Attachment F

MEDICAL STAFF COMMITTEE MANUAL
TABLE OF CONTENTS
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MEDICAL STAFF COMMITTEE MANUAL

GENERAL: The Committee Manual describes the makeup and duties of each committee except the Medical Executive Committee and the Dispute Mediation Committee, which are described in the Medical Staff Bylaws. The voting rights of committee members are described in the Bylaws or the Committee Manual. The President of the Medical Staff is an ex-officio member of all committees except those committees of which he is already a regular member. Medical Staff committees shall be responsible to the Medical Executive Committee.

Terms of Committee Members

Chairman:

All Medical Staff Committee Chairmen will be members of the Active Medical Staff, unless otherwise specified and approved by the Medical Executive Committee. Unless otherwise specified, Committee Chairmen shall be appointed by the President of the Medical Staff, with the approval of the Medical Executive Committee, for a term of 2 years and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

Each Committee Chairman shall appoint a Vice Chairman to fulfill the duties of the Chairman in his or her absence and to assist as requested by the Chairman.

Member:

Unless otherwise specified, committee members shall be appointed by the President of the Medical Staff, with the approval of the Medical Executive Committee, for a term of 2 years and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee. Any committee member may serve multiple terms until he/she resigns or is replaced.

Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, or if any other good cause exists, that member may be removed from the committee by the Medical Executive Committee.

Vacancies

Unless otherwise specified, vacancies on any Committee shall be filled in the same manner in which the original appointment to the committee was made. For vacancies of the Chair of Committees normally chaired by Medical Staff members by virtue of office, the vacancy shall be filled by appointment by the President of the Medical Staff, with the approval of the Medical Executive Committee.

In addition to standing committees, the President of the Medical Staff may convene ad hoc committees as needed. Such committees shall confine their work to the purposes for which commissioned and shall report to the Medical Executive Committee. They will not have the power of action unless such is specifically granted by the authority creating the committee. Special committees shall meet as often as necessary to complete their work.

Section 1: Bylaws Committee

A. Composition

No fewer than three Active Medical Staff members appointed by the President of the Medical Staff. The President-Elect of the Medical Staff shall serve as Chairman.

B. Duties

1. Ensure that the Medical Staff Bylaws, Rules and Regulations, and Committee Manual adequately and accurately describe the structure of the Medical Staff Organization.

2. The Medical Staff Bylaws, Rules and Regulations, and Committee Manual are to be reviewed and updated as necessary, at least annually.

3. Submit proposed modifications to the Medical Executive Committee for action.

C. Meetings

The Committee shall meet at least annually and as requested by the Chairman.

Section 2: Continuing Medical Education Committee (CME)

A. Composition

The Medical Staff shall participate in CME activities. The Committee shall be made up of members of the Medical Staff, a representative from Performance Improvement; the Hospital Education Director; and the Director of the Medical Center or his/her designee.

B. Duties

1. Provide comprehensive education goals and plans for CME.
2. Oversee the annual budget and advise the Medical Center Administration and Medical Staff of the financial needs of the CME program.
3. Assure that all CME accreditation standards are met.
4. Plan, implement, coordinate, and promote clinical and scientific programs for the Medical Staff. This includes:
   a. Identifying the educational needs of the Medical Staff.
   b. Formulating clear statements of objectives for each program.
   c. Assessing the effectiveness of each program.
   d. Choosing appropriate teaching methods and knowledgeable faculty for each program.
5. Establish liaison with the Performance Improvement Plan of the Medical Center in order to be apprised of the issues in patient care, which may be addressed by a specific continuing medical education activity.
6. Assist in developing processes to assure optimal patient care and contribute to the continuing education of all practitioners.
7. Make at least annual recommendations to the Medical Executive Committee regarding library needs of the Medical Staff.
8. Document staff attendance at each program.

C. Meetings

The Committee shall meet as often as necessary, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee.

Section 3: Credentials Committee

A. Composition

No fewer than seven members of the Active Medical Staff.

B. Duties

1. Evaluate the qualifications of each applicant for Medical Staff appointment and reappointment, and of each Certified and/or Graduate Registered Nurse Anesthetist and Certified Nurse Midwife applying for clinical privileges.

2. Make recommendations for granting or curtailing privileges, granting of Medical Staff or Advanced Professional Practice memberships, and the assignment to Departments and Medical Staff categories, all to be reported to the Medical Executive Committee.

3. Review proctoring reports submitted by Departments, and recommend the appropriate course of action to the Medical Executive Committee.

4. Review proposed departmental descriptions of clinical privileges, and departmental rules and regulations, and recommend action to the Medical Executive Committee.

C. Meetings

The Credentials Committee shall meet at least 10 times per year.

Section 4: Graduate Medical Education Committee for ACGME-accredited Residency Programs (GMECA)

A. Composition

Designated Institutional Official (DIO), representative sample of program directors (minimum of two) from ACGME-accredited programs, a minimum of two peer-selected residents/fellows from among ACGME-accredited programs; and a Hospital Department of Performance Improvement or Patient Safety Officer or designee.

B. Duties

1. Establish and implement policies and procedures regarding the quality of education and the work environment for the residents in ACGME programs. Details of responsibilities are outlined in the ACGME Institutional Requirements**.**

2. Provide quarterly reports to the Medical Executive Committee

3. Provide an annual report to the organized Medical Staff and the Governing Body.

C. Meetings

The Committee shall meet at least quarterly

~~Section 5: **Osteopathic Medical Education Committee (OMEC)**~~

~~A. Composition~~

~~The Director of Medical Education for Osteopathic Residency Programs (DME), all osteopathic Program Directors of Osteopathic Residency Programs sponsored by the Medical Center, A minimum of two peer selected residents, and a Hospital Department of Performance Improvement representative, and Medical Center Administration representative.~~

~~B. Duties~~

~~1. Oversee Medical Center AOA residency programs to ensure compliance with AOA Institutional Requirements.~~

~~2. Provide quarterly reports to the Medical Executive Committee~~

~~3. Provide an annual report to the organized Medical Staff and the Governing Body.~~

~~C. Meetings~~

~~The Committee shall meet at least ten times a year.~~

Section ~~6~~5: Medical Executive Committee

Refer to Medical Staff Bylaws.

Section ~~7~~6: Committee on Interdisciplinary Practice (CIDP)

A. Composition

Three members of the Medical Staff, one registered nurse appointed by the Chief Nursing Officer, two nurse practitioners, and two physician Assistants. The Chief Nursing Officer and Associate Administrator of Professional Services are representatives from Medical Center Administration, and are given voting rights. A representative from other Advanced Practice Professional Staff (APP) categories whose privileges are approved by the committee may also be appointed as recommended by the Committee Chairman.

A quorum for conducting business shall consist of an equal number of physicians and nurses, and one representative from Medical Center Administration. The administrative representative may not serve in two capacities. The Chairman shall not count toward the quorum.

B. Duties

1. Perform functions consistent with the requirements of the law and regulation.

2. Review and make recommendations regarding the need for and appropriateness of the performance of patient care services by APP credentialed by the Medical Staff.

3. Review the mechanism for evaluating the qualifications and credentials of APPs who are eligible to apply for APP Staff membership, and provide patient care services.

4. Review the minimum standards of training, education, character, competence, and overall fitness of APPs eligible to apply for APP Staff Membership.

5. Review patient care services which may be performed by an APP, or category of APPs, as well as any applicable terms and conditions thereon.

6. Review professional responsibilities of APPs who have been determined eligible to perform patient care services.

7. Review and evaluate the qualifications of APPs applying for initial membership, reappointment, or modification of privileges.

8. Evaluate and report whether patient care services proposed to be performed or actually performed by APPs are inconsistent with the rendering of quality medical care and with the responsibilities of Members of the Medical Staff.

9. Evaluate the effectiveness of supervision requirements imposed upon APPs who

are rendering patient care services.

10. Review delineation of privileges, protocols and standardized procedures for APPs credentialed through the Medical Staff.

11. Review and approve standardized procedure covering practice by employed staff registered nurses in the facility consistent with the requirements of the law and regulation.

12. Standardized Procedures:

    a. Standardized procedures are required whenever registered nurse practices beyond the scope of practice taught in the basic curriculum for registered nurses as outlined by the California Nurse Practice Act (i.e., whenever special training and/or experience are necessary in order for the nurse to perform the procedure or practice in question).

    b. Standardized procedures may be initiated by the appropriate Department, nurse, or supervising practitioner. The standardized procedure is a collaborative effort among the Medical Center Director, supervising physician, Chief Nursing Officer, and nurse.

    c. Standardized procedure requires approval from the appropriate Department Chairman or Member of the Medical Staff, Chief Nursing Officer and Medical Center Director before it is submitted to CIDP.

    b. Each standardized procedure shall be in writing and:

        i. specify the standardized procedure registered nurses may perform and under what circumstances;

        ii. state any specific requirements which are to be followed by registered nurses in performing a particular standardized procedure;

        iii. specify experience, training, and/or education requirements for performance of a standardized procedure;

        iv. specify the method for initial and continuing evaluation of the competence of those registered nurses authorized to perform a standardized procedure. The method can be through on-line education, course, direct observation, chart review, and any other methods stated in the standardized procedure. Evaluations shall be on file in the Chief Nursing Officer's nursing office.

        v. maintain a written record of those persons authorized to perform a standardized procedure. The names of the nurses shall be on file in the Chief Nursing Officer's nursing office;

        vi. specify the nature and scope of review and/or supervision required for practitioners performing standardized procedures; for example, whether a standardized procedure must be performed under the immediate supervision of a physician;

        vii. set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition;

        viii. state the limitations on settings or Departments, if any, in which standardized procedures may be performed;

        ix. specify patient record keeping requirements;

        x. review at least every three years; and

        xi. indicate approval date by CIDP and the Medical Executive Committee.

C. Provide reports to the Medical Executive Committee and Governing Body.

D. Meetings

The Committee shall meet at least quarterly.

Section ~~8~~7: Joint Conference Committee

The Joint Conference Committee serves as a forum for education and discussion of issues of mutual concern related to patient care, medical policies, staffing and resources, and the relationship of the Medical Center and the members of the Medical Staff. The Joint Conference Committee provides a mechanism for promoting open communications, building strong relationships, and resolving conflicts among the Governing Body, Medical Executive Committee, and Medical Center Administration. Additionally, the Joint Conference Committee acts as an advisory committee to the Governing Body reviewing annual reports and overseeing quality of care and patient safety.

A. Composition

The Joint Conference Committee shall consist of two members of the Governing Body, the Director of the Medical Center, the Medical Director, the County Chief Executive Officer, three members of the Medical Staff appointed by the Medical Executive Committee. Other County and Medical Center staff may be invited to attend meetings to provide support, information and guidance.

B. Duties

The Joint Conference Committee shall review the following reports and make recommendation to the Governing Body regarding their approval:

1. Annual Operating Budget and Business Plan
2. All Medical Center Policies and Procedures (finance and operations)
3. Annual Review of Physician Contract Compliance and Performance
4. Annual Review of Capital Expenditures (over $5000)
5. Annual Appraisal of Medical Center Services (AAMCS)
6. Annual Facilities Review
7. Annual Human Resource Activity Report
8. Annual Safety Report (Employee & Patient)
9. Annual Review of the Performance Improvement (PI) Plan
10. Annual Review of the Medical Center's Medical Risk Performance
11. Annual Review of the Medical Center's Compliance Program.
12. Quarterly Review of Medical Center Press-Ganey (Patient Satisfaction) Scores and HCAHPS (Hospital Consumer Assessment of Hospital Provided Services) Results

C. Meetings

The Joint Conference Committee shall meet a minimum of 4 (4) times per year and shall be subject to the Ralph M. Brown Act (Government Code section 54950 et. seq.), except that Evidence Code sections 1157 and 1157.7 and Health & Safety Code sections 1461 and 1462 shall apply with regard to the need for portions of the meetings to be held in Closed Session.

Section ~~9~~8: Medical Ethics Committee

A. Composition

A Chairman, no less than two other members of the Medical Staff, and representatives from nursing, social services, Medical Center Administration, and clergy. Others may be appointed at the discretion of the Chairman.

B. Duties

1. Provide education to the Medical Staff, Medical Center employees, and others about medical ethical issues.

2. Recommend to the Medical Executive Committee policies and guidelines for the management of cases having ethical implications, such as those involving patients' rights, or the withholding of medical care.

3. Serve as an advisory body, if requested, in the management of cases with ethical implications.

C. Meetings

Committee shall meet as often as necessary at the call of its Chairman. It shall maintain a record of its activities and report to the Medical Executive Committee.

Section ~~10~~9: Nominating Committee

A. Composition

The President, President-Elect, and the Immediate Past President of the Medical Staff. The President of the Medical Staff shall be Chairman of the Committee.

B. Duties

1. To solicit nominations of qualified Officer candidates from the Active Medical Staff.

2. Publish a ballot of qualified candidates for President-Elect and Secretary-Treasurer of the Medical Staff. A candidate may only run for one of the Officer slots and may not also run for an "At-large" slot during the same election year.

3. Publish a ballot of qualified candidates for the two "At Large" members of the Executive Committee. A candidate for an "At-large" slot may not run for an Officer slot during the same election year.

4. Submit the slate of nominees to the Medical Executive Committee no fewer than sixty days prior to the end of the odd-numbered Medical Staff year and to the Medical Staff no fewer than 30 days prior to the meeting at which the election will be held.

C. Meetings

The Committee shall meet as needed in the odd-numbered years.

Section ~~11~~10: Peer Review Committee

The Peer Review Committee (PRC) is designated to provide oversight of the overall peer review process that includes the Ongoing Professional Practice Evaluation (OPPE) and the Focused Professional Practice Evaluation (FPPE) processes. Any and all deliberations discussed and conducted at the PRC are confidential and protected by California Evidence Code 1157.

A. Composition

The Chairman, Vice Chairman, Patient Safety Officer, Chief Medical Officer, and at least eight Medical Staff members all of whom have current Medical Staff clinical privileges and are currently providing patient care services at ARMC. The Chief Medical Officer shall be a member of the Committee without vote.

B. Duties

Responsibilities include, but are not limited to:

1. Instituting activities for measuring, assessing, and improving processes that primarily depend on the actions of one or more privileged practitioners.
2. Providing ongoing measurement, assessment, and improvement of:
    a. Medical evaluation and treatment of patients
    b. Morbidity and mortality data
    c. Department-specific indicators
    d. Blood utilization, tissue review, and medication usage
    e. Operative and other clinical procedures and their outcomes
    f. Core Measure failures
    g. Infections
    h. Compliance with hospital and Medical Staff Bylaws, rules, or policies
3. Additional evaluations may be conducted when any of the following occur:
    a. Sentinel events or near-misses with potential for major or permanent injury that occurred as a result of the practitioner's practice and/or performance.

    b. Unusual adverse individual cases or clinical patterns of care including substantiated staff concerns related to a practitioner's clinical skill and performance.

    c. Significant trends or events identified based on review of aggregate data or individual case review.

    d. Any event that has the potential for, or results in, an untoward patient outcome, or that involves clinical practice that may lie outside acceptable standards directly related to practice-specific issues. This includes events reported by individuals having direct knowledge of the event, and reports derived from patient/family complaints.

    e. Occurrence reports that identify a pattern of practice or behavior that is outside of acceptable standards.

    f. Concerns related to disruptive or unprofessional behavior.

4. Review Peer Review policies and procedures to assure reliability and consistency across specialties.

C. Reports

Provide monthly reports to the involved Medical Staff Departments or Services regarding peer review outcome. PRC~~s~~ may suggest corrective action, when indicated, to Department Chairmen, but the final decision regarding type and duration of corrective action will reside with the Department Chairman. The involved Department shall report back to the PRC about actions taken, thereby closing the documentation loop.

D. Meetings

The Committee shall meet at least 10 times a year, and as requested by the Chairman. The PRC shall maintain a record of its proceedings, and report monthly its activities and recommendations directly to the Medical Executive Committee.

Section ~~12~~11: Physician Well-Being Committee

A. Composition

At least three physicians one of whom is designated as Chairman. Insofar as possible, members of this Committee will not serve on the Quality Management Committee or on a peer review committee.

B. Duties

1. Offer assistance to impaired members of the Medical Staff and/or House Staff.

2. Receive and review reports related to the well-being or impairment of Medical Staff members and/or House Staff and, as appropriate, investigate such reports.

3. Provide advice, consultation, or appropriate referrals as may seem appropriate. Such activities shall be confidential. However, if the Committee receives information that demonstrates that the health or impairment of the Medical Staff Member, Advanced Practice Professional (APP), or House Staff may pose a risk of harm to the Medical Center's patients or prospective patients, that information shall be referred to the President of the Medical Staff who will determine whether to refer the matter for a corrective action investigation.

4. Maintain confidential records on these individual physicians separate from the general records of the Committee, and report on its activities periodically to the Medical Executive Committee.

5. With the approval of the Medical Executive Committee, develop educational programs or related activities pertaining to the health and well-being of the member of the Medical Staff, APP, or House Staff.

C. Meetings

The Committee will meet as necessary at the call of the Chairman, but at least quarterly.

Section ~~13.0~~12: Quality Management Committee

A. Composition

The President, President-Elect, Secretary-Treasurer, four Medical Staff Members, Chief Executive Officer, Medical Director, Associate Administrator of Professional Services, Hospital Risk Management Coordinator, Hospital Department of Performance Improvement Manager, and House Staff. The President Elect of the Medical Staff, or his/her designees, shall serve as Chairman.

B. General

The Quality Management Committee (QMC) provides oversight and assessment of the hospital-wide quality program. QMC may appoint other subcommittees and Task Forces as needed to carry out its duties. The subcommittees shall confine their work to the purposes for which they are assigned and shall report to the QMC. They shall have such authority as delegated by the QMC and shall meet as often as necessary to complete their work.

C. Duties

1. Provides Oversight, analyzes, and manages the Medical Center's quality assessment and performance improvement activities including those of the Patient Safety, Patient Satisfaction and Risk Management programs.

2. Establish a plan for performance improvement activities and assess its effectiveness annually.

3. Oversee and coordinate quality control activities.

4. Receive and review reports from subcommittees and take appropriate action.

5. Establish organizational priorities for performance improvement activities.

6 Educate practitioners and employees about the principles of performance improvement and the Medical Center's specific programs.

7. Provide quarterly reports to the Medical Executive Committee, which will then be submitted to the Joint Conference Committee.

D. Meetings

The Committee shall meet no less than quarterly.

Section ~~13~~12.1: Blood Usage Committee

A. Composition

Representatives from the Medical Staff and House Staff, and a Blood Bank Technologist.

B. Duties

1. Review and approve the policies related to the acquisition, distribution, and administration of blood and blood products. Review and approve services and agreements that govern the procurement, transfer, and availability of blood and blood products.

2. Review the appropriateness and effectiveness of blood use based upon objective clinically valid criteria.

3. Oversee the system to identify transfusion reactions and evaluate same.

4. Review and approve policies and procedures regarding transfusions of potentially HIV infectious blood and blood products.

5. Assess the effectiveness of the systems for the acquisition, distribution, handling, and administration of blood products.

6. Provide quarterly reports to the Quality Management Committee.

C. Meetings

The Committee shall meet at least quarterly.

Section ~~13~~12.2: Health Information Management Committee

A. Composition

Representatives of the Medical Staff, Health Information Management, representatives from Nursing, Medical Center Administration, House Staff, Information Management, and Compliance.

Duties

1. Approve the format and structure of the medical record.

2. Establish standards for clinical documentation including forms, electronic templates, and order sets which are a part of the permanent medical record.

3. Standardize a universal document order for the medical record.

4. Review and approve requests for abbreviations.

5. Review requests for new or revised clinical documentation including forms, electronic templates and order sets, and take appropriate actions.

6. Develop criteria for and monitor compliance with production, timely completion, and availability and retention of records.

7. Establish criteria for and evaluate compliance with assessment of completeness of documentation in the record.

8. Conduct a bi-annual review of all pre-printed and electronic orders and revise as needed.

9. Develop criteria and monitor quality of the medical history and physical exam.

10. Develop criteria and define scope of the medical history and physical exam for non-inpatient services.

11. Review and approve policies and procedures related to clinical documentation and electronic health record compliance.

12. Oversee the operations of health information in compliance with all applicable regulatory standards.

13. Provide quarterly reports to the Quality Management Committee.

B. Meetings

The Committee shall meet at least quarterly.

Section ~~13~~12.2.1 Document Control Committee

A. Composition
Representatives of Medical Center Administration, Nursing, Health Information Management, Materiel Management, Behavioral Health, Ambulatory Services, Pharmacy, Compliance Department, Patient Registration, Respiratory Care, Information Management, and Printing Services (vendor). The Director of Health Information Management shall be the Chair. A representative from Information Management or Materiel Management shall serve as co-chair.

B. Duties

1. Review and approve format for all clinical documentation including forms, electronic templates, and order sets that are part of the permanent medical record.

2. Provide quarterly reports to the HIM Committee.

C. Meetings
The Committee shall meet at least monthly.

Section ~~13~~12.3 Infection Control Committee

A. Composition

The Nurse Epidemiologist, Director of Nursing, and representatives from the Medical Staff, House Staff, Nursing, Central Supply, Environmental Services, Pharmacy, Laboratory, Operating Room, Medical Center Administration, Employee Health, and Nutrition Services.

B. Duties

1. Review and approve policies and procedures related to infection surveillance, prevention, and control for the Medical Center.

2. Coordinate programs to monitor the incidence of infections, using objective clinically valid criteria.

3. Establish priorities for action based in part upon the results of surveillance monitoring.

4. Recommend actions to reduce the incidence of infections and minimize the risks of same.

5. Evaluate products with respect to infection control issues.

6. Ensure that appropriate quality control measures are in place and action is taken as appropriate based upon the results of these activities.

7. Oversee education related to infection control issues, for both employees and Medical Staff.

8. Schedule emergency surveillance, prevention, and/or control measures when there is reason to believe that any patient or staff is in danger due to nosocomial transmission of infection. The Chairman of the Committee, or designee, or the Medical Center Epidemiologist, may act for the Committee, which shall ratify the action at its next meeting.

9. Monitor community-acquired and healthcare-acquired infections in inpatients and healthcare workers.

10. Provide quarterly reports to the Quality Management Committee.

C. Meetings

The Committee shall meet at least quarterly.

Section ~~13~~12.4 Pharmacy and Therapeutics Committee

A. Composition

Representatives from the Medical Staff, Pharmacy, Nursing, House Staff, Nutrition Services, and Medical Center Administration.

B. Duties

1. Review and approve policies and practices related to medication ordering, preparation, administration, and distribution.

2. Oversee the system for monitoring drugs for reactions and interactions. Formulate procedures for reporting drug reactions and errors in administration of drugs. Investigate and evaluate issues and implement appropriate action to correct identified problems and improve medication administration safety.

3. Review and approve a formulary for use in the Medical Center.

4. Oversee the operation of the intravenous admixture program.

5. Monitor the appropriateness and effectiveness of the practices related to the ordering, evaluation, preparation, selection, distribution, and administration of medication and related quality control activities.

6. Advise the Medical Staff and Pharmaceutical Service on matters related to the choice of available drugs.

7. Review and approve any order sets with medications.

8. Conduct an annual review of all pre-printed medication orders and revise as needed.

9. Review untoward drug reactions.

10. Evaluate clinical data concerning new drugs requested for use in the hospital.

11. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

12. Review all findings and activities of the hospital-wide Medication Safety Committee.

13. Provide quarterly reports to the Quality Management Committee.

C. Meetings

The Committee shall meet at least quarterly.

Section ~~13~~12.5: Oncology Committee

A. Composition

A Chairman, Diagnostic Radiologist, Pathologist, Surgeon (includes general surgeon and surgical specialists(s) involved in cancer care), Medical Oncologist, Radiation Oncologist, Program Administrator (responsible for the administrative oversight and having budget authority for the cancer program), Oncology Nurse, Social Worker or Case Manager, Certified Tumor Registrar (CTR), Palliative Care professional. The Cancer Registrar and Cancer Program Coordinator will be ex-officio members.

B. Duties

1. Develop and evaluate the annual goals and objectives for clinical, educational, and programmatic activities related to cancer.

2. Promote a coordinated, multidisciplinary approach to patient management.

3. Ensure that educational and consultative cancer conferences cover all major organ sites and related issues.

4. Ensure that a supportive care system is in place for patients, families, and staff.

5. Monitor quality management and improvement through completion studies and/or action on quality management studies that focus on quality, access to care, and outcomes.

6. Promote clinical research.

7. Supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up reporting of registry data.

C. Meetings

The Committee shall meet at least quarterly.

~~13~~12.5.1 Carlos B. Hilliard Memorial Tumor Board Sub-committee

A. Composition

The Chairman of the Oncology Committee, at least three additional members of the Medical Staff, and representatives of Medical Center. The Tumor Registrar and Cancer Program Coordinator will be ex-officio members.

B. Duties

1. Provide consultation related to the management of cancer patients to Medical Staff members and to other physicians upon request.

2. Provide written reports of opinions and recommendations to the referring physician.

C. Meetings

The Subcommittee shall meet as called by the Chairman.

Section ~~13~~12.6: Operative and other Invasive Procedures Committee

A. Composition

Medical Staff representatives from Anesthesiology, Orthopedics, Surgery, Pathology, Women's Health, and other Medical Staff departments as indicated, and representatives from the Operating Room, Nursing, Risk Management, and House Staff.

B. Duties

1. Review and evaluate the systems for scheduling, admitting, and discharging surgical patients, and recommend changes as indicated.

2. Evaluate the adequacy and appropriateness of available resources and recommend changes as indicated.

3. Ensure the safety of the environment in which operative and non-operative invasive procedures are performed.

4. Recommend policies and procedures for the conduct of and operation of areas in which such procedures are performed.

5. Monitor and evaluate the appropriateness of the practices related to the selection of procedures, patient preparation, patient monitoring, and patient education using objective, clinically valid criteria.

6. Review of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as from certain cases in which no specimen is removed. The review shall include the indications for surgery, and all cases in which there is a major discrepancy between the pre-operative and post-operative (including pathologic) diagnosis. Discrepancies identified are sent to the appropriate committee and surgical department for further review. Report of tissue review findings is reported to the Peer Review Committee, surgical departments, and Medical Executive Committee at least quarterly.

7. Provide quarterly reports to Quality Management Committee.

C. Meetings

The Committee shall meet at least quarterly.

Section ~~13~~12.7: Critical Care Committee

A. Composition

The Directors of the Intensive Care Units and Burn Unit, Nurse Managers from the Intensive Care Units, and a representative from House Staff.

B. Duties

1. Review and approve criteria for admission to and discharge from each of the units.

2. Evaluate the adequacy and availability of resources and recommend changes as indicated.

3. Monitor and evaluate the quality of care provided in the units and suggest any action necessary to resolve problems identified.

4. Ensure the safety of the environment in each special care unit.

5. Review and approve policies and procedures for operation of each unit.

6. Monitor and evaluate the systems for management of Codes Blue.

6. Provide quarterly reports to the Quality Management Committee.

C. Meetings

The Committee shall meet at least quarterly.

Section ~~13~~12.8 Stroke Committee

A. Composition

Medical Staff representatives from Neurosurgery, Internal Medicine, Neurology , Emergency Medicine, Family Medicine, Rehabilitation Medicine, Medical Imaging, Stroke Director and Stroke Coordinator, and the Managers of the Laboratory, Emergency Room, Stroke Unit,

Intensive Care Unit, Pharmacy, Research, Emergency Medical Services, Medical Imaging, Rehabilitation Services, House Staff, Marketing, Education (community and staff), and Performance Improvement. The Chairman shall be the Stroke Director.

B. Duties

1. Oversee the operation of the Stroke Program, including community outreach.

2. Make recommendations to the Medical Executive Committee and Medical Center Administration related to resources needed, provider qualifications, and other operational matters.

3. Develop and oversee relevant performance improvement and quality improvement activities and quality initiatives either directly or by review of information provided by other entities and departments.

4. Oversee the operation of the Stroke Registry in compliance with all applicable regulations.

5. Develop, coordinate and/or oversee appropriate educational programs related to the optimal management of stroke patients.

6. Provide quarterly reports to the Quality Management Committee.

7. Develop and oversee stroke budget.

C. Meetings

The Committee meets monthly.

Section ~~13~~12.9: Trauma Committee

A. Composition

Medical Staff representatives from Surgery, Anesthesiology, Emergency Medicine, Orthopedics, and Laboratory Medicine, and the Nurse Managers of the Operating Room, Emergency Room, and Surgical Intensive Care Unit. The Chairman will be the Chairman of the Department of Surgery or the Director of Trauma Services. The Trauma Coordinator will be an ex-officio member of the Committee.

B. Duties

1. Oversee the operation of the Trauma Program, including community outreach.

2. Make recommendations to the Medical Executive Committee and Medical Center Administration related to resources needed, provider qualifications, and other operational matters.

3. Oversee relevant performance improvement activities either directly or by review of information provided by other entities.

4. Oversee the operation of the Trauma and Burn Registries in compliance with all applicable regulations.

5. Coordinate and/or oversee appropriate educational programs related to the optimal management of trauma victims.

6. Provide quarterly reports to the Quality Management Committee.

C. Meetings

The Committee will meet at least quarterly.

Section ~~13~~12.10 Utilization Management

A. Composition

Representatives from Medical Staff (two from Internal Medicine, two from Family Medicine, two from Surgery), Nursing, Medical Center Administration, House Staff, Utilization Review, and Compliance.

B. Duties

1. Monitor and evaluate the appropriateness of the practices related to resource use, using objective, valid criteria, and recommend changes in utilization practice as indicated.

2. Conduct quality control monitoring of the appropriateness of utilization reviews conducted.

3. Review and approve the criteria against which medical necessity is evaluated, and review and evaluate the information and raw statistical data obtained by case management.

4. Consult with providers as required regarding the appropriate use of medical resources in individual cases.

5. Review and update the utilization plan at least every two years for approval by the Medical Executive Committee and Joint Conference Committee.

6. Provide quarterly reports to the Quality Management Committee.

C. Meetings

The Committee shall meet at least quarterly. For regulatory compliance physician attendance should be seventy-five percent (75%).

Section ~~14~~13 Physician Assistant Post-Graduate Training Committee (PA PGTC)

A. Composition

Program Directors or their representatives from each P.A. post-graduate training programs affiliated with the Medical Center, a member of Medical Staff appointed by MEC, a member of OMEC appointed by the OMEC Chairman, and a member of Graduate Medical Education Committee appointed by the GMEC Chairman.

The PA PGTC Chairman will be a PA post-graduate training program director selected by the PA PGTC.

B. Duties

1. Oversee affiliated Physician Assistant post-graduate training programs to ensure compliance with institutional requirements.

2. Establish and implement policies and procedures regarding the quality of education and the work environment for members of the P.A. post-graduate training programs.

3. Review and make recommendations for the approval of P.A. post-graduate training program Letters of Affiliation (PLA) with the Medical Center.

4. Ensure P.A. post-graduate training programs affiliated with the Medical Center

have the internal policies and procedures in place to meet regulatory requirements for credentialing, and on-going evaluations of Physician Assistants.

5. Ensure that the holdings of the Medical Library are appropriate for P.A. post-graduate training programs.

6. Work with OMEC and GMEC to ensure a cooperative educational environment for all institutional learners.

7. Provide quarterly reports to the Medical Executive Committee

8. Provide an annual report to the organized Medical Staff and the Governing Body.

C. Meetings

The Committee shall meet at least quarterly.

Section 14 **Point of Care Committee**

A. Composition

The Committee shall be comprised of members of the Medical Staff, Nursing Manager or designee, and representation from Laboratory and Pharmacy.

B. Duties

1. Review and oversee all point of care testing within the Medical Center and Clinics.

2. Evaluate, develop, and coordinate any requested point of care testing as instructed by the Medical Executive Committee.

3. Involve Medical Center Administration, Purchasing, Information Technology, and Education as needed to help implement point of care testing.

4. Provide quarterly reports to Quality Management Committee.

C. Meetings

The Committee shall meet at least quarterly.

Section 15 **Professional Standards Committee**

The Professional Standards Committee (PSC) will assess issues related to professional behavior and rule violations, by providing collegial feedback and/or collegial counseling regarding expected standards of professionalism. Concerns related to unprofessional conduct will not be routinely referred to the Peer Review Committee.

A. Composition

The President, President-Elect, Patient Safety Officer, and the Department Chairman(men) of the involved Practitioner(s), and the Peer Review Committee Chairman. The Chief Medical Officer (CMO) shall be a member of the Committee without vote. Additional non-voting members may be appointed by the Chairman on an as needed basis. The President of the Medical Staff will serve as Chairman.

B. Duties

1. Assess issues related to unprofessional conduct.

2. Review current pending practitioner professionalism concerns along with a summary or

log of past professionalism concerns reported to the Medical Staff, a trending report, and a report of how concerns have been addressed.

3. Obtain facts through convergent validity, document review, and interviews.

4. Take progressive action to assure quality and patient safety

5. Make appropriate recommendations and referrals when necessary.

C. Meetings

The Committee will meet as necessary, at the call of the Chairman. The PSC shall maintain a record of its proceedings, and provide a report of its activities and recommendations directly to the Medical Executive Committee.