ORGANIZATION AND FUNCTIONS MANUAL

MCKEE MEDICAL CENTER

LOVELAND, COLORADO

August 2011

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PART 1
DEFINITIONS

1.1 APPLICANT

The term "Applicant" means any Practitioner who has applied for initial appointment to the Medical Staff or any Member who has applied for reappointment to the Medical Staff, additional clinical privileges or a change in Medical Staff category.

1.2 BHS

The term "BHS" means Banner Health System, an Arizona non-profit corporation, the owner and operator of the Hospital.

1.3 CHIEF EXECUTIVE OFFICER

The term "Chief Executive Officer" means the individual appointed by the President of BHS, or his/her designee, to act on BHS' behalf in the overall management of the Hospital.

1.4 CORPORATE BYLAWS

The term “Corporate Bylaws” means the corporate bylaws of BHS.

1.5 CREDENTIALS MANUAL

The term "Credentials Manual" means the Credentials Policy and Procedure Manual, which has been recommended by the Medical Executive Committee and approved by the Governing Board.

1.6 DEPARTMENT

The term " Department” refers to a group of Members who have been granted clinical privileges in one of the following medical specialties: Anesthesiology, Emergency Medicine, Medicine, Perinatal Medicine, Surgery, Family Practice, Pathology or Radiology.

1.7 GOVERNING BOARD

The term "Governing Board" means the governing body of BHS, or any subcommittee thereof, as may be designated by the governing body of BHS, unless otherwise specified.

1.8 HOSPITAL

The term "Hospital" means McKee Medical Center, an acute care hospital located at 2000 Boise Avenue, Loveland, Colorado.

1.9 JCAHO

The term "JCAHO" means the Joint Commission on Accreditation of Healthcare Organizations.

1.10 MANUAL

The term "Manual" means this Organization and Functions Manual, which has been recommended by the Medical Executive Committee and approved by the Governing Board.

1.11 MEDICAL EXECUTIVE COMMITTEE

The term "Medical Executive Committee" means the executive committee of the Medical Staff.

1.12 MEDICAL STAFF

The term "Medical Staff" means all Practitioners who hold a valid Colorado license and who have been appointed to membership on the Medical Staff and granted clinical privileges by the Governing Board to attend patients at the Hospital. The term "Medical Staff" also will include members of the Affiliate Staff.

1.13 MEDICAL STAFF BYLAWS

The term "Medical Staff Bylaws" refers to the major written statements governing the Medical Staff and the Members.

1.14 MEDICAL STAFF RULES AND REGULATIONS

The term "Medical Staff Rules and Regulations" refers to the written statements regulating the conduct of the Medical Staff within the broad guidelines provided by the Medical Staff Bylaws.

1.15 MEMBER

The term "Member" means any Practitioner who has been appointed to membership on the Medical Staff by the Governing Board.

1.16 PRACTITIONER

The term "Practitioner" means a doctor of medicine, a doctor of osteopathy, a doctor of medical dentistry, or a doctor of dental surgery.

PART 2
FUNCTIONS OF THE MEDICAL STAFF

2.1 GENERALLY

This Manual is intended to establish guidelines for the functions of the Medical Staff and the Departments, the responsibilities of Medical Staff leadership and Medical Staff committees, and the organization of the Medical Staff and Medical Staff Committees.

The required functions of the Medical Staff are as described in Section 2.2 below. The Medical Staff officer(s) and/or the organizational entity(ies) responsible for each of the activities to be carried out in accomplishing a function are identified in brackets following the description of the activity.

The Medical Staff will be organized into eight (8) Departments. Each Department will have a chair and a vice-chair with overall responsibility for the supervision and satisfactory discharge of assigned functions of the Department. The Departments will be responsible to the Medical Executive Committee for the promotion of quality of care and for reviewing the professional performance of Members rendering care at the Hospital.

The Departments with multiple specialties, include, but are not limited to, the following:

a. Department of Anesthesiology

   i. Anesthesiology
   ii. Pain Management

b. Department of Medicine

   i. Allergy and Immunology
   ii. Cardiology
   iii. Dermatology
   iv. Endocrinology
   v. Gastroenterology
   vi. Geriatric Medicine
   vii. Hematology/Oncology
   viii. Infectious Disease
   ix. Internal Medicine
   x. Nephrology
   xi. Neurology
   xii. Occupational Medicine

xiii. Physical Medicine and Rehabilitation
xiv. Psychiatry
xv. Pulmonary Medicine
xvi. Rheumatology

c. Department of Perinatal Medicine

i. Obstetrics and Gynecology
ii. Pediatrics

d. Department of Radiology

i. Diagnostic Radiology
ii. Radiation Oncology

e. Department of Surgery

i. Dental Surgery
ii. General Surgery
iii. Gynecology
iv. Maxillofacial Surgery
v. Neurological Surgery
vi. Ophthalmology
vii. Orthopedic Surgery
viii. Otorhinolaryngology
ix. Plastic Surgery
x. Thoracic Surgery
xi. Urology

2.2 DESCRIPTION OF GENERAL FUNCTIONS OF THE MEDICAL STAFF

2.2.1 Governance, Direction, Coordination and Action

The general governance functions of the Medical Staff include the following:

a. Receiving, coordinating and acting upon, as necessary, the reports and recommendations from sections, committees, other groups and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities [Medical Executive Committee and certain Medical Staff committees].

b. Accounting to the Governing Board and the Medical Staff by written reports for the overall quality and efficiency of patient care at the Hospital [Medical Executive Committee and the Chief of Staff].

c. Taking reasonable steps to assure professionally ethical conduct and competent clinical performance on the part of Members, including initiating investigations and initiating and pursuing corrective action when warranted [Medical Executive Committee and the Chief of Staff].

d. Making recommendations on medico-administrative and Hospital management matters [Medical Executive Committee and the Chief of Staff].

e. Informing the Medical Staff of the accreditation program and the accreditation and licensure status of the Hospital [Medical Executive Committee and the Chief of Staff].

f. Acting on all matters of Medical Staff business and fulfilling any state and federal reporting requirements [Medical Executive Committee and certain Medical Staff committees].

2.2.2 Quality Improvement

a. Objectives

i. Define the responsibility for monitoring and improving every aspect of patient care, from the time the patient enters the system through diagnosis, treatment, recovery and continuum of care.

ii. Provide for identifying and resolving any problems that may result in sub optimal patient care and safety, while striving to continuously improve and facilitate positive outcomes.

iii. Provide a systematic approach to improving performance while meeting customers' needs and exceeding their expectations.

iv. Increase the efficiency of Hospital and Medical Staff processes while providing cost effective care.

v. Improve clinical and non-clinical processes that require Medical Staff leadership or participation.

b. Activities

i. Adopting, modifying and supervising, subject to the approval of the Medical Executive Committee and the Governing Board, the conduct of specific programs and procedures for assessing, maintaining, and improving the quality and efficiency of the Medical Staff [Quality Improvement Committees reporting to the Medical Executive Committee].

ii. Implementing the procedures required under Section 2.2.2.a above 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 [Quality Improvement Committees reporting to the Medical Executive Committee].

iii. Formulating and acting upon specific recommendations that address identified opportunities to improve [Medical Executive Committee and the Chief of Staff].

iv. Following up on action taken and monitor impact of change.

v. Coordinating quality improvement activities of the Medical Staff with those of other health care disciplines [Quality Improvement Committees, the Chief of Staff and Hospital Administration].

vi. Participating or representing the Medical Staff on Hospital performance improvement teams and projects, the purpose and goals of which will impact Member responsibilities and care; team reports will be made to the appropriate Department Quality Improvement Committee and/or Department.

vii. Analyzing utilization profiles on a periodic basis, including determination of their effectiveness in allocating resources.

viii. Sending written reports, when appropriate, to the next higher authority in the organizational structure on the results (including findings, actions taken, and follow up) and progress of all quality review and risk management activities [All Medical Staff committees].

ix. Participating in periodic evaluations of, and recommending improvements in, the overall quality review program for its comprehensiveness, integration, effectiveness, and cost efficiency and establishing priorities [Quality Improvement Committees, the Medical Executive Committees, and the Governing Board].

c. Monitoring Activities

i. Adopting, modifying, supervising and coordinating the conduct and findings of the patient care monitoring activities associated with the Medical Staff [Quality Improvement Committees].

ii. Periodically reviewing and evaluating operative and other invasive procedure reviews, including tissue review, evaluation and comparison of preoperative and postoperative diagnoses, indications for surgery, actual diagnosis of tissue removed and situations in which no tissue was removed [Quality Improvement Committees].

iii. Periodically reviewing and evaluating 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 (including the amount requested, the amount used and the amount wasted) [Quality Improvement Committees].

iv. Periodically reviewing and evaluating medication therapy practices and drug utilization, including review of the appropriateness of empirical and therapeutic use of drugs [Pharmacy and Therapeutics Committee and the Quality Improvement Committees].

v. Reviewing and reporting to the Medical Executive Committee, and evaluating, on an ongoing basis, the appropriateness, safety and effectiveness of the prophylactic, empirical and therapeutic use of antibiotics at the Hospital, and reporting conclusions, recommendations, actions taken and action results [Pharmacy and Therapeutics Committee and the Quality Improvement Committees].

vi. Reviewing and reporting to the Medical Executive Committee on a continuous basis other general indicators of the medical assessment and treatment of patients and of clinical performance, including unexpected patient care management events [Quality Improvement Committees].

vii. Participating in the measurement, assessment and improvement of other patient care processes, including, but not limited to:

- Patient and family education
- Coordination of care with other Members and Hospital personnel
- Accurate, timely, legible completion of medical records
- Use of peer review information for renewal or revision of clinical privileges
- BHS and JCAHO indicators
- Patient satisfaction
- Restraint usage
- Mortalities (autopsy protocol measurement)

- Major events
- Risk management – occurrence reporting
- Utilization management
- Infection control
- Trauma

viii. Reviewing and reporting to the Medical Executive Committee on a continuous basis and enforcing or coordinating compliance with established policies and protocols related to clinical practice in the Hospital [Chief of Staff, Department chairs, and Hospital representatives].

d. Communication Activities

The communication activities will include submitting reports of indicator results as well as findings, conclusions, recommendations and actions taken. In addition to reports to the Medical Executive Committee, communication may be completed by the following methods:

- Department meetings
- Individual discussions for education and/or counseling
- Team meetings
- Documentation of findings to Members
- Continuing medical education programs
- Other communication mechanisms, i.e. newsletters, notifications

2.2.3 Credentials Review (see the Credentials Manual)

2.2.4 Information Management

a. Reviewing and evaluating medical records to determine if they

i. properly describe the condition and progress of the patient, the therapy given, the tests provided and the results thereof, and the identification of responsibility for all actions taken [Quality Improvement Committees and the Medical Executive Committee]; and

ii. are sufficiently complete at all times so as to facilitate continuity of care and communications among all those providing patient care services at the Hospital [Quality Improvement Committees and the Medical Executive Committee].

b. Developing, reviewing, enforcing and maintaining 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 recommending methods of enforcement thereof and changes therein [Quality Improvement Committees for review and enforcement of compliance].

c. Providing liaison with Hospital Administration, Patient Care Services and Medical Records professionals in the employ of the Hospital on matters relating to medical records practices and information management planning [Quality Improvement Committees].

2.2.5 Emergency Preparedness

Assisting Hospital Administration in developing, implementing, and periodically reviewing a plan that addresses disasters, both external and internal to the Hospital [Medical Staff representation on the Hospital Environment of Care Committee].

2.2.6 Planning

a. Participating in the evaluation of, on an as-needed basis, existing programs, services and facilities of the Hospital and the Medical Staff, and recommending continuation, expansion, abridgment or termination of each [Medical Executive Committee, Chief of Staff, Department chairs, and the Governing Board].

b. Participating in the evaluation of 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 assessing the relative priorities of services and needs and the allocation of present and future resources [Medical Executive Committee, the Chief of Staff, Department chairs, and the Governing Board].

c. Submitting written reports as necessary or required to relevant Medical Staff organizational components and to the Governing Board, or appropriate committees thereof, through the Chief of Staff with findings and recommendations for action.

2.2.7 Medical Staff Bylaws Review

a. Conducting periodic review of the Medical Staff Bylaws and the related manuals and forms promulgated in connection therewith [Medical Executive Committee].

b. Conducting periodic review of the clinical policies and rules of the Medical Staff [Medical Executive Committee].

c. Submitting written recommendations to the Medical Executive Committee and the Governing Board, if required, for changes in these documents [for Bylaws, the Medical Executive Committee, the Medical Staff, and the Governing Board, and for related manuals, policies and rules, the Medical Executive Committee and the Governing Board].

PART 3
RESPONSIBLITIES OF OFFICERS

3.1 RESPONSIBILITIES OF MEDICAL STAFF OFFICERS

3.1.1 Chief of Staff

The Chief of Staff is the primary elected officer of the Medical Staff and the Medical Staff's advocate and representative in its relationships to others within the Hospital. The Chief of Staff, jointly with the Medical Executive Committee, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services provided and all in other functions of the Medical Staff as outlined in the Medical Staff Bylaws and related manuals. Specific responsibilities and authority of the Chief of Staff are to:

a. call and preside at all general and special meetings of the Medical Staff;

b. serve as chair of the Medical Executive Committee and as an ex-officio member of all other Medical Staff committees without vote and of specified Hospital or Governing Board committees;

c. enforce the Medical Staff Bylaws, the Medical Staff Rules and Regulations, Medical Staff policies and procedures and appropriate Hospital rules and policies;

d. facilitate the appointment of the chairs and members of Medical Staff committees, in consultation with the Chief Executive Officer, appoint Medical Staff members of Hospital committees, and in consultation with the chair of the Governing Board, appoint the Medical Staff members of Governing Board committees when such members are not designated by position or by specific direction of the Governing Board;

e. support and encourage Medical Staff leadership and participation in the interdisciplinary clinical performance improvement activities;

f. report to the Governing Board the recommendations of the Medical Executive Committee concerning appointment/affiliation, reappointment/reappraisal, delineation of clinical privileges or specified

services, and corrective action with respect to Applicants or allied health professionals who are applying for appointment/affiliation or privileges/services, or to Members or allied health professionals who are appointed to the Medical Staff or who are otherwise affiliated with or are exercising privileges or services at the Hospital;

g. continuously evaluate and periodically report to the Chief Executive Officer, the Medical Executive Committee and the Governing Board on the effectiveness of the Members or allied health professionals exercising privileges/services at the Hospital;

h. review and enforce compliance with standards of ethical conduct and professional demeanor among the Members in their relations with each other, the Governing Board, Hospital management, other professional and support staff, and the community that the Hospital serves;

i. communicate and represent the opinions and concerns of the Medical Staff and individual Members on organizational and individual matters affecting Hospital operations to the Chief Executive Officer, the Medical Executive Committee and the Governing Board;

j attend meetings of the Governing Board and other Governing Board committees upon invitation of the Governing Board;

k. ensure that the decisions of the Governing Board are carried out within the Medical Staff; and

l. perform such other duties and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.

3.1.2 Chief of Staff-Elect (Secretary-Treasurer)

The Chief of Staff-Elect will:

a. in the absence of the Chief of Staff, assume all the duties and have the authority of the Chief of Staff;

b. serve as a member of the Medical Executive Committee;

c. serve as the chair of the Bylaws Committee and have responsibility for review and revision of the Medical Staff Bylaws, the Medical Staff Rules and Regulations and Medical Staff policies and procedures;

d. Assure that accurate and complete minutes of Medical Staff meetings are prepared;

e. serve as Treasurer of the Medical Staff account; and

f. perform other duties as may, from time to time, be assigned by the Chief of Staff.

3.2 RESPONSIBILITIES OF DEPARTMENT OFFICERS

3.2.1 Responsibilities of a Department Chair

a. The Department chair will establish, together with the Medical Staff and Hospital Administration, the type and scope of services required to meet the needs of the patients and the Hospital.

b. The Department chair will give guidance on the overall medical policies of the Hospital and make specific recommendations and suggestions concerning the development and implementation of policies and procedures that guide and support the provision of services in the Department.

c. The Department chair will develop and recommend to the Medical Staff criteria for clinical privileges in the Department.

d. The Department chair will review applications, reapplications and any credentialing review and submit recommendations to the Credentials Committee and the Medical Executive Committee regarding clinical privileges for each Applicant to the Department. If needed, the Department chair may consult with the chair of the appropriate Department Quality Improvement Committee.

e. The Department chair assures continuing surveillance of the professional performance of all Members and other individuals with clinical privileges in the Department.

f. The Department chair will be responsible for assessing and improving the quality of care and services provided by the Department, for assuring the implementation of a planned and systematic process of monitoring and for evaluating the quality and appropriateness of care and treatment of patients served by the Department, including comparative and aggregate data analysis.

g. The Department chair will serve as a member of the Medical Executive Committee, will represent the Department and will implement within the Department actions taken by the Medical Executive Committee.

h. The Department chair will call and preside at Department meetings, will be an ex-officio member of all Departmental committees and will have

general supervision over all the professional work of the Department. The Department chair may review any medical record of any patient in the Department as necessary.

i. The Department chair will be accountable to the Governing Board through the Medical Executive Committee for all Medical Staff and administrative activities within the Department.

j. The Department chair will assume responsibility for enforcing the Medical Staff Bylaws, the Medical Staff Rules and Regulations, and all Department rules and regulations within the Department.

k. The Department chair will participate in every phase of administration of the Department through cooperation with Hospital Administration and clinical care services in matters affecting patient care, including personnel, supplies, special techniques, and standing and preprinted orders. The Department will integrate into the primary functions of the Hospital including:

- The coordination and integration of interdepartmental and intradepartmental services;
- The development and implementation of policies and procedures that guide and support the provision of services;
- The recommendations for a sufficient number of qualified and competent persons to provide care or service;
- The determination of the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide patient care services;
- The continuous assessment and improvement of the quality of care and services provided;
- The maintenance of quality control programs, as appropriate;
- The orientation and continuing education of all persons in the Department or service;
- The recommendation for space and other resources needed by the Department or service.

l. The Department chair will assess and recommend to the Hospital through the Medical Executive Committee off-site sources for needed patient care services not provided by the Department or the Hospital.

m. The Department chair will appoint such committees as are necessary to conduct the functions of the Department specified herein and designate a chair for each.

n. The Department chair will perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief

of Staff, the Medical Executive Committee, the Chief Executive Officer, or the Governing Board.

o. The Department chair will be responsible for bringing to the attention of any offending Member/allied health professional any infraction of the rules. It will be the Department chair's prerogative to handle any infraction on a personal basis or present it to the Department Quality Improvement Committee for disposition.

3.2.2 Responsibilities of a Department Vice-Chair

a. In the absence of the Department chair, the Department vice-chair will assume all of his/her duties and will have all of his/her authority. The Department vice-chair will be expected to perform such duties of supervision as may be assigned to him/her by the Department chair.

b. The Department vice-chair will be the chair of the Department Quality Improvement Committee, unless otherwise specified in the Department rules and regulations.

c. The Department vice-chair may plan scientific and continuing medical education programs for Department meetings, unless otherwise specified in the Department rules and regulations.

PART 4
COMMITTEE ORGANIZATION

4.1 COMMITTEE ASSIGNMENT

The members and chairs of committees will be appointed by the Chief of Staff and will be responsible to and report to the Medical Executive Committee. Attempts will be made to accommodate requests for specific committee membership. Attempts will be made to provide continuity in the committee structure so that all members of a committee are not new every year.

4.2 NON-PRACTITIONER MEMBERS

Unless otherwise specified, the Medical Staff committees will include non-Practitioner members, including allied health professionals and Hospital representatives, who will serve without vote, but who will have all the other privileges of committee membership. Non-Practitioner members may not participate in decisions and actions regarding Member peer review.

4.3 SPECIAL AND NEW COMMITTEES

Committees may be created by the Medical Executive Committee for a specific purpose or on an ad hoc basis to perform special tasks. The existence of such committees will terminate at the end of the project or Medical Staff year, as applicable, unless renewed by the Medical Executive Committee. The Chief of Staff, subject to the Medical Executive Committee's approval, will appoint the members of special committees.

4.4 TERM OF APPOINTMENT

Unless otherwise specified, membership on a committee will be for one (1) year. Members will serve until the end of the term or until a successor is appointed, unless the member is removed or unable to complete the term. Any committee member who is appointed by the Chief of Staff may be removed for cause by a majority vote of the Medical Executive Committee.

4.5 VACANCIES

Unless otherwise specified, vacancies on any committee will be filled in the same manner in which an original appointment to such committee is made.

4.6 MEETING PROCEDURES, AGENDAS AND NOTICES

Unless specified elsewhere, a notice stating the day, hour and location of a committee meeting will be provided to members prior to the meeting. Notice of cancellation of any meeting will be communicated prior to the meeting date and time. Agendas will include the topic and responsible person. Minutes will be maintained recording the topic, discussion, recommendations, and action.

4.7 QUORUM AND MANNER OF ACTION

Unless otherwise provided, fifty percent (50%) of the voting members of a committee or three (3) voting members, whichever is less, will constitute a quorum for voting issues. If a quorum is present when a committee is convened, the quorum will exist until the meeting is adjourned, notwithstanding the departure of one or more members. Action may be taken without a meeting by a document setting forth the action to be so taken and signed by each member of the committee who is entitled to vote.

PART 5
FUNCTIONS OF DEPARTMENT

5.1 ESTABLISHMENT OF RULES AND REGULATIONS

Each Department will establish its own rules and regulations consistent with the Medical Staff Bylaws, the Medical Staff Rules and Regulations, applicable policies and protocols of the Medical Staff and applicable policies and regulations of the Governing Board. The

Department rules and regulations will include the minimum criteria for membership within the Department. The Department rules and regulations are submitted to the Medical Executive Committee for approval. The Department rules and regulations may cover:

- Name
- Definitions
- Purpose
- Membership
- Appointment and privileges
- Voting privileges
- Officers and committees
- Meetings
- Specific Department rules
- Amendments
- Acceptance and approval

5.2 QUALITY ASSESSMENT/QUALITY IMPROVEMENT PROGRAM

Each Department will participate in the Quality Assessment/Quality Improvement Program of the Medical Staff and the Hospital, as outlined in Section 2.2.2 above, and the current Quality Improvement Plan.

5.3 ESTABLISHMENT OF A DEPARTMENT SECTION

Should four (4) or more Members in the recognized specialty and/or subspecialty express a desire to form a section for the purpose of conducting regular meetings, the chair of the appropriate Department, with majority approval, will authorize the establishment of such a section. The appropriate Department may delegate any or all of the Departmental functions as are applicable to the section.

5.4 ESTABLISHMENT OF NEW DEPARTMENTS

Upon petition from any Member or group of Members, the Medical Executive Committee, subject to Medical Staff approval, may recommend to the Governing Board, the creation, elimination, subdivision, further subdivision or combination of any Department or Departments.

PART 6
MEDICAL STAFF COMMITTEES

6.1 DESIGNATION

There will be a Medical Executive Committee, and the following committees are responsible to the Medical Executive Committee:

- Anesthesia Department and Quality Improvement Committee
- Bylaws Committee
- Cancer Committee
- Cardiovascular Lab Quality Improvement Committee
- Credentials Committee
- Critical Care Committee
- Emergency Medicine Department and Quality Improvement Committee
- Family Medicine Department
- Family Medicine Quality Improvement Committee
- Institutional Review Board/Ethics Committee
- Medical Education and Library Committee
- Medicine Department
- Medicine Quality Improvement Committee
- Operating Room Committee
- Pathology Department and Quality Improvement Committee
- Perinatal Medicine Department
- Perinatal Medicine Quality Improvement Committee
- Pharmacy and Therapeutics Committee/Infection Control/Employee Health
- Practitioner Health Committee
- Professional Conduct Panel
- Radiology Department and Quality Improvement Committee
- Surgery Department
- Surgery Quality Improvement Committee
- Trauma Services Committee
- Trauma Services Quality, Morbidity and Mortality Review Committee
- Women and Children's Services Committee

The above committees will routinely report to the Medical Executive Committee their findings, conclusions, recommendations and actions.

6.2 COMMITTEES OF THE MEDICAL STAFF

The chair of each committee will be appointed by the Chief of Staff for a one (1) year term, which will be effective from January 1st through December 31st, unless otherwise specified in this Manual, and will serve terms as specified in this Part 6.

Members of the standing committees will be appointed and will serve terms as specified in this Part 6.

These committees will report and be accountable to the Medical Executive Committee. A permanent record of the proceedings and actions of each committee will be maintained.

6.2.1 Bylaws Committee

a. Composition

The Bylaws Committee will be composed of a chair (the Chief of Staff-Elect) and additional two (2) members, together with representation from Medical Staff Services. BHS legal counsel will be an ex-officio member of the Bylaws Committee.

b. Duties

i. Provide review of the Medical Staff Bylaws, the Medical Staff Rules and Regulations and Medical Staff policies and procedures and recommend changes or revisions.

ii. Review proposed changes to the Medical Staff Bylaws and the Medical Staff Rules and Regulations from the standing committees and the Departments for appropriateness, placement and legality, recommend changes to the appropriate committee or Department and recommend acceptance or rejection to the Medical Executive Committee.

c. Meetings

The Bylaws Committee will meet at the discretion of the chair of the Bylaws Committee.

6.2.2 Cancer Committee

a. Composition

The chair of the Cancer Committee will be elected annually from among the members of the Cancer Committee for a one (1) year term of office. Members of the Cancer Committee will be appointed by the appropriate Department chairs and will include the following: at least one (1) member from the Department of Surgery, including one (1) general surgeon, two (2) members from the Department of Medicine, including one (1) medical oncologist and one (1) pain control/palliative care physician or specialist, two (2) members from the Department of Radiology, including one (1)

diagnostic radiologist and one (1) radiation oncologist, and one (1) member from the Department of Pathology.

Representatives from the following areas of the Hospital will serve as ex-officio members of the Cancer Committee: Care Coordination, Oncology Data Registry, Oncology Nursing, Hospital Administration, clinical research data manager or nurse, and performance improvement or Quality Management professional.

All functions of the Cancer Committee, including Cancer Conferences (Tumor Board), will proceed as a professional review/quality improvement committee. The process, recommendations, trends and outcomes will be documented under the guidelines of the applicable peer review statutes governing professional review committees and will be reported to the appropriate Department Quality Improvement Committees, the appropriate Departments and/or Credentials Committee, as applicable.

b. Duties

i. Develop and evaluate annual goals and objective for the eandeaveors related to cancer care as appropriate for the facility and category of Cancer Program approval.

ii. Establish and monitor Cancer Conference (Tumor Boad) frequency, multidisciplinary attendance and case presentation

iii. Oversee the functions of the Oncology Data Registry including data collection, abstracting timeliness, and follow up completeness.

iv. Be responsible for a system of evaluation of quality of care with documentation of its operations.

vi. Obtain or generate criteria concerning diagnosis, treatment, follow-up, and rehabilitation of patients with neoplasms according to site.

vii. Monitor patient data conformity to the above criteria through quality assessment studies.

c. Meetings

The Cancer Conference (Tumor Board) will meet as needed, generally twice per month, for case presentations. A minimum of 75% of cases will be presented prospectively. Records of attendance and case presentations will be kept on file in the Oncology Data Registry, with attendance maintained by Medical Staff Services. The Cancer Conferences (Tumor

Board) will be presided over by a representative from the Department of Pathology.

Cancer Committee meetings will be held periodically as needed, but no less than quarterly, to perform the duties as listed above (b). Minutes of meetings will be kept on file in the Medical Staff Services office.

6.2.3 Cardiovascular Lab QI Committee

a. Composition

The Cardiovascular Lab QI Committee will consist of two (2) cardiologists, representatives from the Cardiovascular Lab, Cardiovascular Services, and Quality Management. Medical Imaging representatives may participate as needed.

b. Duties

i. Assure that the quality, safety and appropriateness of patient care services in the Cardiovascular Lab are reviewed and evaluated on a regular basis, that appropriate action is taken based on the analysis, and that improvements are implemented.

ii. Develop and maintain policies and procedures concerning the scope and provision of care.

iii. Encourage, initiate and participate in educational activities pertaining to the Cardiovascular Lab.

iv. Evaluate and report on new technologies and products as they become available.

c. Meetings

The Cardiovascular Lab QI Committee will meet quarterly or as often as necessary to fulfill its functions and responsibilities.

6.2.4 Credentials Committee

a. Composition

The Credentials Committee will be composed of at least six (6) members appointed by the Medical Executive Committee. Members of the Credentials Committee will be selected from members of the Active and Community-Based Physician Staff with past medical staff leadership experience. A majority of the members shall be required to be members

of the Active Staff. In addition, the Chief Executive Officer and the Hospital Chief Medical Officer will be ex-officio, voting members. The Director of Medical Staff Services will be an ex-officio, nonvoting member of the Credentials Committee.

b. Duties

The members of the Credentials Committee are charged with evaluation of the qualifications of Applicants and allied health professionals. They are expected to use their knowledge in their respective fields of expertise to contribute to the function of the Credentials Committee as a whole and not to function sole as representatives of their respective Departments.

The Credentials Committee will:

i. Review and evaluate the qualifications of each Applicant in accordance with the criteria and the policies and procedures established jointly by the Medical Executive Committee and the Departments (as specified in the Credentials Manual) and make recommendations on the applications for appointment and requests for clinical privileges to the Medical Executive Committee before such applications and requests are submitted to the Governing Board.

ii. Study, investigate and submit recommendations to the Medical Executive Committee for criteria for credentialing Applicants and allied health professionals.

iii. Investigate, review and report on matters, including the clinical and ethical conduct of any Member or any allied health professional, as may be assigned or referred to it in accordance with polices and procedures established by the Medical Staff Bylaws and as proscribed in the Credentials Manual.

iv. Perform such other duties and make such other studies, reviews and recommendations as may be assigned or delegated to it by the Medical Executive Committee or the Governing Board.

c. Meetings

The Credentials Committee will meet at least monthly or as required at the discretion of the chair of the Credentials Committee.

The requirement for a quorum is designated as no less than fifty percent (50%) of the voting membership of the Credentials Committee.

d. Recommendations

The Credentials Committee will prepare a written report that will contain recommendations as to Medical Staff appointment and, if appointment is recommended, as to Medical Staff category, Department assignment, clinical privileges and any special conditions to be attached to the appointment. The reasons for the recommendations, positive or negative, will be stated and supported as prescribed in the Credentials Manual. A member of the Credentials Committee who is in the same specialty as the Applicant may participate in the discussions with respect to such Applicant, but will abstain from participating in the final recommendation of the Credentials Committee. A Credentials Committee member who believes he/she may have a potential conflict of interest with any Applicant will abstain from participating in the final recommendation of the Credentials Committee with respect to such Applicant to avoid any such potential conflict of interest.

6.2.5 Critical Care Committee

a. Composition

The Critical Care Committee will consist of five (5) to six (6) members with a representative from each of the following specialties: cardiology, pulmonary medicine, general surgery and emergency medicine. Representatives from Critical Care Services, Respiratory Therapy, Pharmacy, Emergency Services, Nutrition, Laboratory and Medical Staff Services will be nonvoting members of the Critical Care Committee.

The Critical Care Committee will make recommendations regarding the medical director of the Critical Care Unit. The medical director will be a member of the Active Staff who has received training, acquired experience, and documented competence in a specialty related to care provided in the Critical Care Unit.

The Hospital Code Blue Committee will report activities and receive recommendations from the Critical Care Committee.

b. Duties

i. Assure that the quality, safety and appropriateness of patient care services provided within the Critical Care Unit are reviewed and evaluated on a regular basis and that appropriate action is taken based upon these findings.

ii. Develop and maintain policies and procedures concerning the scope and provision of care in cooperation with the Hospital.

These policies and procedures are to be reviewed as necessary and in any event no less frequently than once every three (3) years, and enforced as prescribed by the Medical Staff Bylaws.

iii. Advise on standards of care and Critical Care Unit operations.

iv. Encourage, initiate, and participate in educational activities for all providers of health care in the Critical Care Unit.

v. Participate with the formal orientation and training program required for registered nurses and support staff who perform patient care services in the Critical Care Unit.

c. Meetings

The Critical Care Committee will meet at least quarterly or as often as necessary to fulfill its functions and responsibilities.

6.2.6 Ethics Committee

a. Composition

Voting members of the Ethics Committee will include at least five (5) Members representing various Departments, community members, local Hospital advisory board members, attorneys, clergy and representatives of Patient Care Services, the Pharmacy and Risk Management. The chair of the Ethics Committee will be a Member, and a Hospital administrative employee will be designated to assist with routine responsibilities. Members of the Ethics Committee will be chosen from resumes that indicate relevant experience, training, and interest involving bioethics. The term of appointment to the Ethics Committee is one (1) year.

b. Duties

i. Develop and maintain polices and procedures concerning ethics issues.

ii. Serve as a consultative body for Departments or individuals regarding ethical decision-making.

iii. Encourage, initiate and participate in educational activities for providers of health care on ethical issues and decisions.

c. Meetings

The Ethics Committee will meet every other month or as often as necessary to fulfill its function and responsibilities.

6.2.7 Medical Education and Library Committee

a. Composition

The Medical Education and Library Committee will be composed of five (5) to six (6) members appointed by the Chief of Staff. The members of the Medical Education and Library Committee will designate the chair of the Medical Education and Library Committee. The Medical Education Coordinator, the Librarian and other Hospital representatives will serve as non-voting members of the Medical Education and Library Committee. Representatives from the following areas of the Hospital will attend meetings of the Medical Education and Library Committee on an as needed basis to participate in planning: Nutrition, Pharmacy, Infection Control, Risk Management and Quality Management.

b. Duties

i. Develop overall objectives for meeting continuing medical education needs of the Medical Staff and pursue implementation of the directive.

ii. Be aware of Medical Staff educational and practice needs as learned from findings of quality assessment and other activities, determine educational methods for addressing those areas, and provide opportunities to improve patient care.

iii. Provide education about the purpose and use of new services and patient care methodologies introduced at the Hospital.

iv. Provide guidance to the medical library in meeting the informational needs of the Medical Staff.

v. Evaluate the effectiveness of the medical library in meeting the informational and educational needs of the users.

vi. Fulfill the requirements set forth in the Colorado Medical Society's Essentials and Standards for the accreditation of sponsors of continuing medical education.

c. Meetings

The Medical Education and Library Committee will meet every other month or as often as necessary to fulfill its functions and responsibilities.

6.2.8 Medical Executive Committee

The composition and duties of the Medical Executive Committee are as set forth in the Medical Staff Bylaws. In addition, the Medical Executive Committee supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its clinical units and the functions of the Medical Records Committee.

6.2.9 Operating Room Committee

a. Composition

The Operating Room Committee will consist of representatives from the Department of Surgery sections, the Department of Anesthesiology and the Obstetrics and Gynecology section. The Operating Room Committee will also consist of the Director of Surgical Services, the operating room supervisors and managers, Hospital Administration and Medical Staff Services.

b. Duties

i. Establish criteria for, and allocate, block times and monitor the same for the efficient and effective utilization of operating time both during scheduled blocks and other times in the operating room.

ii. Recommend the establishment of rules regarding operational responsibilities and the activities of the surgeons and the anesthesiologists in the Surgical Services areas of the Hospital to the Medical Executive Committee and to Hospital Administration, and monitor the compliance with such rules.

iii. Develop and maintain policies and procedures concerning the scope and provision of care in Surgical Services area.

iv. Establish, monitor and enforce compliance with criteria for emergent, urgent and elective cases and turnover time.

v. Provide input into the planning and budget process and capital needs for the Surgical Services area of the Hospital.

vi. Assist with the evaluation of new product trials.

vii. Provide a forum for effective communication among surgeons, Hospital staff members in the Surgical Services area, and Hospital Administration.

viii. Report and be accountable to the Department of Surgery, the Department of Anesthesiology and the Medical Executive Committee.

c. Meetings

The Operating Room Committee will meet at least quarterly or as needed to fulfill its functions and responsibilities.

6.2.10 Pharmacy and Therapeutics Committee/Infection Control/Employee Health

a. Composition

The Pharmacy and Therapeutics Committee/Infection Control/Employee Health will be comprised of a chair and a representative from each of the following Departments/sections: Medicine, Pediatrics, Infectious Disease, Surgery and Pathology. The Pharmacy and Therapeutics Committee/Infection Control/Employee Health will also include as voting members the Director of Patient Care Services or designee, the Director of Pharmacy and, for Infection Control, the Infection Control Manager.

Meetings of the Pharmacy and Therapeutics Committee/Infection Control/Employee Health are open to the general Medical Staff. If a Department chair or designee attends a meeting of the Pharmacy and Therapeutics Committee/Infection Control/Employee Health, he/she will be considered a voting member of the Pharmacy and Therapeutics Committee/Infection Control/Employee Health at that meeting.

Representatives from Quality Management, the Laboratory, the Pharmacy, Medical Staff Services, Risk Management and Infection Control (for pharmacy and therapeutics) will be ex-officio members of the Pharmacy and Therapeutics Committee/Infection Control/Employee Health.

Hospital performance improvement teams related to safe medication practices and pain management report activities and receive recommendations from Pharmacy and Therapeutics Committee/Infection Control/Employee Health.

b. Duties

Monitoring functions of the Pharmacy and Therapeutics Committee/Infection Control/Employee Health includes, at least, the following:

i. Development or approval of policies and procedures relating to: (A) the selection, distribution, handling, use, administration, and prescribing of drugs and diagnostic testing materials, and (B) the surveillance, prevention and control of infections;

ii. Development and maintenance of a drug formulary or drug list;

iii. Evaluation and, when no other such mechanism exists, approval of protocol concerned with the use of investigational or experimental drugs;

iv. Definition and review of all significant untoward drug reactions;

v. Review of drug use evaluation studies and development of policies, guidelines, and recommendation of educational strategies with regard to the (A) appropriateness, safety, and effectiveness of drug therapy, and (B) control of infection; and

vi. Development of educational plans for safe medication practices.

c. Meetings

The Pharmacy and Therapeutics Committee/Infection Control/Employee Health will meet every month and on an as needed basis or as JCAHO standards require.

6.2.11 Practitioner Health Committee

a. Composition

The chair of the Practitioner Health Committee will be selected by the members of the Practitioner Health Committee. The Practitioner Health Committee will be composed of the three (3) most recent past-Chiefs of Staff available, or a designee if necessary to avoid potential conflict of interest, and may be reappointed for additional terms in accordance with the Policy Regarding Impaired Practitioners (Practitioners Health Policy).

b. Duties

Investigate reports of incident(s) in which a Member may be impaired, or ill to the extent that it affects his/her ability to practice medicine with skill and safety to patients, if requested by another Member, the Hospital Medical Director or the Chief Executive Officer in accordance with the Policy Regarding Impaired Practitioners (Practitioner Health Policy).

c. Meetings

The Practitioner Health Committee will meet as requested.

6.2.12 Professional Conduct Panel

a. Composition

The Professional Conduct Panel will be composed of the Chief of Staff, the two (2) most recent past Chiefs of Staff available, unless otherwise determined by the Medical Executive Committee, the Hospital Medical Director and the Director of Patient Care Services in accordance with provisions in the Disruptive Medical Staff Member Policy and/or Procedure to Investigate a Complaint of Sexual Harassment by the Physician.

b. Duties

i. Addresses disruptive Members, citizenship complaints or complaint of sexual harassment with the goal of early investigation and intervention.

ii. Act in a peer review capacity to receive and make recommendations regarding complaints of disruptive behavior involving Members in accordance with provisions in the Disruptive Medical Staff Member Policy and/or Procedure to Investigate a Complaint of Sexual Harassment by the Physician.

c. Meetings

The Professional Conduct Panel will meet as requested.

6.2.13 Professional Review Committee

a. Composition:

The Professional Review Committee shall consist of at least five (5) members, including the Chief Medical Officer of the Hospital, who shall

serve as chair of the Professional Review Committee. Members of the Professional Review Committee shall be Members who are willing to assist the Medical Staff in the performance of its functions and duties, including its peer review and quality improvement activities. The Chief of Staff and a representative of Hospital administration may serve as ex-officio members without vote. Members of the Professional Review Committee shall be appointed for terms of two (2) years each and may be appointed for successive terms. Commencing as of January 1, 2010, the terms will be staggered to that approximately one-half (1/2) of the terms will expire every year, and the length of the then-current terms will be adjusted accordingly.

b. Qualifications:

Each member of the Professional Review Committee, other than the chief Medical Officer of the Hospital, must continuously satisfy the qualifications and discharge the responsibilities of membership on the Active Medical staff. Members of the Professional Review Committee must demonstrate leadership skills and may not have any conflicting interests that would prevent them from carrying out their respective obligations hereunder.

c. Selection Process:

One-half (1/2) of the members of the Professional Review Committee shall be chosen by the Medical Executive Committee, and one-half (1/2) of the members of the Professional Review Committee shall be chosen by the Medical Staff. By December of each year, the Medical Executive Committee and the Medical Staff shall each select the appropriate number of Members to serve as members of the Professional Review Committee.

d. Duties:

i. Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of staff members.

ii. Enforce the Bylaws, the Medical Staff Rules and Regulations, and policies and procedures of the Departments and the Hospital.

iii. Review sentinel events, near misses, root cause analyses, and complex clinical issues.

iv. Review potential conflicts of interest and recommend actions to address actual conflicts.

v. Investigate, review, and resolve complaints of disruptive conduct by any Member or any allied health professional.

vi. Serve as a resource for moral and ethical issues.

vii. Monitor and evaluate the quality and appropriateness of patient care and the professional performance of Members and allied health professionals.

viii. Seek peer review assistance from external sources if, and when, the Professional Review Committee determines that such assistance is appropriate and/or necessary.

ix. Review aggregate quality performance data of individual Members and make recommendations for quality improvement in the context of peer review.

x. Share information with the Departments and other Medical Staff committees to provide opportunities for learning and process improvement.

xi. Review professional competence issues identified as part of its ongoing quality and performance improvement, clinical, administrative, and educational functions as well as issues referred from a Department chair or medical director.

xii. Implement investigative and precautionary tools as required, including requiring educational/health assessments, supervision, and consultation and as warranted.

xiii. Make recommendations to the Medical Executive Committee for corrective action, as required.

xiv. Establish a subcommittee or subcommittees as are necessary to perform its duties. Members of subcommittees may include Practitioners who are not members of the Professional Review Committee and/or who are not Members.

e. Meetings

The Professional Review Committee will meet twice a month or as often as necessary to fulfill its functions and responsibilities. Each member of the Professional Review Committee is expected to attend seventy-five percent (75%) of the monthly meetings. If any member of the Professional Review Committee does not attend seventy-five percent (75%) of the monthly meetings, as determined on an annual basis, such member shall be deemed to have resigned from the Professional Review

Committee, at which time the Medical Executive Committee will appoint a replacement to serve out the remainder of such member's term.

6.2.14 Quality Improvement Committees

a. Composition

The Quality Improvement Committee for each Department will consist of the vice-chair of the Department as chair of the Department Quality Improvement Committee, or as otherwise determined by the Department, and another representative from the Department. Ex-officio members of each Department Quality Improvement Committee include representatives from Quality Management, the Director of Patient Care Services, Patient Care Services managers and Medical Staff Services.

Members, Quality Management staff and Hospital department representatives or managers may be requested to attend meetings of the Department Quality Improvement Committees to discuss areas of improvement in patient care.

Each Department will determine the membership of its respective Department Quality Improvement Committee and a membership term of either one (1) or two (2) years. The term for the chair of each Department Quality Improvement Committee is two (2) years unless otherwise determined by the appropriate Department chair.

Hospital performance improvement teams report activities and receive recommendations from the appropriate Department Quality Improvement Committee; i.e. - Moderate Sedation Team to Department of Anesthesia Quality Improvement Committee.

b. Duties

i. Complete the systematic and ongoing review of the appropriateness and quality of blood, drug use, surgery and invasive procedures, timeliness of completion of medical records, and Member-related infection data

ii. Measure, assess and improve quality of care to meet the following objectives:

- To define the responsibility for monitoring and improving every aspect of patient care, from the time the patient enters the system through diagnosis, treatment, recovery and continuum of care.

- To provide for identifying and resolving any breakdowns that may result in sub optimal patient care and safety, while striving to continuously improve and facilitate positive outcomes.
- To provide a systematic approach to improving performance while meeting customers' needs and exceeding their expectations.
- To increase the efficiency of Hospital and Medical Staff processes resulting in cost effective care.
- To improve clinical and non-clinical processes that require Medical Staff leadership or participation.

iii. Coordinate, prioritize, and monitor the Department's data gathering and analysis components of the quality review program and coordinate activities in this area with those of the other professional and support services at the Hospital.

iv. Review the quality review profiles for Department members and criteria trends and report at Department meetings or refer to the Medical Executive Committee.

v. Supervise the maintenance of a quality review profile on each Member, and transmit, via the Hospital's Quality Management department the same to be used in connection with the periodic reappraisal of each Member.

vi. Implement a system for screening clinical risk management issues, including unexpected patient care management events, morbidity concerns and analyze aggregate data on significant high risk events by identifying possible patterns and communicating same to the professional staff and Hospital groups with related responsibilities.

vii. Analyze trends of hazardous and risk management events reported and attempt to determine effective solutions and implement appropriate systems or suggest action to enhance the quality and safety of patient care.

viii. Communicate and educate on the findings and solutions to enhance the quality and safety of patient care.

c. Meetings

Each Department Quality Improvement Committee will meet quarterly or as often as necessary to fulfill its functions and responsibilities.

6.2.15 Trauma Committee

a. Composition

The chair of the Trauma Committee will be the Medical Director of the Trauma Service and a board-certified surgeon. The Trauma Committee will be composed of those Members granted privileges as trauma surgeons, representatives from the following Departments/sections: Emergency Medicine, Anesthesiology, Orthopedic Surgery and Radiology. The Trauma Committee will also include, as voting members, the Trauma Coordinator, the Clinical Manager of Emergency Medical Services, the Manager of Surgical Services, a representative from Hospital Administration, and a paramedic selected by TVEMS and approved by the Trauma Committee. In addition, non-Member representatives from the following areas of the Hospital will attend and participate as requested: the Laboratory, Radiology, Respiratory Care, patient care units, Medical Imaging, Quality Management and Medical Staff Services.

b. Duties

The Trauma Committee has the authority and responsibility to review any and all matters related to the care of an injured patient. The Trauma Committee may make recommendations to individuals in the Hospital, Members and Medical Staff and Hospital committees, Departments and sections.

Specific functions of the Trauma Committee include the following:

i. Promote quality care of the trauma patient at the Hospital by ongoing review of the safety and appropriateness of patient care provided by Members, nursing staff and ancillary departments.

ii. Establish appropriate standards of care and review the effectiveness of the Trauma Service against these standards.

iii. Develop and maintain policies concerning the scope and provision of care of trauma patients.

iv. Assist in the establishment and revisions of criteria for credentialing for trauma care.

v. Review and make reports to the Credentials Committee on applications for privileges in trauma care.

vi. Provide input into the Trauma Service rules, regulations and operating guidelines.

vii. Conduct a trauma quality assurance program and quality improvement program in a planned and systematic way to measure compliance with trauma indicators and audit filters selected by the Trauma Committee.

viii. Conduct peer and multidisciplinary review to evaluate specific cases or problems identified by the monitoring process. The process, recommendations, trends and outcomes will be documented under the guidelines of the applicable peer review statutes governing professional review committees and reported to the Medical Executive Committee, appropriate Departments and/or Credentials Committee, as applicable.

When problems of patient care system performance are identified, a plan for corrective action will be developed. The corrective action plan may include one or more of the following:

- Making recommendations for revising existing policies, protocols, rules or regulations
- Recommending, facilitating or providing professional education for the entire trauma service, specific Members, or all Members and Hospital staff who care for trauma patients
- Providing Member counseling
- Reporting to the Credentials Committee and the applicable Department chair with recommendations concerning Members privileges

c. Meetings

The Trauma Committee meets monthly or as determined by the chair.

6.2.16 Women and Children's Services Committee

a. Composition

The Women and Children's Services Committee will consist of representatives from the Perinatal Department, including obstetricians, gynecologists and pediatricians and family practice physicians with obstetrical privileges. Representatives from the Hospital will include the Director of Women Services, Women Services supervisors and managers, the Director of Medical Inpatient Services, Medical Inpatient Services supervisors and managers, Hospital Administration and Medical Staff Services.

b. Duties

i. Recommend the establishment of rules regarding operational responsibilities and the activities of Members and allied health professionals in the obstetrical/nursery areas and areas pertaining to women and/or children's services of the Hospital and monitor the compliance with such rules.

ii. Establish criteria for the efficient and effective use of the C-section room(s).

iii. Provide input into the planning and budget process and capital needs for the Perinatal Medicine services areas.

iv. Develop and maintain policies and procedures concerning the scope and provision of care in the Perinatal Medicine services areas.

v. Assist with the evaluation of new product trials.

vi. Provide a forum for effective communication among Members, allied health professionals, Hospital staff and Hospital Administration in the Perinatal Medicine services area.

vii. Report and be accountable to the Perinatal Medicine Department and the Medical Executive Committee.

c. Meetings

The Women and Children's Services Committee will meet at least quarterly or as needed to fulfill its functions and responsibilities.

PART 7
USE OF TERMS

When used herein, the terms “Department chair”, “Credentials Committee chair”, “Chief Executive Officer”, and “Chief of Staff” will be considered to include such individual’s designee.

PART 8
CONFIDENTIALITY, RELEASES, AND IMMUNITY FROM LIABILITY

In performing the functions of the Medical Staff as set forth in this Manual, each Member agrees to be bound by the provisions of the Medical Staff Bylaws, including, without limitation, the provisions relating to confidentiality, releases and immunity from liability.

PART 9
ADOPTION AND AMENDMENT

8.1 POLICY REVIEW

The Medical Executive Committee will review this Manual as needed, based on revisions in regulations and practices, but in no event less frequently than once every three (3) years.

8.2 AMENDMENT

This Manual may be adopted, amended or repealed, in whole or in part, upon recommendation by the Medical Executive Committee and adoption by the Governing Board.

8.3 CORRECTIONS

The Medical Executive Committee may adopt such amendments to this Manual as are, in the judgment of the Medical Executive Committee, technical or legal modifications or clarifications (i.e. reorganization or renumbering or changes needed due to punctuation, spelling or other errors of grammar or expression).

8.4 RESPONSIBILITIES AND AUTHORITY

The procedures outlined in the Medical Staff Bylaws and the Corporate Bylaws regarding Medical Staff responsibility and authority to formulate, adopt and recommend Medical Staff Bylaws, and amendments thereto, apply as well to the formulation, adoption and amendment of this Manual.

MCKEE MEDICAL CENTER
ORGANIZATION AND FUNCTIONS MANUAL
CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee:_____
Date

_____
Chief of Staff

_____
Chief of Staff Elect

Adopted by the Governing Board: _____
Date

_____
Secretary, Governing Board