

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
GOTTLIEB MEMORIAL HOSPITAL**

**MEDICAL STAFF
ORGANIZATION MANUAL**

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

- (1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.
- (2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

CLINICAL DEPARTMENTS AND SECTIONS

2.A. DEPARTMENTS

The Medical Staff shall be organized into the following departments and sections:

Anesthesiology

Cardiology

Emergency Medicine

Family Medicine

Pediatrics

Internal Medicine

Hospitalist Medicine

Obstetrics and Gynecology

Oncology

Pathology

Radiology

Radiation Oncology

Surgery

Dentistry

General Surgery

Orthopedic Surgery

Podiatry

Urology

Wound Care

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS,
DEPARTMENT CHAIRS, SECTIONS AND SECTION CHIEFS

The functions and responsibilities of departments, department chairs, sections, and sections chiefs are set forth in Article 4 of the Medical Staff Bylaws.

2.C. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

- (1) Clinical departments shall be created and may be consolidated or dissolved by the MEC upon approval by the Board as set forth below.
- (2) The following factors shall be considered in determining whether a clinical department should be created:
 - (a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in the Bylaws);
 - (b) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;
 - (c) a majority of the voting members of the proposed department vote in favor of the creation of a new department;
 - (d) it has been determined by the Medical Staff leadership and the President that there is a clinical and administrative need for a new department; and
 - (e) the voting Medical Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.
- (3) The following factors shall be considered in determining whether the dissolution of a clinical department is warranted:
 - (a) there is no longer an adequate number of members of the Medical Staff in the clinical department to enable it to accomplish the functions set forth in the Bylaws and related policies;
 - (b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;

- (c) the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;
- (d) no qualified individual is willing to serve as chair of the department; or
- (e) a majority of the voting members of the department vote for its dissolution.

2.D. CREATION AND DISSOLUTION OF SECTIONS

- (1) The recommendation for creation and/or dissolution of sections within a clinical department shall be proposed by the Department Chair to the MEC for approval. The amendment process is then followed as outlined in Article 9 of the Medical Staff Bylaws.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

- (1) This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.
- (2) Procedures for the appointment of committee chairs and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.
- (3) This Article details the standing members of each Medical Staff committee. However, other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Staff committee meeting in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. All such individuals are an integral part of the credentialing, quality assurance, and professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of such committees.
- (4) A waiver request for any of the Medical Staff Committee composition requirements set forth below must be submitted in writing to the MEC for consideration and exemption approval.

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 report after each meeting to the MEC 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 at least four members of the Active Medical Staff, representatives from Administration, and representatives from specialty areas who may be added in an advisory capacity when deemed necessary.

3.C.2. Duties:

The Bylaws Committee shall:

- (a) review the Medical Staff Bylaws, the Credentials Policy, the Policy on Allied Health Professionals, the Organization Manual, and the Medical Staff Rules and Regulations annually and make recommendations for appropriate amendments and revisions;
- (b) submit recommendations to the MEC for changes in these documents as necessary to reflect current Medical Staff practices or changes in legal, statutory, or regulatory requirements; and
- (c) receive and consider all recommendations for changes to these documents made by any committee or department of the Medical Staff, any individual appointed to the Medical Staff, the CMO, and/or the President, and provide a report to the MEC regarding them.

3.D. CANCER COMMITTEE

3.D.1. Composition:

The Cancer Committee is a multidisciplinary committee and members shall include Medical Staff representatives of the major clinical departments, including a board certified physician from surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, internal medicine, family medicine, cancer liaison physician, oncology nurse specialist and pain control specialist, the Cancer Registrar, and representatives from Administration and others as necessary.

3.D.2. Duties:

The Cancer Committee shall:

- (a) develop and evaluate annual goals and objectives for the clinical, educational, and programmatic activities related to cancer and the provision of cancer-related services;
- (b) organize, publicize, conduct, and evaluate regular educational and consultative cancer conferences that are multidisciplinary and patient-oriented;
- (c) ensure that consultative services from all major disciplines are available to all patients;
- (d) supervise the Cancer Registry for quality control of abstracting, staging, and reporting;
- (e) plan and complete patient care evaluation studies to include survival data and, if available, comparison data;
- (f) ensure that cancer rehabilitation services are available and used; and

- (g) encourage a supportive care system for all patients with cancer.

3.E. CME/LIBRARY COMMITTEE

3.E.1. Composition:

The CME/Library Committee shall consist of at least three Medical Staff members broadly representative of the clinical departments and other Hospital and Administrative representatives as necessary.

3.E.2. Duties:

The CME/Library Committee shall:

- (a) organize a program to provide educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public and the profession;
- (b) maintain documentation of physician participation in continuing education programs within the Hospital; and
- (c) oversee the professional library service.

3.F. CREDENTIALS COMMITTEE

3.F.1. Composition:

The Credentials Committee shall consist of the CMO, the chair of the Professional Practice Evaluation Committee, and up to six members of the Active Staff.

3.F.2. Duties:

The Credentials Committee shall:

- (a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make reports of its findings and recommendations;
- (b) in accordance with the Credentials Policy, review requests for waivers of any threshold eligibility criteria and make recommendations on the same to the MEC;

- (c) in accordance with the Policy on Allied Health Professionals, review the credentials of all applicants seeking to practice as Category I and Category II practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make reports of its findings and recommendations;
- (d) review, as may be requested by the MEC, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff and, as a result of such review, make a report of its findings and recommendations; and
- (e) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.3 (“Clinical Privileges for New Procedures”) and Section 4.A.4 (“Clinical Privileges That Cross Specialty Lines”) of the Credentials Policy.

3.G. INFECTION CONTROL COMMITTEE

3.G.1. Composition:

The Infection Control Committee shall consist of at least three Active Staff members broadly representative of the clinical departments and other Hospital and Administrative representatives as necessary to fulfill its functions.

3.G.2. Duties:

The Infection Control Committee shall:

- (a) be responsible for reviewing potential sources of inadvertent Hospital infections, reviewing and analyzing actual infections, promoting a preventive and corrective program designed to minimize infection hazards, and supervising infection control in all phases of the Hospital’s activities;
- (b) review, study and supervise infection prevention procedures in operating rooms, recovery rooms, special care units and all other clinical areas of the Hospital; and
- (c) review, study and supervise other situations as requested by the MEC or other Medical Staff or Hospital committees.

3.H. LEADERSHIP COUNCIL

3.H.1. Composition:

- (a) The Leadership Council shall be comprised of the following voting members:

- (1) President of the Medical Staff, who shall serve as the Chair;
 - (2) Chair, Professional Practice Evaluation Committee; and
 - (3) Immediate Past President of the Medical Staff.
- (b) The CMO, CQO, and PPE Support Staff representatives shall serve as *ex officio* members, without vote, to facilitate the Leadership Council’s activities.
- (c) Other Medical Staff members or Hospital personnel may be invited to attend a particular Leadership Council meeting (as guests, without vote) in order to assist the Leadership Council in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant agenda item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.H.2. Duties:

The Leadership Council shall perform the following functions:

- (a) review and address concerns about practitioners’ professional conduct as outlined in the Medical Staff Professionalism Policy;
- (b) review and address concerns about practitioners’ health status and the ability to provide safe and competent care as outlined in the Practitioner Health Policy;
- (c) appoint the Chair and the members of the Professional Practice Evaluation Committee (“PPEC”), after appropriate consultation with department chairs;
- (d) appoint Physician Advisors and Pre-Determined Reviewers to function in accordance with the Professional Practice Evaluation Policy (Peer Review), after appropriate consultation with department chairs;
- (e) meet, as necessary, to consider and address any situation that may require immediate action;
- (f) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all facilities within the Hospital; and
- (g) perform any additional functions as outlined in the Professional Practice Evaluation Policy (Peer Review) or as may be requested by the PPEC, the MEC, or the Board.

3.I. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the MEC are set forth in Section 5.D of the Medical Staff Bylaws.

3.J. NOMINATING COMMITTEE

The composition and duties of the Nominating Committee are set forth in Section 3.D of the Medical Staff Bylaws.

3.K. PHARMACY AND THERAPEUTICS COMMITTEE

3.K.1. Composition:

The Pharmacy and Therapeutics Committee shall consist of at least three representatives of the Medical Staff, the Director of Pharmacy, a representative of the Hospital Nursing Department and such administrative Hospital representatives as may be necessary.

3.K.2. Duties:

The Pharmacy and Therapeutics Committee shall:

- (a) examine and survey all Hospital drug utilization policies and practices to assure optimum clinical results with 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 advisors to the Medical Staff and the Hospital department of pharmacy on matters pertaining to the choice of available drugs;
- (d) make recommendations concerning drugs to be stocked on the nursing unit floors and other places in the Hospital;
- (e) develop and periodically review a formulary or drug list for use in the Hospital;
and
- (f) evaluate clinical data about new drugs or preparations requested for use in the Hospital.

3L. PHYSICIAN LEADERSHIP DEVELOPMENT COMMITTEE

3.L.1. Composition:

The Physician Leadership Development Committee shall consist of both formal and informal physician leaders recommended by the Medical Staff Officers and Administration and appointed by the President of the Medical Staff.

3.L.2. Duties:

The Physician Leadership Development Committee shall:

- (a) Focus on the continuing professional development of managerial, social, and personal skills as well as traditional clinical medical subjects;
- (b) Ensure the continuing professional development of skills in leadership, finances, human resources, diversity, and legal and regulatory developments;
- (c) Ensure the continuing professional development of skills in team dynamics, project management, negotiation, influence without authority, and dealing with difficult conversations; and
- (d) Focus on the continuing professional development of skills in patience, consensus building, and meeting facilitation skills.

3.M. PROFESSIONAL AFFAIRS COMMITTEE

3.M.1. Composition:

The Professional Affairs Committee shall be comprised of the President of the Medical Staff, the President-Elect, the Secretary-Treasurer, four members from Administration who shall be appointed by the President, and the CMO. All members shall have an equal vote on the Committee.

3.M.2. Duties:

The Professional Affairs Committee shall act as a liaison between the Medical Staff and the Board for the consideration of questions in which the Medical Staff and Board are jointly interested. The Committee shall meet on an as needed basis with meetings called by the Chair, the President of the Medical Staff, and/or the President.

3.N. PROFESSIONAL PRACTICE EVALUATION COMMITTEE (“PPEC”)

3.N.1. Composition:

The PPEC shall consist of the following:

(a) Voting Members:

- (1) Immediate Past President of the Medical Staff;
- (2) one other Past President of the Medical Staff; and
- (3) Physician Advisors.

(b) Non-Voting Members:

- (1) CMO;
- (2) CQO;
- (3) Chief Medical Informatics Officer; and
- (4) PPE Support Staff representatives.

Before any PPEC member begins serving, the member must understand the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on professional practice evaluation, with the nature of the training to be identified by the Leadership Council or the PPEC.

To the fullest extent possible, PPEC members shall serve staggered, multiple-year terms, so that the Committee always includes experienced members. Appointed members may be reappointed for additional terms.

Other Medical Staff members or Hospital personnel may be invited to attend a particular PPEC meeting (as guests, without vote) in order to assist the PPEC in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant agenda item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and shall be bound by the same confidentiality requirements as the standing members of the committee.

3.N.2. Duties:

The PPEC shall perform the following functions:

- (a) oversee the implementation of the Professional Practice Evaluation Policy (Peer Review) (“PPE Policy”) and ensure that all components of the process receive appropriate training and support;
- (b) review and approve ongoing professional practice evaluation (“OPPE”) quality data elements that are identified by departments;
- (c) review and approve the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;
- (d) review, approve, and/or assist in the development of patient care protocols and guidelines that are recommended by departments, specialties, or others;
- (e) identify those variances from rules, regulations, policies, or protocols which do not require physician review, but for which an informational letter may be sent to the practitioner involved in the case;
- (f) review cases referred to it as outlined in the PPE Policy;
- (g) develop, when appropriate, performance improvement plans for practitioners, as described in the PPE Policy;
- (h) monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;
- (i) periodically review the effectiveness of the PPE Policy and recommend revisions as may be necessary; and
- (j) perform any additional functions as may be requested by the Leadership Council, the MEC, or the Board.

3.O. UTILIZATION MANAGEMENT COMMITTEE

3.O.1. Composition:

The Utilization Management Committee shall consist of at least two members of the Active Medical Staff, hospital administration, nursing services, case management, utilization management, clinical documentation improvement, and patient financial services.

3.O.2. Duties:

The Utilization Management Committee:

- (a) is required by the CMS Conditions of Participation

- (b) meets at least ten times per year and usually on a monthly basis
- (c) reports to the Medical Executive Committee at least annually
- (d) has a physician chairperson
- (e) reviews the following information:
 - 1) length of stay
 - 2) observation monitoring
 - 3) avoidable days
 - 4) readmissions
 - 5) case mix index
 - 6) utilization of resources such as medical imagining and other testing
 - 7) reviews the Utilization Plan on an annual basis

ARTICLE 4

AMENDMENTS

This Manual may be amended in accordance with the process set forth in Article 9 of the Medical Staff Bylaws.

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Adopted by the Medical Staff: September 23, 2014

Approved by the Board: September 29, 2014