MEDICAL STAFF ORGANIZATION MANUAL

ROANE MEDICAL CENTER

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ORGANIZATION MANUAL

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GENERAL

1.A DEFINITIONS

The definitions and other general provisions that apply to all the Medical Staff documents are set forth in the Medical Staff Bylaws.

ARTICLE 2

CLINICAL DEPARTMENTS

2.A LIST OF DEPARTMENTS

Clinical departments of the Medical Staff shall be:

Medicine
Surgery

Each department may organize sections and subsections, subject to the approval of the Medical Executive Committee and the System Quality Committee.

2.B DEPARTMENT OF MEDICINE

The Department of Medicine will include: Internal Medicine, Family Practice, General Practice, Pediatrics, Emergency Medicine, Cardiology, Pulmonary Medicine, Oncology, Neurology, Radiology, Dermatology, Psychiatry, Critical Care and Nephrology.

2.C DEPARTMENT OF SURGERY

The Department of Surgery will include: General Surgery, Anesthesiology, Orthopedics, Pathology, Oral & Maxillofacial Surgery, Plastic Surgery, Ophthalmology, Urology, Podiatry, Obstetrics/Gynecology, Vascular Surgery, Otolaryngology and Neurosurgery.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff Committees that carry out performance improvement and peer review functions.

(2) Procedures for the appointment of Committee chairs and members of the Committees are set forth in the Medical Staff Bylaws.

3.B. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each Committee described in this Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each Committee shall make a timely written report after each meeting to the Executive Committee and to other Committees and individuals as may be indicated in this Manual.

3.C. BYLAWS COMMITTEE

3.C.1. Composition:

The Bylaws Committee shall consist of the Active Staff members of the MECC. The current Chief of Staff will serve as chairman of the committee.

3.C.2. Duties:

The Bylaws Committee shall:

(a) consider and propose Bylaws and related Policies, Manuals and Rules and Regulations, and amendments thereto;

(b) review suggestions for changes presented by individuals and committees;

(c) review the Bylaws, Policies, Manuals, and Rules and Regulations and amendments thereto on an ongoing basis and as necessary; and

(d) designate one or more representatives to serve on any similar systemwide committee or working group.

3.D. CREDENTIALS COMMITTEE

3.D.1. Composition:

The Credentials Committee shall consist of at least three (3) members of the Active Medical Staff appointed by the Chief of Staff, one of which is a Past Chief of Staff (if available) in such a manner so as to be broadly representative of the major clinical specialties, the Hospital-based specialties and the Medical Staff at large who have previously served as Chief of Staff, Department Chair or other leadership positions.

3.D.2. Duties:

The Credentials Committee shall:

(a) evaluate and verify the credentials and qualifications of all applicants for appointment and reappointment and delineation of clinical privileges;

(b) oversee the Ongoing and Focused Professional Practice Evaluation (OPPE and FPPE) policies and processes;

(c) review and evaluate data and information from OPPE and FPPE processes in making privileging recommendations to the MEC;

(d) report and make recommendations to the MEC on each applicant for Medical Staff appointment and clinical privileges, including APPs, including specific consideration of the recommendations from the Chair(s) of the Department(s) in which such applicant requests privileges; and

(e) review and evaluate criteria for clinical privileges developed by the Departments.

3.E. ETHICS COMMITTEE

3.E.1 Composition:

The Ethics Committee consists of the following members: the Chief of Staff or his representative; one representative from the community, preferably with background in legal, psychological or spiritual needs professions; one nursing representative; and other hospital employees as deemed necessary by Administration.

3.E.2. Duties:

The Ethics Committee will:

(a) address the moral, social, philosophical, and legal implications of delivering healthcare services in the current hospital environment;

(b) assist in management of clinical decisions and provide a forum for the diffusion of responsibility when there are difficult decisions; and

All information gathered by the Ethics Committee regarding ethical issues will be kept confidential, and used solely for the purpose of assisting the committee members in their recommendations regarding such ethical issues. When data gathered by the committee raises questions of deficiencies in quality of care, such cases should be shared with the hospital's Medical Executive Committee.

3.F. PROFESSIONAL QUALITY AND PEER REVIEW COMMITTEE (PQPR)

3.F.1. Composition:

This Committee will be chaired by the Chief of Staff Elect. Other members will include the Vice Chairs of the Medical Staff Departments, and appropriate administrative and quality representatives.

3.F.2. Duties:

The PQPR Committee will:

(a) approve OPPE data elements that are identified by individual departments, and adopt Medical Staff-wide OPPE data elements;

(b) approve the specialty-specific quality indicators identified by the departments that will trigger the FPPE process;

(c) identify variances from rules, regulations, policies, or protocols for which an informational letter may be sent to involved practitioners;

(d) review, assist in the development of, and approve patient care protocols that are recommended by Departments, specialties, or others;

(e) review cases referred to it;

(f) develop, when appropriate, performance improvement plans for practitioners;

(g) monitor and determine that system issues that are identified as part of professional practice evaluation (PPE) activities are successfully resolved;

(h) work with department chairs to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through education sessions in the department or through some other mechanism;

(i) perform any additional functions as may be set forth in applicable policy or as requested by the Leadership Council, the MEC, the System Quality Committee, the System Credentials and Clinical Standards Committee, or the Board; and

(j) meet monthly to review the reports and recommendations of the various Departments and develop its own reports and recommendations with regard to individual practitioners whose care of individual patients has been reviewed.

3.G. PHARMACY AND THERAPEUTICS COMMITTEE

3.G.1. Composition:

The Pharmacy and Therapeutics Committee shall be composed of physicians, APPs and Pharmacy representatives and may appoint one or more representatives to serve on a separate System Pharmacy and Therapeutics Committee.

3.G.2. Duties:

The Pharmacy and Therapeutics Committee shall:

(a) be responsible for the development and surveillance of all drug utilization policies and practices in order to facilitate optimum clinical results and a minimum potential for hazard;

(b) assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital;

(c) serve as an advisory group to the Medical Staff and pharmacists on matters pertaining to the choice of available drugs;

(d) make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(e) develop and review periodically a formulary or drug list;

(f) prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

(g) evaluate clinical data concerning new drugs or preparations requested for use;

(h) seek to resolve differences which may arise involving drugs or pharmaceuticals between the Pharmacy, Nursing and members of the Medical Staff;

(i) review significant untoward drug reactions by patients;

(j) review the appropriateness, safety and effectiveness of the use of antibiotics; and

(k) evaluate the use of medications.

3.H. PRACTITIONER HEALTH AND WELLNESS COMMITTEE

The Practitioner Health and Wellness Committee shall be composed of members of the Medical Staff of each hospital, and such other executive and professional personnel as the Chief of Staff and the CMO and CAO deem to be of value to the Committee. The Committee shall have the following functions: assisting Medical Staff members who may be in need of support in dealing with health, physical impairment or addiction matters and assisting the Medical Staff and the Hospital in education and training with regard to physician health and impairment. Individual members of the Medical Staff may directly seek the assistance of the Committee, or they may be referred to the Committee by Department leadership, the Leadership Council, the MEC, the Chief of Staff, the CMO or CAO. The Committee shall adopt and implement, subject to the approval of the MEC and System Credentials and Clinical Standards Committee, policies and procedures to allow it to effectively assist practitioners working with the Committee while recognizing the need for quality care being provided to patients of the Hospital. The Committee shall hold meetings at the call of the Chair, and special meetings at the call of the Chief of Staff or the CAO to address particular situations. It shall report to the Chief of Staff and the MEC in a manner that safeguards confidentiality. In lieu of a hospital-specific Practitioner Health and Wellness Committee, a system-wide committee may be requested by the MEC to perform some or all of these functions.

3.I RADIATION SAFETY COMMITTEE

3.I.1 Composition:

The Radiation Safety Committee shall consist of a radiologist who will serve as Radiation Safety Officer, the chairman of the committee, who shall be a member of the Active medical staff, a representative of the Nuclear Medicine Department, the Radiology Manager, and representatives from other departments as indicated.

3.I.2 Duties:

(a) Establish a program to ensure that all individuals whose duties require them to work in the vicinity of radioactive material (e.g., nursing, security, and housekeeping personnel) are properly instructed as required by SRPAR 0400-20-04-.12.

(b) Review and approve all results for use of radioactive material within the institution.

(c) Prescribe special conditions that will be required during a proposed use of radioactive material such as requirements for bioassays, physical examinations of users, and special monitoring procedures.

(d) Review the entire radiation safety program at least annually to determine that all activities are being conducted safely and in accordance with State regulations and the conditions of the license. The review shall include an examination of all records, reports from the radiation safety officer, results of State inspection, written safety procedures, and management control system.

(e) Recommend remedial action to correct any deficiencies identified in the radiation safety program.

(f) Maintain written records of all committee meetings, actions, recommendations, and decisions.

(g) Ensure that the radioactive material license is amended, when necessary, prior to any changes in facilities, equipment, policies, procedures, and personnel.

3.J UTILIZATION MANAGEMENT COMMITTEE

3.J.1 Composition:

This Committee will be chaired by the Vice Chief of Staff. Other members will include at least two members of the Active Medical Staff, administrative representative, Risk Manager, Quality Manager, and a representative from Utilization Management. The nurse case managers may be invited to attend the committee meetings on an as needed basis.

3.J.2 Duties:

(a) Evaluate the medical necessity of hospital admissions, the length of hospital stays, and the efficient use of professional services and hospital resources.

(b) Serve as an adjunct to hospital process improvement.

(c) Involved in analysis of care trends, length of stay outliers, and insurance claim denials.

(d) Formulate a annual Utilization Review plan that is submitted to the MECC.