and internal to the hospital. (MEC)

1.2.8 Planning (President, VPMA, MEC, Service Chiefs):

1.2.8.1 Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation, expansion, abridgment, or termination of each;

1.2.8.2 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; and

1.2.8.3 Communicate strategic, operations, capital, human resources, information management, and corporate compliance plans to medical staff members.

1.2.9 Bylaws review (MEC):

1.2.9.1 Conduct periodic review of the Medical Staff Bylaws, Organization and Functions Manual, Credentials Procedure Manual, and Medical Staff Rules and Regulations;

1.2.9.2 Conduct periodic review of the clinical policies and rules; and

1.2.9.3 Submit written recommendations to the MEC and to the Board of Trustees for amendments to the Medical Staff Bylaws, Credentials Procedure Manual, Organization and Functions Manual, and Rules and Regulations.

1.2.10 Nominating (MEC):

1.2.10.1 Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure.

1.2.10.2 In identifying nominees consults with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.2.11 The hospital-wide infection control function (MEC and the Quality Medical Management Committee):

1.2.11.1 The medical staff oversees the development and coordination of the hospital-wide program for surveillance, prevention implementation, and control of infection.

1.2.11.2 The following issues will routinely be addressed and reported:

Develop and approve policies describing the type and scope of surveillance activities including:

- Review of cumulative microbiology recurrence and sensitivity reports;

- Determination of definitions and criteria for nosocomial infections;

- Review of prevalence and incidence studies, as appropriate; and

- Collection of additional data as needed.

1.2.11.3 Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

1.2.11.4 Evaluate and revise the type and scope of surveillance annually;

1.2.11.5 Develop a surveillance plan for all sampling of personnel and environments;

1.2.11.6 Develop procedures and systems for identifying, reporting and analyzing the incidence and causes of infections;

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

1.2.11.8 Report nosocomial infection findings on a day-to-day basis to the attending physician and appropriate clinical or administrative leader;

1.2.11.9 Review all policies and procedures on infection prevention, surveillance and control at least biannually;

1.2.11.10 Review and analyzes any anti-microbial susceptibility/resistance trend studies; and

1.2.11.11 Participate in the orientation of new employees and continuing education of all employees regarding infection control.

1.2.12 Pharmacy and Therapeutics Functions (MEC and the Quality Medical Management Committee):

1.2.12.1 Maintain a formulary of drugs approved for use by the hospital;

1.2.12.2 Create treatment guidelines and protocols in cooperation with medical and nursing staff;

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

1.2.12.4 Perform drug usage evaluation studies on selected topics;

1.2.12.5 Perform medication usage evaluation studies as required by the JCAHO;

1.2.12.6 Perform blinded practitioner profile analysis related to medication use; and

1.2.12.7 Approve policies and procedures related to the JCAHO Care of Patient Standards: to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement, storage, distribution, use, safety procedures; and other matters relating to medication use within the health system.

1.2.12.8 Develop and measure indicators for the following elements of the patient treatment functions:

1.2.12.8.1 Prescribing/ordering of medications;

1.2.12.8.2 Preparing and dispensing of medications;

1.2.12.8.3 Administrating of medications; and

1.2.12.8.4 Monitoring of the effects of medication.

1.2.12.9 Analyze and profile data regarding the measurement of the patient treatment functions by service and practitioner, where appropriate;

1.2.12.10 Provide routine summaries of the above analyses, and recommend process improvement when opportunities are identified;

1.2.12.11 Serve as an advisory group to the health system and medical staffs pertaining to the choice of available medications; and

1.2.12.12 Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.2.13 All functions mentioned above shall be reported through the Quality Medical Management Committee to the MEC. All minutes and records reviewed will be maintained as a permanent record and will be kept in compliance with the confidentiality policies of the medical staff and the hospital.

1.3 Responsibilities of Service chiefs:

1.3.1 The responsibilities of the Service Chiefs shall be:

1.3.1.1 To oversee all clinically related activities of the Service;

1.3.1.2 To oversee all administratively related activities of the Service otherwise provided for by Davis Memorial Hospital;

1.3.1.3 To provide ongoing surveillance of the performance of all individuals in the medical staff Service who have been granted clinical privileges;

1.3.1.4 To recommend to the Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff Service;

1.3.1.5 To recommend clinical privileges for each member of the Service and licensed independent practitioners;

1.3.1.6 To assign and recommend to the MEC and hospital administration of Davis Memorial Hospital off-site sources for needed patient care services not provided by the medical staff Service or the hospital;

1.3.1.7 To monitor and evaluate the quality and appropriateness of patient care provided in the medical staff Service and to implement action following review and recommendations by the Quality Medical Management Committee and/or the MEC;

1.3.1.8 To integrate the Service into the primary functions of the hospital;

1.3.1.9 To coordinate and integrate interdepartmental and intradepartmental services and communication;

1.3.1.10 To participate in the administration of the Service through cooperation with nursing services and hospital administration in matters affecting patient care;

1.3.1.11 To develop and implement medical staff and hospital policies and procedures that guide and support the provision of patient care services;

1.3.1.12 To recommend to the hospital administrator the sufficient numbers of qualified and competent persons to provide patient care and service;

1.3.1.13 To provide input to the hospital administrator regarding the qualifications and competence of licensed independent practitioners such as nurse practitioners, physician assistants, and certified registered nurse anesthetists who are granted privileges to provide patient care services and are not members of the medical staff; and

1.3.1.14 To make recommendations to the MEC and the hospital administrator for space and other resources needed by the medical staff Service to provide patient care services.

1.4 Responsibilities of the Medical Staff Officers: are outlined in the Medical Staff Bylaws, Article III, Section 6, Duties of Officers.

1.5 Responsibilities of Medical Staff President:

1.5.1 The President of the Medical Staff is the primary elected officer of the medical staff and is the medical staff's advocate and representative in its relationships to the Board of Trustees and the administration of the hospital. The President, jointly with the MEC, provides direction to and oversees medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the Medical Staff Bylaws, the Credentials Procedure Manual, the Organization and Functions Manual, and the Medical Staff Rules and Regulations. Specific responsibilities and authority are to:

1.5.1.1 Call and preside at all general and special meetings of the medical staff;

1.5.1.2 Serve as chair of the MEC and as ex-officio member of all other medical staff committees without vote, and to participate as invited by the Board of Trustees and the hospital administrator on hospital or board committees;

1.5.1.3 Enforce Medical Staff Bylaws, the Credentials Procedure Manual, the Organization and Functions Manual, Medical Staff Rules and Regulations, and hospital policies;

1.5.1.4 Appoint committee chairpersons and all members of the medical staff standing and ad hoc committees; in consultation with hospital administration, appoints medical staff members to appropriate hospital committees; in consultation with the chair of the Board of Trustees, appoint the medical staff members to appropriate board committees when those are not designated by position or by specific direction of the Board of Trustees or otherwise prohibited by state law;

1.5.1.5 Support and encourage medical staff leadership and participation on the interdisciplinary clinical performance improvement activities;

1.5.1.6 Report to the Board of Trustees the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners or allied health professionals who are applying for

appointment or privileges, or who are granted privileges or providing services in the hospital;

1.5.1.7 Continuously evaluate and periodically report to the hospital, MEC, and the Board of Trustees regarding the effectiveness of the credentialing and privileging processes;

1.5.1.8 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 of Trustees, the hospital management, other professional and support staff, and the community the hospital serves;

1.5.1.9 Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board of Trustees;

1.5.1.10 Attend Board of Trustee meetings; attend Board Committee Meetings as invited by the Board of Trustees;

1.5.1.11 Ensure that the decisions of the Board of Trustees are communicated and carried out within the medical staff; and

1.5.1.12 Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.

SECTION 2: PROFESSIONAL STAFF COMMITTEES

2.1 Designation:

2.1.1 There will be a MEC as designated in the Bylaws, and the following standing committees to be responsible to the MEC: Quality Medical Management Committee, Credentials Committee, (for the composition of Credentials Procedure Manual, see Part II, Credentials Procedure Manual, Section 1.1).

2.1.2 The following functions shall routinely report to the Quality Medical Management Committee their findings, conclusions, recommendations, actions, and effectiveness of action: medical records, anesthesia/operative/other procedure review, utilization management, drug use review, blood use review, infection control, radiation safety, and pharmacy and therapeutics.

2.1.3 The principles governing committees are provided in the Medical Staff Bylaws. Additionally, the President of the Medical Staff will appoint the chairs and members of ad hoc and/or standing medical staff committees. Members of the committee shall be appointed for a term of one (1) year, although consideration will be given to reappointment of members to a second

term for continuity. Committees shall generally meet quarterly or on call of the chair or President.

2.2 Medical Executive Committee: The composition and duties of the MEC are as set forth in the Bylaws. In addition, the MEC supervises overall medical staff compliance with accreditation and other state and federal regulatory requirements applicable to the medical staff.

2.3 Quality Medical Management Committee:

2.3.1 Composition: the Quality Medical Management Committee includes:

2.3.1.1 A minimum of five (5) active members of the medical staff.

2.3.1.2 Other hospital staff without vote to present data or reports, as requested by the chair.

2.3.2 Responsibilities: The Quality Medical Management Committee:

2.3.2.1 Coordinates the systematic and ongoing review of the appropriateness and quality of: blood usage, drug usage, anesthesia/operative and other invasive procedures, timeliness, completion, and accuracy of medical records;

2.3.2.2 Reviews and approves blood usage review plan;

2.3.2.3 Coordinates, prioritizes, and monitors the medical staff data gathering and analysis components of the hospital's quality review program and coordinates the medical staff's activities in this area with those of the other professional and support services in the hospital;

2.3.2.4 Serves as a liaison for quality review issues with the medical staff, the hospital staff, and the committees responsible for compliance with accreditation standards and federal and state and licensure requirements; and

2.3.2.5 Coordinates, with the administrative director, clinical information services, the medical staff's performance improvement activities, and annually reviews the effectiveness and cost efficiency of the medical staff's PI activities

2.3.2.6 Is responsible for establishing:

2.3.2.6.1 Formats for the aggregation, display, and reporting of data and findings;

2.3.2.6.2 Systems for follow up to determine that corrective action taken results in problem resolution; and

2.3.2.6.3 Formats and schedules for submission of data and findings, committee minutes, and special quality reports.

2.3.2.7 Receives and synthesizes information regarding critical care, utilization review, and the cancer center on a routine basis;

2.3.2.8 Supervises the maintenance and analysis of data and transmits that analysis to the appropriate Service Chief to use in the periodic reappraisal of each staff member;

2.3.2.9 Implements a system for screening of clinical risk management issues, including unexpected patient care management events, and morbidity concerns; analyzes aggregate data on significant high risk events by identifying possible patterns and communicating same to the Service Chief and the MEC; and

2.3.2.10 Analyzes trends of hazardous and risk management events reported, and attempts to determine effective solutions and implement appropriate systems

2.4 Cancer Committee

2.4.1 Composition: the Cancer Committee includes:

2.4.1.1.1 At least one (1) physician member from the required specialties: diagnostic radiology, pathology, general surgery, medical oncology, and radiation oncology. The cancer committee includes at least one (1) physician member representing the five major cancer sites.

2.4.1.2 The committee shall consist of at least one (1) non-physician member from: cancer program administration, oncology nursing, social worker or case management, certified tumor registry, and quality improvement.

2.4.1.3 Additional physician or non-physician members include: hospice, palliative care, clinical research, nutrition, pharmacy, pastoral care, mental health, American Cancer Society, and public member of the community served.

2.4.1.4 The cancer committee chair is a physician who may also fulfill the role of one of the required physician specialties. The Cancer Liaison Physician must be a member of the cancer committee and fulfill the role of one of the required physician specialties.

2.4.2 Responsibilities:

2.4.2.1.1 Responsible and accountable for all cancer program activities at Davis Memorial Hospital.

2.4.2.1.2 Designates one coordinator for each of the four areas of cancer committee activity: cancer conference, quality control of cancer registry data, quality improvement, and community outreach. The community liaison will assume responsibilities of the wellness coordinator.

2.4.2.1.3 Develops annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care.

2.4.2.1.4 Evaluates annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors on an annual basis.

2.4.2.1.5 Establishes the cancer conference frequency, format, and multidisciplinary attendance requirements for cancer conferences on an annual basis.

2.4.2.1.6 Ensures that the required number of cases are discussed at cancer conference and that at least 75 percent of the cases discussed at cancer conferences are presented prospectively; also include clinical staging documented and discussed according to national guidelines.

2.4.2.1.7 Monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis.

2.4.2.1.8 Establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis.

2.4.2.1.9 Completes site-specific analysis that includes comparison and outcome data and disseminates the results of the analysis to the medical staff.

2.4.2.1.10 Reviews 10 percent of the analytic caseload to ensure that clinical staging is documented in medical records of 50% of the cases.

2.4.2.1.11 Reviews 10 percent of the analytic case load to ensure that 90 percent of cancer pathology reports include the scientifically validated data elements outlined in the CAP protocols.

2.4.2.1.12 The committee monitors physician use of AJCC or other staging, site-specific indicators, national guidelines in treatment planning.

2.4.2.1.13 Provides a formal mechanism to educate patients about cancer-related clinical trials each year.

2.4.2.1.14 Monitors and evaluates community outreach activities on an annual basis.

2.4.2.1.15 Offers two (2) cancer related educational activities each year. One must be based on collaborative/clinical staging education.

2.4.2.1.16 Completes and documents the required studies that measure quality and outcomes and monitors facility quality performance.

2.4.2.1.17 Implements two improvements that directly affect patient care.

2.4.2.1.18 Establishes subcommittees or working groups as needed to fulfill the cancer program goals.

2.4.2.1.19 Appoint a member to act as registry Physician Advisor and supervise the registry and ensures accurate and timely abstracting, staging and follow-up reporting by performing quality control review of registry data and encouraging data usage and regular reporting. Encourage systemic, lifelong surveillance of all cancer patients.

2.4.3 Meetings: The cancer committee shall meet at least quarterly with quorum and attendance requirements maintained.

SECTION 3: CONFIDENTIALITY, IMMUNITY, AND RELEASES

3.1 Confidentiality of information: Information submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of: assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of health care provided; evaluating current clinical competence and qualifications for staff appointment/affiliation, or clinical privileges or specified services; contributing to teaching or clinical research; or determining that health care services were indicated or were performed in compliance with an applicable standard of care shall, to the fullest extent permitted by law, be confidential. This information will not be disseminated to anyone other than a representative of the hospital or to other health care facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed. Such confidentiality shall also extend to information that may be provided by third parties. Each practitioner expressly acknowledges that violation of the confidentiality provided here are grounds for immediate and permanent revocation of staff appointment and/or clinical privileges or specified services.

3.2 Immunity from Liability: No representative shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of this hospital or for providing information, opinion, counsel, or services to a

representative or to any health care facility or organization of health professionals concerning said practitioner. Immunity protections afforded in these Bylaws are in addition to those prescribed by applicable state and federal law.

3.3 Activities: The confidentiality and immunity provided by this article applies to all information or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

3.3.1 Applications for appointment/affiliation, clinical privileges, or specified services;

3.3.2 Periodic reappraisals for renewed appointment/affiliations, clinical privileges, or specified services; Corrective or disciplinary actions;

3.3.3 Hearings and appellate reviews;

3.3.4 Quality assessment and performance improvement activities;

3.3.5 Utilization review and improvement activities;

3.3.6 Claims reviews;

3.3.7 Risk management and liability prevention activities;

3.3.8 Other hospital, committee, department/division, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.