ORGANIZATIONAL MANUAL & PROCEDURES OF THE MEDICAL STAFF

179-300

ORGANIZATIONAL MANUAL OF THE MEDICAL STAFF

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PART ONE. RESPONSIBILITIES AND AUTHORITY OF OFFICERS

1.1 RESPONSIBILITIES AND AUTHORITY OF THE MEDICAL STAFF PRESIDENT

The Medical Staff President, as the primary Medical Staff officer, the chief medical administrative officer of the Medical Staff, and the Medical Staff's representative in its relationships to others, has the following responsibilities and authority:

1.1-1 AS THE MEDICALSTAFF'S REPRESENTATIVE TO OTHERS

A. Transmit to the Board or the appropriate Committee(s) and to the Hospital President the views and recommendations of the Medical Staff and the Medical Executive Committee (MEC) on matters of Hospital policy, planning, operations, governance, and relations with external agencies; and transmit the views and decisions of the Board and Hospital President to the MEC and the Medical Staff Membership.

B. Communicate and represent the opinions and concerns of the Medical Staff and its individual Members on organizational and individual matters affecting Hospital operations to the Board and the Hospital President.

C. Oversee compliance on the part of the Medical Staff with the procedural safeguards and rights of individual Staff Members in all stages of the Medical Staff credentialing process.

1.1-2 AS THE CHIEF MEDICAL ADMINISTRATIVE OFFICER (CMO)

A. Direct the efficient operation and organization of the administrative policy-making and representative aspects of the Medical Staff organization; work with the Hospital CEO to coordinate Medical Staff activities and policies with administration, nursing, support and other personnel and services; enforce compliance with the provisions of the Bylaws, Rules and Regulations, Policies, and Procedures of the Staff and the Hospital; enforce compliance with regulatory and accrediting agencies' requirements, and periodically evaluate the effectiveness of the Medical Staff organization.

B. Be responsible for the agenda of and preside at all General and Special Meetings of the Medical Staff and of the MEC.

C. Appoint, subject to MEC approval, Medical Staff Members to Committees formed to accomplish Staff administrative, environmental, or representation functions; unless otherwise provided in the Medical Staff Bylaws or this Manual,

D. Review and enforce compliance with standards of ethical conduct and professional demeanor among the Members of the Medical Staff in their relations with each other, the Board, Hospital management, other professional and support staff, and the community.

1.1-3 AS THE CHIEF DEPARTMENT CLINICAL OFFICER

A. Supervise the clinical organization of the Staff, coordinate the delivery of services among the clinical services, and work with the Hospital President in coordinating activities of administration, nursing, support and other personnel and services with Medical Staff clinical units.

B. Advise the Board, the Hospital President and the MEC on matters impacting patient and clinical services, including the need for new or modified programs and services, the need for recruitment and training of professional and support staff personnel, and the need for specific staffing patterns.

1.2 RESPONSIBILITIES AND AUTHORITY OF THE VICE PRESIDENT

As the second ranking Medical Staff officer, the Vice President has the following responsibilities and authority:

A. Assume all of the duties and responsibilities and exercise all of the authority of the Medical Staff President when the Medical Staff President is unable--temporarily or permanently--to accomplish the same by reason of illness, absence, other incapacity or unavailability, or refusal.

B. Serve as a member of the MEC and as Chair of the Medical Staff Quality Assessment Committee (MSQA). As Chair of the MSQA Committee, fulfill the responsibilities of Chief Quality Assessment Officer including the following:

1. Direct the development, implementation, and overall functioning and organization of the Medical Staff components of the Quality Assessment (QA) program, and assure that they are clinically and professionally sound and accomplish their objectives and are in compliance with regulatory and accrediting agency requirements.

2. Advise the Board, Hospital CEO, MEC, and other relevant Medical Staff and Hospital individuals and groups on the functioning of the QA program.

3. Consult with and report to the Board on the findings of Medical Staff Quality Assessment activities, provide recommendations for actions that are required, and with the assistance of the Hospital President, assure that any Board decisions are carried out by the Medical Staff.

C. Perform such additional duties as may be assigned by the Medical Staff President, the MEC, or the Board.

1.3 RESPONSIBILITIES AND AUTHORITY OF THE SECRETARY-TREASURER

The Secretary-Treasurer has the following responsibilities and authority:

A. Serve as a member of the MEC.

B. Report on meetings of the Medical Staff and the MEC.

C. Give proper Notice of all Medical Staff and MEC meetings.

D. Supervise the collection of and account for any funds that may be collected in the form of dues, assessments, or otherwise.

E. Prepare an annual financial report for transmittal to the Medical Staff at its Annual Meeting and to the Board and Hospital CEO, and prepare any other interim reports that may be requested by the Medical Staff President or the MEC.

F. Perform such additional duties as may be assigned by the Medical Staff President, the MEC, or the Board.

1.4 ROLES AND RESPONSIBILITIES OF DEPARTMENT CHIEF AND VICE-CHIEF

The roles and responsibilities of Department Chief are delineated in the Bylaws.

1.5 SPECIAL STAFF OFFICERS

1.5-1 DESIGNATION

A Special Staff Officer is a Medical Staff Member serving full or part-time under contract or other working arrangement with the Hospital to perform medico-administrative or education functions. The current Special Staff Officer positions include: the Vice President of Medical Affairs.

1.5-2 QUALIFICATIONS, SELECTION AND TERM

Vice President of Medical Affairs
The Vice President of Medical Affairs will:

1. Report to the Hospital President and Chief Executive Officer and is charged with the duties of promoting, stimulating, and cultivating a climate that is supportive of the highest level of quality patient care and medical education.

2. Be responsible for overseeing all of the professional and medical activities at the Hospital and acting as an advocate for quality care.

3. These activities will be carried out in conjunction with Medical Staff Officers and Department Chiefs.

When a Vice President of Medical Affairs is to be selected, an ad hoc Search Committee will be constituted for the purpose of recommending one or more qualified nominees for the office. It is recommended that the Search Committee include Members of the Active Staff in Good Standing, appointed by the President of the Medical Staff, the Hospital CEO, and the Chairman of the Board.

1.5-3 RESIGNATION AND REMOVAL

A. Resignation
Any Special Staff Officer may resign from office at any time by giving written notice to the authority designated below. Such resignation, which may or may not be made contingent on formal acceptance, takes effect on the date of receipt or at any later time specified therein.

1. Vice President for Medical Affairs to the Hospital CEO

B. **Removal**
Removal of a Special Staff Officer will be governed by the terms of the Special Staff Officer's employment contract. The MEC may make recommendations for removal of a Special Staff Officer to the Hospital President, the Board, or others to whom the Special Staff Officer is responsible. Grounds for removal of a Special Staff Officer include:

1. Failure to perform the duties of the position in a timely and appropriate manner.

2. Failure to continuously satisfy the position's specific qualifications.

PART TWO. MEDICAL STAFF COMMITTEES AND DEPARTMENTS

2.1 DESIGNATION

There will be a Medical Executive Committee (MEC) and other Standing Committees as delineated in this Part which are responsible to the MEC.

2.2 MEDICAL EXECUTIVE COMMITTEE

2.2-1 PURPOSE

The purpose, composition, functions, and reporting mechanisms for the MEC are delineated in the Bylaws.

A. Circulation of Agenda
The agenda will be provided to members of the Committee at least one week in advance of each Regular MEC Meeting.

B. Request to Participate
At least three (3) working days prior to a Regular MEC Meeting, any Staff Member or Privilege holder who does not hold a position on the Committee may, by written notice to the Medical Staff President, request to participate at the Meeting in the discussion of specific agenda items. Each such notice must make reference to the agenda items involved and must be supported by reasons for the request. The request to appear may be denied If the Medical Staff President believes that the request is not substantiated or that a denial is in the best interests of the efficient functioning of the MEC. The MEC must be informed of the request and of the action. The MEC may over-ride the Medical Staff President and postpone consideration of the item in question or otherwise allow participation by the requesting individual.

2.3 BYLAWS COMMITTEE

2.3-1 PURPOSE AND MEETINGS

The Bylaws Committee fulfills Medical Staff responsibilities related to review and revision of the Medical Staff Bylaws, the Related Manuals, the Rules and Regulations, the Policy Manuals, and any forms promulgated in connection with these documents. It also assumes the responsibility for investigating and providing recommendations on such Administrative policy-making and planning matters and activities of concern to the Staff as are referred by the MEC. It also supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its clinical units. The Committee meets annually or as needed and reports to the MEC.

2.3-2 COMPOSITION

The Bylaws Committee includes at least five (5) Members of the Medical Staff. A representative of Administration serves without a vote.

2.3-3 FUNCTION

The Bylaws Committee conducts, on a periodic basis, a review and revision of the Medical Staff Bylaws, the Related Manuals, the Rules and Regulations, the Policy Manuals, and any forms promulgated in connection with these documents. These review activities are undertaken both as a good governance practice and in order to assist the MEC in fulfilling the document review responsibilities that are established in the Bylaws.

2.4 CREDENTIALS COMMITTEE

2.4-1 PURPOSE AND MEETINGS

The Credentials Committee coordinates the credentialing function of the Medical Staff by receiving and analyzing applications and issuing recommendations for appointment, reappointment, and Clinical Privileges. It also supervises the process and procedure for credentialing Advanced Practitioners and Allied Health Professionals. The Committee meets as often as necessary and reports to the MEC.

2.4-2 COMPOSITION

The Credentials Committee will be composed of at least five (5) Members of the Medical Staff. A representative of Administration serves without vote.

2.4-3 CREDENTIALS REVIEW

A. Review, evaluate, and transmit written reports as required by the Bylaws or Credentialing Procedures Manual on the qualifications of each applicant, Member, or Privilege holder for appointment, reappointment or modification of appointment or grant or modification of Clinical Privileges.

B. Review, evaluate, and transmit written reports on the qualifications of each Allied Health Professional and AHP applicant for the performance of specified services.

C. Assist the MEC on the initiation, investigation, reviewing, and reporting of Corrective Action matters and any other matters involving the clinical, ethical, or professional conduct of any Member or Privilege holder assigned or referred by the MEC, the Board, any Medical Staff Officer, the Hospital CEO, or any Department Chief or Committee Chair.

D. Submit written reports monthly to the MEC and the Board on the status of pending applications or other credentialing matters including the specific reasons for any inordinate delay in the processing of any application.

E. Maintain, in conjunction with the Medical Staff office, a credentials file for each Medical Staff Member and Privilege holder including records of participation in Staff activities and results of Quality Assessment monitoring and utilization activities.

2.5 PERFORMANCE IMPROVEMENT COMMITTEE

2.5-1 Composition:

(a) Medical Staff participates in the Performance Improvement (PI) Committee, The PI committee will consist of Medical Staff chairpersons from the following committees:

(1) Infection Prevention and Control Committee;

(2) Health Information Management Committee;

(3) Pharmacy and Therapeutics Committee;

(4) Utilization Review Committee; and

(5) Bariatric Surgery Committee

(b) Additional members may be added as deemed necessary. The President of the Medical Staff will appoint an officer of the Medical Staff to serve as chairperson of the Performance Improvement Committee, with vote, and with reporting responsibilities to the Medical Executive Committee.

2.5-2 Duties:

The Performance Improvement Committee will perform the following duties:

(a) integrate Hospital-based operational committee activities which assess processes of care, Hospital services and operations;

(b) review issues of a Hospital-wide operational nature to recommend policy changes to support a culture of improvement of health outcomes systemwide;

(c) submit reports of its actions and recommendations to the Medical Executive Committee; and

(d) perform other duties as requested by the Medical Executive Committee to support a culture of continuous performance improvement.

2.5-3 Reporting:

The Performance Improvement Committee will meet as often as necessary, at least quarterly. It will maintain a permanent record of its proceedings and actions and report its recommendations to the Medical Executive Committee.

2.6 INFECTION CONTROL COMMITTEE

2.6-1 PURPOSE AND MEETINGS

The Infection Control Committee reviews infection reports and investigates causes of Hospital infections and makes recommendations concerning the prevention and proper isolation of infectious diseases. Participate in antibiotic stewardship program maintenance and development. The Committee submits any findings of significant variances to the MEC and, where appropriate, to the Performance Improvement Committee. The Committee meets at least quarterly.

2.6-2 COMPOSITION

Suggested membership includes at least five (5) Members of the Medical Staff from the Departments of Surgery, Medicine, Orthopedics, anesthesia, bariatrics and Family Medicine,. Representatives from Nursing Services, Administration, and other appropriate Hospital departments may serve without vote.

2.6-3 FUNCTION

A. Maintain surveillance over the Hospital Infection Control Program.

B. Maintain surveillance over the Hospital Antibiotic stewardship program

C. Develop a system for reporting, identifying, and analyzing the incidence and cause of infections, and usage trending of antibiotic usage.

D. Develop and implement a preventive and corrective program that is designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic isolation and sanitation techniques.

E. Develop, evaluate, and review preventive, surveillance, and control policies and procedures relating to all phases of the Hospital's activities, including:

1. Operating Rooms
2. ICU
3. Central Sterile Processing
4. Isolation procedures
5. Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment
6. Testing of Hospital personnel for carrier status
7. Disposal of infectious materials
8. Environmental Services disinfection procedures

9. Food sanitation and waste management
10. Other situations as required.

F. Coordinate activities with the Pharmacy and Therapeutics Committee.

G. Conduct on a periodic basis, statistical studies of antibiotic usage and susceptibility/resistance trend studies in conjunction with the Pharmacy and Therapeutics Committee.

2.7 NOMINATION COMMITTEE

2.7-1 PURPOSE AND MEETINGS

The purpose of the Leadership and Succession Committee is to identify Medical Staff Members who are have leadership capabilities and are willing to serve in leadership positions in the Medical Staff Organizational structure.

2.7-2 COMPOSITION

Membership is as delineated in the Bylaws.

2.7-3 FUNCTION

The Committee is to convene and offer nominees for Medical Staff Officers as delineated in the Bylaws, and is to verify the qualifications of other nominees for Staff Officers as described in the Bylaws.

2.8 MEDICAL STAFF PEER REVIEW COMMITTEE

2.8-1 PURPOSE AND MEETINGS

The Medical Staff Peer Review Committee (PRC) coordinates and monitors the Medical Staff data gathering and analysis components of the Medical Staff's Peer Review Program. It meets at least quarterly and as necessary, and transmits its findings for informational purposes or for follow-up to the Medical Executive Committee.

2.8-2 COMPOSITION

The Medical Staff Peer Review Committee (PRC) includes physicians appointed by the Medical Staff President representing the diverse medical specialties contained within the MISH Medical Staff. The current elected Vice President of the Medical Staff is also a standing member of the Committee.

2.8-3 FUNCTION

A. Adopt, modify, and supervise the conduct of specific programs and procedures for the assessment and improvement of the quality and efficiency of medical care provided at the Hospital, subject to the approval of the MEC and the Board.

B. Formulate and act upon specific recommendations to correct any identified improvable situations with subsequent follow-up on any actions taken.

C. Coordinate the Medical Staff's performance improvement activities with those of other health care disciplines.

D. Send quarterly reports to the Medical Executive Committee that include findings, action taken, and follow-up.

2.8-4 MONITORING ACTIVITIES

A. Supervise and coordinate the conduct of, and review the findings of, clinical care

monitoring activities.

B. Review on a continuous basis other general indicators of the quality of care and of clinical performance including unexpected clinical occurrences.

C. Review the Concurrent Medical Record Reviews that are conducted at the point of care by a multidisciplinary hospital team for presence, timeliness, legibility, accuracy, authentication, and completeness of the medical record.

2.9 PHARMACY AND THERAPEUTICS COMMITTEE

2.9-1 PURPOSE AND MEETINGS

The purpose of the Pharmacy and Therapeutics Committee is to promote and maximize rational drug use within the Hospital. This purpose is both advisory and educational in nature. In an advisory capacity, the Committee recommends the adoption of, or assists in the formulation of, policies regarding the evaluation, selection, and therapeutic use of drugs in the Hospital. In an educational capacity, the Committee recommends or assists in the formulation of programs designed to meet the needs of the professional staff (physicians, nurses, pharmacists, and other healthcare practitioners) for complete and current knowledge on matters related to drugs and drug use. The Committee meets at least quarterly and reports to the MEC.

2.9-2 COMPOSITION

The Committee is comprised of at least five (5) Members of the Medical Staff representing various Departments. Additional non-voting members may include the Director of Nursing, CEO, and other healthcare professionals who can contribute specialized or unique knowledge and skills.

2.9-3 FUNCTION

A. Advise the Medical Staff and Hospital administration in matters pertaining to the use of drugs.

B. Advise pharmacy on the implementation of effective drug distribution and control procedures.

C. Maintain a formulary system, whereby a formulary of drugs accepted for use in the Hospital is compiled and continually revised. The Committee will define operating policies and procedures for the formulary system including those governing generic substitution, therapeutic interchange, and investigational drugs. These policies and procedures will be made available to, and observed by all Staff Members.

D. Establish programs and procedures which help ensure cost effective drug therapy.

E. Participate in performance improvement activities related to the prescription, distribution, and administration of drugs.

F. Direct drug usage evaluation studies, review the results of such activities, and initiate any necessary follow-up action.

G. Establish educational programs for the Hospital's professional staff on matters related to drug therapy.

H. Review adverse drug reactions occurring in the Hospital.

I. Make recommendations concerning drugs to be stocked in Hospital patient care areas.

2.10 PHYSICIAN ASSISTANCE COMMITTEE

2.10-1 PURPOSE AND MEETINGS

The purpose of the Physician Assistance Committee is:

A. To oversee the medical staff health advisory program, to provide a service that can be performed for Practitioners by their colleagues, by recognizing and encouraging Practitioners who may be impaired and unfit for duty as a result of physical, psychiatric, or emotional illness, or as the result of alcohol or drug use, to submit themselves voluntarily to a peer review committee thereby negating the requirement of direct reporting to the Medical Licensing Board.

B. To define the process for times when the situation ultimately deteriorates to the point of becoming a threat to patient care, and formal reporting to the Hospital Board is required, as well as the initiation of Corrective Action under the Medical Staff Bylaws, and, in the case of a Practitioner who is an employee of the Hospital, the Hospital's employee disciplinary action policies.

C. To assist an individual Practitioner in active medical practice who had previously functioned in a competent and productive fashion and who has demonstrated behaviors that suggest impairment and inadequacy in his function as a Practitioner.

D. To identify and manage matters of individual physician health which are separate from the medical staff disciplinary function.

E. To provide education about Practitioner health, as well as the prevention of physical, psychiatric, or emotional illness and facilitate confidential diagnosis, treatment and rehabilitation of Practitioners who suffer from a potentially impairing condition.

F. To assist and rehabilitate rather than discipline.

G. To aid a Practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients.

The Committee meets as needed and reports to the Medical Executive Committee.

2.10-2 COMPOSITION

The Committee is comprised of at least five (5) Members of the Medical Staff representing various Medical Staff Departments. Additional non-voting members may include other healthcare professionals who can contribute specialized or unique knowledge and skills.

2.10-3 PROCEDURE:

Impairment exists when a Practitioner exemplifies, a change in behavior which might compromise his/her ability to maintain the professional standards of practice established in this community and those mandated by law in the State of Indiana. Changes in behavior that demonstrate a failure to maintain such standards express themselves in many ways and to varying degrees. When a Practitioner is in this state, he/she is "impaired" and requires treatment. Until appropriate initial treatment and continuing care programs are completed, the Practitioner is still considered impaired.

If at any time during the diagnosis, treatment, or rehabilitation phase of the process, it is

determined that a Practitioner is unable to safely perform the Privileges he or she has been granted, the matter will be forwarded to Medical Staff Leadership for appropriate Corrective Action that includes strict adherence to any state or federally mandated reporting requirements.

A. Identifying the impaired Practitioner is the beginning of his/her recovery. The impairment may be self-reported by the Practitioner or it may be reported by colleagues or staff members. Prompt intervention and treatment are the next steps. Continuing care and monitored re-entry into professional, social, and family responsibilities represent the next phase in recovery. At this point, the Practitioner is not impaired, but recovering. As long as he exhibits satisfactory progress in a monitored program of assistance, he becomes more "recovered" and less "impaired." After two years, the "repaired" state can be expected to become "fixed" in the chemically dependent Practitioner.

B. Once a potential impairment has been identified, it falls to medical peers or hospital administrative staffs to initiate an immediate investigation, as the possibility of risk to the general public or patients from the potentially impaired Practitioner exists. Such assessment may lead to temporary Suspension of Privileges or other efforts to protect the individual patient. Once this has been achieved, the focus should be shifted to the Practitioner individually. He or she should be confronted in a gentle and supportive way. The Practitioner may deny all difficulties or minimize problems, in which case, consistent efforts should be continued to provide help and guidance toward treatment and rehabilitation. It may be necessary to force further treatment as a requirement for restitution of Medical Staff Privileges, etc. Whenever possible, the goal should be to return the Practitioner, in a rehabilitated state, to competent practice, but with ongoing scrutiny through an identified and personalized monitoring system.

C. When impairment is identified within the Hospital, the Committee must be immediately available to act. Usually this involves confronting the Practitioner with at least two members of the Committee or Medical Staff Officers; they never act alone.

D. Practitioner impairment may be in the obvious areas of alcohol or other drug abuse, physical impairment, or in psychiatric disturbances, such as progressive depression or manic-depressive illness. Significant stress leading to impairment can also occur from sexual misbehavior, or severe financial and business problems leading to anxiety, etc.

E. It is not the intention of the Physician Assistance Committee to address the issue of incompetence where lack of adequate training or skills is a problem unto itself and there pre-exists a particular complaint suggesting impairment.

F. The Committee will meet on an as needed basis to review the treatment progress of Practitioners for whom they are advocating, and if necessary, interview these Practitioners personally. Special meetings should be held promptly when a new complaint of impairment arises against a Practitioner or a Practitioner in recovery relapses. The Director of Risk Management will serve as the coordinator of this program.

G. The Medical Licensing Board of Indiana at 844 IAC 5-1-2(g) (2) requires a Practitioner who has personal knowledge, based upon a reasonable belief that

another Practitioner has engaged in illegal, unlawful, incompetent, or fraudulent conduct in the practice of medicine, to promptly report such conduct to a peer review committee. This provision does not prohibit a Practitioner from promptly reporting the conduct directly to the Medical Licensing Board, if he so chooses.

The regulation further provides that a practitioner who voluntarily submits himself to a peer review committee, or who is otherwise undergoing a course of treatment for addiction, severe dependency upon alcohol or other drugs or controlled substances, or for psychiatric impairment, where such treatment is sponsored or supervised by an impaired physician committee, is exempt from reporting to the Medical Licensing Board so long as the practitioner is complying with the course of treatment and so long as the practitioner is making satisfactory progress.

If a practitioner fails to comply with the peer review committee, or is not benefited by the course of treatment outlined by the peer review committee, then the chief administrative officer of the peer review committee, his designee, or any member of the impaired physician committee is required to promptly report the facts and circumstances of the case to the Medical Licensing Board.

H. Indiana's Peer Review Immunity Statutes provide immunity for any Practitioner serving on the Physician Assistance Committee as long as the actions are taken in good faith. Confidentiality of Committee proceedings and communications are protected. This legal framework empowers the Committee to advocate and monitor impaired Practitioners without interference from outside peer review organizations or fear of litigation.

2.10-4 Guidelines for Dealing with Impaired Practitioners:

A. When Hospital personnel, a patient, or a patient's family expresses concern over the behavior of a Practitioner to a Hospital employee, then that Hospital employee must contact the Department Director, Chief Medical Officer, Chief Executive Officer or the Director of Nursing immediately.

B. The Department Director, or Nursing Supervisor will first confirm the Practitioner's behavior is inappropriate, and then will inform the Practitioner that, "It is my responsibility to contact the Chief Medical Officer." The Risk Management Manager may provide assistance with notification.

C. The Chief Medical Officer will talk with the Practitioner regarding his/her behavior. As a result of the conversation, if the Chief believes the Practitioner is unable to provide care to patients, then the Chief Medical Officer assumes responsibility for the delegation of patient care and the incident will be forwarded to the MEC for review.

D. In the case where the CMO is not available, then the following people will be contacted in the following order:

1. The Vice President for Medical Staff Affairs.

2. The Chief Executive Officer

E. The Chief Medical Officer should contact a member of the Physician Assistance Committee or the Risk Management Manager for assistance in dealing with a Practitioner who may be impaired.

F. The Practitioner may be requested to submit to drug screening as well as a blood/breath alcohol test. Failure to consent to such a request may be grounds for disciplinary action under the Medical Staff Bylaws and/or the Hospital's personnel policies in the case of an employed Practitioner.

With any type of drug/alcohol testing, i.e., breath, blood, or urine, the physician must sign a consent form. If the Practitioner refuses the testing, have him/her sign a form indicating refusal to submit to drug/alcohol testing.

If the Practitioner agrees to the test and is found to have a positive drug/alcohol level, the Chief Medical Officer will inform the Practitioner he/she is to leave the Hospital. If the Practitioner refuses to leave the Hospital, then the Chief Medical Officer will contact the CEO of the Hospital to Summarily Suspend his/her Clinical Privileges. Upon refusing to leave the Hospital, the Chief Medical Officer will arrange to have security escort the Practitioner off of Hospital premises. If the Practitioner is deemed impaired, transportation for the Practitioner should be arranged. In both situations, the Chief Medical Officer will assume immediate responsibility for the delegation of care of the Practitioner's patient(s), or will arrange for immediate care of the patient(s), if necessary.

G. A report of the incident will be given to the Physician Assistance Committee for further evaluation, if necessary. A report will also be given to the Chief Medical Officer for evaluation and may be placed in the Practitioner's quality assurance file. Information placed in a Practitioner's file will be used to assess the credentials of that Practitioner for Clinical Privileges at MISH Hospital.

H. All actions taken in implementing these guidelines for dealing with impaired Practitioners shall be confidential and will constitute peer review activity.

I. Information relating to the Physician Assistance Committee involvement with a Practitioner will be maintained in a file separate from quality assurance and credential files

2.11 Health Information Management Committee

2.11-1 Composition:

1. The Health Information Management Committee will include Medical Staff representation and non-physician representation, appointed by the President of the Medical Staff.

2. Both physician and non-physician members of the Health Information Management Committee will serve with vote.

2.11-2 Duties:

The Health Information Management Committee will perform the following duties:

1. oversee the organization's record review program, primarily consisting of concurrent, ongoing review, but also including review of discharged charts, to identify opportunities for improvement;

2. review and approve forms and format for the medical record, including electronic

applications;

3. ensure medical records are reviewed on an ongoing basis at the point of care based on organizational defined indicators that address the presence, timeliness, readability, quality, consistency, clarity, accuracy, completeness, and authentication of data and information contained in the record, as well as appropriate scanning and indexing for document imaging;

4. establish standards for acceptable abbreviations and assist in the development of a "do not use" abbreviation list;

5. monitor delinquency statistics and make recommendations to the President of the Medical Staff and Chief Medical Officer when practitioners with delinquent records need to be suspended from admitting and surgical privileges until such charts are completed; and

6. make recommendations to the Medical Executive Committee when action needs to be taken to improve the quality of documentation that impacts patient care.

2.12 UTILIZATION REVIEW COMMITTEE

2.12-1 Composition:

1. The Utilization Review Committee will include three to four members of the Active Staff selected for their interest and/or experience in utilization review matters and who meet the medical staff eligibility criteria set forth in the Medical Staff Bylaws.

2. The President of the Medical Staff will appoint a committee chairperson. The chairperson of the Utilization Review Committee will be appointed.

3. The committee is assisted by professional personnel, including the Director of Health Information Management, the Billing Manager, the Director of Nursing, Chief Medical Officer and the Chief Executive Officer.

4. New members of the Utilization Review Committee are expected to obtain specific education and training regarding the utilization review process.

5. Two or more members of the committee may act as Physician Advisors for case review.

2.12-2 Duties:

The Utilization Review Committee will, in action to further the quality of care rendered to patients in the Hospital, perform the following duties:

1. establish and carry out a program of admission review and extended stay review of patients in accordance with applicable statutes and regulations;

2. monitor utilization to identify overutilization, underutilization, and the efficient use of resources;

3. study patterns of care and use of evidence-based order sets and protocols and other plans of care developed in collaboration with appropriate disciplines and approved by the Medical Staff;

4. review appropriateness of the utilization of support services;

5. oversee utilization activities of other departments;

6. assist in ongoing modifications of review criteria, practice guidelines, and standards of care;

7. recommend changes in hospital procedure or Medical Staff practices as indicated on analysis of utilization review; and

8. serve as a resource to assist in developing corrective action plans for issues as indicated by Medicare, Medicaid, and quality improvement organizations.

2.11-3 Meetings, Reports, and Recommendations:

1. The Utilization Review Committee may meet as often as necessary, but at least quarterly, to fulfill its responsibilities.

2. The Utilization Review Committee will keep a permanent record of its proceedings and actions. Copies of minutes will be transferred to the Performance Improvement Committee routinely as prepared, with recommendations from the Utilization Review Committee transmitted to the Medical Executive Committee through the Performance Improvement Committee.

2.13 CURRENT CLINICAL DEPARTMENTS

The clinical Departments are Anesthesiology, Surgery, Orthopedics, and Radiology.

PART THREE. MEETING PROCEDURES

3.1 NOTICE OF MEETINGS

A schedule of Regular General Staff, Department, and Committee Meetings will be distributed to all Medical Staff Members at the beginning of each Medical Staff year. Notice of any Special Meeting of the Medical Staff, or any special Meeting of a Department, or a Committee will be distributed to the appropriate Medical Staff Members. Personal attendance at a Meeting constitutes a waiver of Notice of such Meeting, except when a person attends a Meeting for the express purpose of objecting, at the beginning of the Meeting, to the transaction of any business because the Meeting was not duly called or convened. No business shall be transacted at any Special Meeting except that stated in the Meeting Notice.

3.2 QUORUM

The quorum requirement for the MEC and Credentials Committee shall be 30 percent. All other Medical Staff Department and Committee Meetings shall be those present and voting.

3.3 ORDER OF BUSINESS AT REGULAR MEETINGS OF THE MEDICAL STAFF

The order of business at a Regular General Staff Meeting is determined by the Medical Staff President. The agenda includes as least:

A. Review and acceptance of the minutes of the last Regular Meeting and any Special Meeting held since the last Regular Meeting.

B. Administrative reports from the Medical Staff President and the Hospital President.

C. The election of Officers and of representatives to Staff and Hospital Committees, if any such election is required by the Medical Staff Bylaws.

D. Reports by responsible Officers, Departments, and Committees, and discussion on the

overall results of the Staff's performance improvement activities and on the fulfillment of the other required Staff functions.

E. New business.

F. Optional education program.

3.4 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a Meeting is the action of the group. Action may be taken by a Department or Committee without a Meeting by unanimous consent in writing setting forth the action taken and signed by each member entitled to vote.

3.5 MINUTES

Minutes of all Meetings shall be prepared including the vote taken on each matter when applicable. Copies of said minutes must be approved by the attendees, forwarded to the MEC, or the parent Committee in the case of a subcommittee, and made available to any Member of the Medical Staff upon request. A permanent file of the minutes of each Meeting shall be maintained.

3.6 PROCEDURAL RULES

Meetings of the Staff, Departments, and Committees will be conducted according to the then current edition of Sturgis Parliamentary Procedures. In the event of conflict between said Rules and any provision of the Medical Staff Bylaws or any of its Related Manuals, the latter shall prevail

PART FOUR. AMENDMENT

4.1 AMENDMENT

This Organizational Manual may be amended or repealed, in whole or in part, by following the procedures outlined in the Medical Staff Bylaws.

This Medical Staff Organization and Proceduress Manual is adopted and made effective upon approval of the Board, superseding and replacing any previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter herein, and henceforth department and committee activities of the Medical Staff and of each individual serving as a member of a department or Medical Staff committee will be undertaken pursuant to the requirements of the Bylaws or this Manual.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Staff
6/6/2006
Date

Approved by the Governing Board
6/23/2006
Date