WASHINGTON HOSPITAL

MEDICAL STAFF

ORGANIZATION MANUAL

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DELEGATION OF FUNCTIONS

When a function is to be carried out by the Chief Executive Officer, by the Chief of Staff, 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. 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

2.A.DEPARTMENTS

The Medical Staff will be organized into the following Departments and Sections:

DEPARTMENTS:	Anesthesiology	Medicine	Pediatrics
	Family & Community Medicine	Obstetrics and Gynecology	Radiology
			Surgery
SECTIONS:	Department of Medicine:	Cardiology	Emergency Medicine
	Department of Surgery:	Cardiac Surgery	Pathology
		General Surgery	Podiatry
		Neurosurgery (changed by MEC 3/21/05 and Board 4/13/05)	Urology
		Orthopaedic Surgery	Vascular (change by MEC 6/20/05 and Board 10/12/05)
	Department of Anesthesiology:	Pain Management	
	Department of Medicine:	Psychiatry and Behavioral Medicine	
SERVICES:	Free standing:	ICU-CCU	
	Department of Medicine:	EKG/EEG	Respiratory Care
		Renal Dialysis	

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND DEPARTMENT CHAIRS

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

2.C.CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS AND DIVISIONS

(1) Clinical departments will be created and may be consolidated or dissolved by the Medical Executive Committee upon approval by the Board as set forth below.

(2) The following factors will 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 Section 4.C of 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 department 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 Chief Executive Officer 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 will 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.

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.

(2) Procedures for the appointment of committee chairs, appointment of committee members, and terms of appointment are set forth in Section 5.B of the Medical Staff Bylaws.

(3) This Article details the standing members of each Medical Staff committee. However, other Medical Staff members 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) Unless otherwise provided in a specific committee composition, voting members of committees are limited to voting members of the Medical Staff.

3.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical Staff committee, members must acknowledge and agree to the following:

(1) be willing and able to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent upon the full participation of its members;

(2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;

(3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee's functions may be performed in an informed, efficient, and effective manner;

(4) attend meetings on a regular basis to promote consistency and good group dynamics;

(5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid anecdotal or sidebar conversations;

(6) voice disagreement in a respectful manner that encourages consensus-building;

(7) understand and strive for "consensus" decision-making, thereby avoiding the majority vote whenever possible;

(8) speak with one voice as a committee and support the actions and decisions made (even if they were not the individual's first choice);

(9) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

(10) bring any conflicts of interest to the attention of the committee chair, in advance of the committee meeting, when possible;

(11) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the committee chair outside of committee meetings;

(12) participate in the development of an annual committee work plan and ensure that the committee plans are in alignment with the strategic goals of the Medical Staff; and

(13) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

3.C.MEETINGS, REPORTS, AND RECOMMENDATIONS

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

3.D.BYLAWS COMMITTEE

3.D.1.Composition:

(a) The Chief of Staff-Elect will serve as chair of the Bylaws Committee.

(b) Whenever possible, the Bylaws Committee will include three Past Chiefs of Staff.

(c) The Chief of Staff will appoint two other Medical Staff members to serve on this committee, subject to approval by the Medical Executive Committee. The Chief of Staff may also appoint further Medical Staff members as necessary if there are not enough Past Chiefs of Staff available to serve.

3.D.2.Duties:

The Bylaws Committee will perform the following functions:

(a) conduct periodic review of the Medical Staff Bylaws and Rules and Regulations;

(b) conduct periodic review of other policies and forms promulgated by the Medical Staff (as well as its departments and sections);

(c) submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices; and

(d) receive and evaluate (for recommendation to the Medical Executive Committee) suggestions for modifying Medical Staff Bylaws, Rules and Regulations, and/or other policies and forms.

3.D.3.Meetings and Reports:

The chair of the Bylaws Committee will determine its meeting schedule.

3.E.CANCER COMMITTEE

3.E.1.Composition:

(a) The Cancer Committee will consist of Active Staff members who represent each of the following specialties:

(i) diagnostic radiology;

(ii) medical oncology;

(iii) pathology;

(iv) radiation oncology; and

(v) surgery.

(b) Non-physician members will include:

(i) community outreach representative;

(ii) genetics representative;

(iii) oncology nurse;

(iv) palliative care representative;

(v) Administration representative(s);

(vi) quality management representative(s);

(vii) research representative;

(viii) social worker; and

(ix) tumor registrar.

(c) The committee will appoint a Cancer Liaison Physician, who will then become a member of the committee.

(d) Additional members will be appointed as needed (including urology and nurse navigator).

3.E.2.Duties:

The Cancer Committee will perform the following functions:

(a) support goal-setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities in the Hospital;

(b) appoint individual members to coordinate important aspects of the cancer program as required by the standards for accreditation (e.g., tumor board coordinator, tumor registry quality coordinator, quality improvement coordinator, psychological services coordinator, genetics professional/counselor, and palliative care team member);

(c) develop and evaluate annual goals for clinical and programmatic endeavors related to cancer care;

(d) monitor and evaluate the tumor board activities of the Hospital, including (but not limited to) determining conference frequency, multidisciplinary attendance, total case presentation, prospective case presentation, discussion of stage, prognostic indicators, treatment planning (using evidence-based treatment guidelines), and options for clinical trials;

(e) establish and implement a plan to evaluate the quality of tumor registry data and activity (on an annual basis); this plan will include procedures to monitor case

findings, accuracy of data collection, abstracting timeliness, follow-up, and data reporting; and

(f) develop and disseminate a report of patient and/or program outcomes to the public.

3.E.3.Meetings and Reports:

The Cancer Committee will meet quarterly and will publish an annual report to the Medical Executive Committee by November 1 (of the following year). It will also publish other reports on an as-needed basis.

3.F. CLINICAL EVALUATION COMMITTEE

3.F.1.Composition:

(a) The Clinical Evaluation Committee will consist of 11 members of the Active Staff.

(b) The committee will include representatives from these departments:

(i) Anesthesiology;

(ii) Family and Community Medicine;

(iii) Medicine;

(iv) OB-GYN;

(v) Pediatrics;

(vi) Radiology; and

(vii) Surgery.

(c) The chair of the Critical Care Committee will serve as a member of this committee, *ex officio*, with vote.

(d) The committee will also include a medical representative from Laboratory/Pathology and a representative from the Pharmacy. There will be additional Hospital staff and nursing representatives as deemed appropriate by the chair of this committee.

(e) The committee chair will appoint coordinators of Infection Control, Medical Records, Pharmacy & Therapeutics, and Tissue and Transfusion from among the members of this committee.

3.F.2. Duties:

The Clinical Evaluation Committee will perform the following functions:

(a) develop and maintain surveillance over a hospital-wide infection control program;

(b) develop a system for identifying, reporting, and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data (as well as follow-up activities);

(c) develop and implement a preventive and corrective program designed to minimize infection hazards (including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques);

(d) develop written policies that define special indications for isolation requirements;

(e) provide advice (related to infection control) on all proposed construction;

(f) act on recommendations (related to infection control) received from the Chief of Staff, Medical Executive Committee, departments, and other committees;

(g) review the sensitivities of organisms specific to the facility;

(h) guide the Health Information Management department in its review and evaluation of medical records;

(i) review and make recommendations for Hospital and Medical Staff policies, including Rules and Regulations relating to medical records (especially on topics such as completion deadlines, retention and destruction, and means of enforcement for rule violations); and

(j) serve as a liaison with Hospital administration and medical records personnel on matters relating to medical records practices.

3.F.3. Meetings and Reports:

This committee will submit quarterly reports to the Medical Executive Committee and Quality and Resource Management Committee regarding its findings, conclusions, and recommendations. The committee will meet at least quarterly and may submit more frequent reports as appropriate to its duties. The Clinical Evaluation Committee will create a record of all actions taken, and its minutes will be maintained on file in the administrative offices of the Hospital.

3.G.CREDENTIALS COMMITTEE

3.G.1.Composition:

(a) The Credentials Committee will consist of at least seven members of the Active Staff appointed by the Chief of Staff (in consultation with the Chief of Medical Services). Members will be selected based on their interest or experience in credentialing matters. Whenever possible, at least three of these members will be past Chiefs of Staff.

(b) The Chief of Staff-Elect will serve as chair of the Credentials Committee.

(c) Members of the committee will be appointed for an initial four-year term and will be replaced on a rotating basis to promote continuity. Members may be reappointed for subsequent terms.

(d) The chair of the committee may appoint one or more representatives from the Allied Health Staff to serve as a member(s) of the committee on an as-needed basis.

3.G.2.Duties:

The Credentials Committee will perform the following functions:

(a) review the credentials of all applicants for appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) collaborate with the Interdisciplinary Practice Committee on matters pertaining to the current clinical competence of individuals currently appointed to the Medical Staff or the Allied Health Staff and, as a result of such review, make a written report of its findings and recommendations;

(c) recommend the numbers and types of cases to be reviewed as part of the initial competency evaluation;

(d) review and approve specialty-specific criteria for ongoing professional practice evaluation, and specialty-specific triggers that are identified by each department; and

(e) recommend to the Medical Executive Committee appropriate threshold eligibility criteria for clinical privileges, including clinical privileges or new procedures and clinical privileges that cross specialty lines.

3.G.3.Meetings and Reports:

The Credentials Committee will meet at least once per month and will make regular reports to the Medical Executive Committee on the status of pending applications (including any reasons for delay in processing an application or request). Meetings of the Credentials Committee will only be open to members of the committee, the Chief of Staff, the Chief Executive Officer, and any other persons that the chair of the Credentials Committee has authorized to be present. The presence of at least 50% of the voting members of the committee shall constitute a quorum.

3.H.CRITICAL CARE COMMITTEE

3.H.1.Composition:

(a) The Critical Care Committee will consist of at least ten members of the Active Staff, including representatives from:

(i) Anesthesiology;

(ii) Family and Community Medicine;

(iii) Medicine;

(iv) OB-GYN;

(v) Pediatrics; and

(vi) Surgery.

(b) The Medical Directors of Emergency Services and a representative from the Emergency Medical Section will be members of this committee.

(c) The Medical Directors of the ICU-CCU and of Respiratory Care will be members of this committee.

(d) Appropriate Hospital staff members will also serve on the committee.

3.H.2. Duties:

The Critical Care Committee will perform the following functions:

(a) recommend and supervise overall service policies of the ICU-CCU and Emergency Services;

(b) provide for ongoing review of equipment, physical facilities, procedures, records, and professional proficiency with the ICU-CCU and Emergency Services;

(c) serve as a liaison between the ICU-CCU, Emergency Services, and the Medical Staff;

(d) coordinate with the Emergency Department and professional staff for community agencies (e.g., civil defense, fire, police, etc.) for the order and disposition of disaster victims; and

(e) review all equipment and supplies in the code blue crash carts (for code blue responses) at least annually.

3.H.3. Meetings and Reports:

This committee will meet at least monthly and will report directly to the Quality and Resource Management Committee.

3.I.INTERDISCIPLINARY PRACTICE COMMITTEE

3.I.1. Composition:

(a) The Interdisciplinary Practice Committee will consist of at least four members of the Medical Staff appointed by the Chief of Staff.

(b) The committee will include an equal number of physician and members of the Allied Health Staff, with at least one registered nurse.

3.I.2. Duties:

The Interdisciplinary Practice Committee will perform the following functions:

(a) make recommendations to the Credentials Committee regarding the credentialing body of Allied Health Staff members;

(b) establish and administer standardized procedures for registered nurses as follows:

(i) prescribe a required form for standardized procedures, including the subject to be covered;

(ii) identify the nursing functions that require the adoption of standardized procedures and ensure that registered nurses perform them only in accordance with standardized procedures;

(iii) establish a method for the review and approval of all proposed standardized procedures;

(iv) review and recommend approval of all proposed standardized procedures covering registered nurses;

(v) ensure that the Chief Nursing Officer has a system in place for identifying and designating the registered nurses who are qualified to practice under each standardized procedure, both on an initial and a continuing basis; and

(vi) ensure that the names of registered nurses approved to perform functions according to each standardized procedure are on file in the office of the Chief Nursing Officer or at some other designated place;

(c) oversee the Allied Health Staff as follows:

(i) identify specific categories of Allied Health Professionals and make appropriate recommendations;

(ii) make recommendations concerning the minimum standards of practice applicable to Allied Health Professional categories;

(iii) make recommendations concerning the supervision required for Allied Health Professionals;

(iv) review applications for permission to practice and renewal of permission to practice and privileges granted to practitioners from accepted categories in accordance with applicable Medical Staff bylaws, rules/regulations and policies; and

(v) conduct investigations and review concerns related to the practice of Allied Health Professionals, in accordance with applicable Medical Staff bylaws, rules/regulations and policies; and

(d) review and recommend approval of standardized procedures under which Registered Nurses practice in expanded roles.

3.I.3. Meetings and Reports:

The Interdisciplinary Practice Committee will meet at least quarterly, and more often if deemed necessary by the chair. It reports to the Medical Executive Committee and (as appropriate) to the Credentials Committee.

3.J.JOINT CONFERENCE COMMITTEE

3.J.1.Composition:

(a) The Chief of Staff will serve as chair of the committee.

(b) The Joint Conference Committee will also include the Chief Executive Officer, Chief of Staff-Elect, the Immediate Past Chief of Staff, the Medical Staff Liaison Officer, the Chief of Medical Services, Chief Nursing Officer, and two representatives from the Board of Directors.

3.J.2.Duties:

The Joint Conference Committee will perform the following functions:

(a) provide a forum for the discussion of Hospital and Medical Staff policies, as well as related matters; and

(b) provide a forum for interaction between the Administration, Board, and Medical Staff.

3.J.3.Meetings and Reports:

The Chief of Staff is responsible for the agenda of the Joint Conference Committee. It will meet at least monthly. The Medical Staff Liaison Officer will be responsible for the preparation of the minutes.

3.K.LEADERSHIP COUNCIL

3.K.1.Composition:

(a) The Leadership Council will consist of the following voting members:

(i) Chief of Staff, who will serve as chair;

(ii) Chief of Staff-Elect;

(iii) Medical Staff Liaison Officer; and

(iv) the Immediate Past Chief of Staff.

(b) The following individuals will serve as *ex officio* members, without vote, to facilitate the Leadership Council's activities:

(i) Chief of Medical Services;

(ii) Liaison Officer;

(iii) Chief of Compliance;

(iv) Chief of Quality; and

(v) PPE Support Staff representative(s).

(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 on its agenda. These individuals will be present only for the relevant agenda item and will be excused for all others. Such individuals are an integral part of the Leadership Council review process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.K.2.Duties:

The Leadership Council will 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 possible health issues that may affect a practitioner's ability to practice safely as outlined in the Practitioner Health Policy;

(c) review and address issues regarding practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy ("PPE Policy");

(d) meet, as necessary, to consider and address any situation involving a practitioner that may require immediate action;

(e) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;

(f) cultivate a physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future; and

(g) perform any additional functions as may be requested by the PPEC, the Medical Executive Committee, or the Board.

3.K.3.Meetings and Reports:

The Leadership Council will collaborate with other committees as described under the Policies noted above.

3.L.LONG RANGE PLANNING COMMITTEE

3.L.1. Composition:

(a) The Long Range Planning Committee will consist of at least eight members of the Active Staff, plus a chair, with representation from a variety of departments and services.

(b) In addition, Hospital Administration will send a designated representative to attend the meetings.

3.L.2. Duties:

The Long Range Planning Committee will perform the following functions:

(a) participate in an advisory capacity to evaluate resource needs for planning clinical programs, facilities, and services;

(b) provide input on assessing service priorities and needs and on allocation of resources;

(c) participate in formal updates of the strategic plan; and

(d) support the mission of the Hospital.

3.L.3. Meetings and Reports:

The Long Range Planning Committee will meet at least twice per year (or more often, as determined by the chair). In addition, it will provide an annual summary to the Medical Executive Committee and Medical Staff.

3.M.MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the Medical Executive Committee are set forth in Article 5 of the Medical Staff Bylaws.

3.N.PERINATAL MORBIDITY AND MORTALITY COMMITTEE

3.N.1.Composition:

(a) The Perinatal Morbidity and Mortality Committee will include:

(i) three obstetricians;

(ii) three pediatricians;

(iii) an anesthesiologist;

(iv) a pathologist, and

(v) a consulting neonatologist.

(b) The Perinatal Morbidity and Mortality Committee will also include appropriate Hospital representatives.

3.N.2.Duties:

The Perinatal Morbidity and Mortality Committee will perform the following functions:

(a) guide the review and study of cases of perinatal mortality and morbidity, reviewing available data and making recommendations for the improvement of perinatal patient care; and

(b) refer cases to other committees when appropriate.

3.N.3. Meetings and Reports:

The committee will meet at least quarterly and as often as necessary to handle cases requiring review.

3.O.PERIPHERAL VASCULAR COMMITTEE

See Page 17.1 (attached).

3.P. PHARMACY, NUTRITION, AND THERAPEUTICS COMMITTEE

3.P.1.Composition:

(a) The committee chair must be a member of the Active Staff.

(b) The Director of Pharmacy will be the secretary of the committee.

(c) This committee will include representatives from the following specialties:

(i) Anesthesiology;

(ii) Critical Care Services;

(iii) Infectious Disease;

(iv) Medical Oncology;

(v) Medicine;

(vi) Surgery; and

(vii) one At-Large Physician.

(d) If a representative from one or more of the above specialties is unavailable, the committee chair may instead select a member of the Active Staff to fill the role.

(e) The Chief of Medical Services, Medication Safety Officer, and the Director of the Nursing Service will be members of this committee. In addition, there will be representatives from:

(i) Administration;

(ii) Clinical Nutrition;

(iii) Compliance/Risk Management;

(iv) Patient Care Services;

(v) Pharmacy; and

(vi) Quality and Resource Management.

(f) The Chief of Staff may place other health professionals on this committee as he or she deems appropriate. The chair of the committee may also invite other individuals from within or outside of the organization to provide input.

3.P.2.Duties:

The Pharmacy, Nutrition, and Therapeutics Committee will perform the following functions:

(a) develop written policies and procedures for establishment of safe and effective systems for procurement, storage, distribution, dispensing and use of drugs and chemicals;

(b) conduct periodic evaluations of pharmaceutical services provided and make appropriate recommendations to the Medical Executive Committee and to Administration;

(c) assist in the standardization and communication of nutrition approaches and processes throughout the organization (including review and approval of the nutrition care manual, clinical nutrition services, and other relevant policies and protocols);

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

(e) provide education on the use of formulary and non-formulary medications;

(f) evaluate clinical data on new drugs and preparations (as requested by members of the Medical Staff) for approval for use in the Hospital;

(g) initiate and direct drug use evaluation programs and studies;

(h) review the results of drug use evaluation programs and studies and make appropriate recommendations to optimize drug use;

(i) establish standards concerning the use and control of investigational drugs and standards for research in the use of recognized drugs;

(j) monitor and evaluate adverse drug events (including drug reactions) for biologics and vaccines (as well as other medications);

(k) make recommendations to prevent the occurrence of adverse drug events;

(l) participate in quality improvement activities related to medication use; and

(m) operate in compliance with all Hospital and Medical Staff policies on conflicts of interest.

3.P.3.Meetings and Reports:

The Pharmacy, Nutrition, and Therapeutics Committee will meet at least every other month (and more often if deemed necessary by the chair). At the beginning of each meeting, members will disclose conflicts of interest in accordance with Hospital and Medical Staff policies. A quorum exists whenever there is a simple majority of the physician membership and a simple majority of the administrative staff members. The committee will prepare a quarterly report of its findings, conclusions, and recommendations and will forward that report to the Medical Executive Committee and to the Quality and Resource Management Committee. It will also maintain a record of all activities it undertakes relating to its functions.

3.Q.PROFESSIONAL PRACTICE EVALUATION COMMITTEE ("PPEC")

3.Q.1.Composition:

(a) The Immediate Past Chief of Staff will serve as the PPEC chair.

(b) The PPEC will also include:

(i) a past chair from each department;

(ii) the Chief of Medical Services;

(iii) the Director of Quality;

(iv) the Professional Practice Officer (a non-voting member who serves as a consultant to the committee); and

(v) additional Medical Staff members who are:

(1) broadly representative of the clinical specialties on the Medical Staff;

(2) interested or experienced in credentialing, privileging, PPE/peer review, or other Medical Staff affairs;

(3) supportive of evidence-based medicine protocols; and

(4) appointed by the Leadership Council (if they are deemed necessary).

(c) PPE Support Staff representatives will serve as *ex officio* members, without vote, to facilitate the PPEC's activities.

(d) If the Immediate Past Chief of Staff (or another Past Chief of Staff) is unwilling or unable to serve, the Leadership Council will appoint another former physician leader (e.g., Medical Staff Officer, department chair, or committee chair) who is experienced in credentialing, privileging, PPE/peer review, or Medical Staff matters.

(e) To the fullest extent possible, PPEC members will serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.

(f) Before any PPEC member begins serving, the member must review 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 PPEC.

(g) 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 on its agenda. These individuals will be present only for the relevant agenda item and will 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 PPEC.

3.Q.2.Duties:

The PPEC will 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 reports showing the number of cases being reviewed through the PPE Policy, by department or specialty, in order to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;

(c) review, approve, and periodically update Ongoing Professional Practice Evaluation ("OPPE") data elements that are identified by individual departments and sections, and adopt Medical Staff-wide data elements;

(d) review, approve, and periodically update the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;

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

(j) perform any additional functions as may be set forth in applicable policy or as requested by the Leadership Council, the Medical Executive Committee, or the Board.

3.Q.3.Meetings, Reports, and Recommendations:

The PPEC will meet at least quarterly to perform its duties. The PPEC chair and/or the Medical Executive Committee may direct the committee to meet more often. The PPEC will submit reports of its activities to the Medical Executive Committee and the Board on

a regular basis. The PPEC's reports will provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty, types and numbers of dispositions for the cases, listing of education initiatives based on reviews, listing of system issues identified). These reports will generally not include the details of any reviews or findings regarding specific practitioners.

3.R.QUALITY AND RESOURCE MANAGEMENT ("QRM") COMMITTEE

3.R.1.Composition:

(a) The Chief of Staff will appoint a member of the Active Staff to serve as chair of the QRM Committee, subject to approval by the Medical Executive Committee. The chair must have ability and experience in the area of quality improvement. Unless the Chief of Staff determines otherwise, the chair will serve for a default term of two years.

(b) The committee will consist of the assistant chairs of each department (unless they are not available, in which case the department may send a substitute representative).

(c) The committee will include a representative from pathology.

(d) The committee will also include:

(i) the chairs of the Critical Care and Clinical Evaluation Committees;

(ii) the Chief Nursing Officer;

(iii) the Chief of Compliance;

(iv) the Chief of Medical Services;

(v) the Chief of Staff-Elect;

(vi) the Clinical Resource Management Coordinator;

(vii) the CME Coordinator;

(viii) the Director of Quality; and

(ix) the Utilization Management Coordinator.

(e) Other appropriate representatives from Administration may serve *ex officio* as non-voting members of the committee.

3.R.2.Duties:

The QRM Committee will perform the following functions:

(a) assist in implementation of the Organizational Performance Improvement Plan;

(b) recommend approval of Medical Executive Committee plans for maintaining quality patient care within the Hospital, which may include mechanisms for:

(i) establishing systems to identify potential problems in patient care;

(ii) setting action priorities on problem correction;

(iii) referring priority problems for assessment and corrective action to appropriate departments or committees; and

(iv) monitoring the results of quality assessment activities throughout the Hospital;

(c) coordinate quality assessment activities;

(d) support a consistent level of care for patients within the facility;

(e) evaluate the overall Quality Assessment and Improvement Program on an annual basis for comprehensiveness, effectiveness, integration, and cost-efficiency;

(f) obtain, review, and evaluate information and raw statistical data generated by the Hospital's case management system;

(g) coordinate the educational needs of each department with the Medical Staff's overall educational plan;

(h) organize and implement educational programs for the Medical Staff, including providing speakers for Medical Staff meetings with programs designed to reach a broad audience and to represent a reasonable cross-section of the medical fields;

(i) evaluate and implement continuing medical education and training programs at the Hospital and in the community (in cooperation with the American Medical Association and the California Medical Association); and

(j) maintain a continuing audit of Medical Staff members' participation in post-graduate continuing medical education programs.

3.R.3.Meetings and Reports:

The QRM Committee will meet at least monthly, when possible, but at least ten times per year. It will submit regular, confidential reports to the Medical Executive Committee on the quality of medical care provided and on quality review activities conducted. The presence of at least 50% of the voting members of the committee shall constitute a quorum.

3.S.UTILIZATION MANAGEMENT COMMITTEE

3.S.1.Composition:

(a) The Utilization Management Committee will consist of at least three physicians.

(b) Members must recuse themselves if they have provided professional care for a patient whose case is under review.

(c) The Chief of Staff will appoint the chair of the Utilization Management Committee.

(d) The Chief Executive Officer will recommend one or more senior administrative representatives to also serve on this committee.

3.S.2.Duties:

The Utilization Management Committee will perform the following functions:

(a) review the medical necessity of admissions, appropriateness of the setting, medical necessity of extended stays, and medical necessity of professional services;

(b) perform its duties in accordance with the Policy on Review of Concerns Related to Utilization;

(c) communicate the results of its studies (and other pertinent data) to the Medical Staff departments, and, where appropriate, the entire Medical Staff;

(d) make recommendations for the optimum utilization of Hospital resources and facilities (commensurate with quality care and safety); and

(e) formulate a written utilization review plan for the Hospital, subject to approval by the Medical Executive Committee and Board.

3.S.3.Meetings and Reports:

The Utilization Management Committee will meet at least quarterly and when deemed necessary by the chair. It reports to the Medical Executive Committee and (when appropriate) to the QRM Committee.

3.T.WELLBEING COMMITTEE

3.T.1.Composition:

(a) The Wellbeing Committee will consist of at least three members of the Medical Staff. Members will be selected based on their experience, expertise, and willingness to serve. To the fullest extent possible, members will serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.

(b) The chair will be a physician.

(c) A majority of the committee's members must be physicians.

(d) Members of this committee shall not simultaneously serve as active participants on other peer review or quality assurance committees.

3.T.2.Duties:

The Wellbeing Committee will perform the following functions:

(a) serve as an identified resource within the Hospital to receive information and concerns about the health and behavior of individual practitioners, whether from third parties or upon self-referral from the practitioners themselves;

(b) provide assistance to the Leadership Council, department chairs, and/or Medical Staff officers when information and/or concerns are brought forth regarding a practitioner's health or behavior related to physical, emotional, or drug dependency-related conditions;

(c) as directed by the Leadership Council and in accordance with the Practitioner Health Policy, facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from physical, emotional, drug-related or other potentially impairing conditions;

(d) provide advice, recommendations and assistance to any practitioner who is referred (and to the referring source);

(e) aid practitioners with regaining or retaining optimal professional functioning consistent with protection of patients and with re-entry issues;

(f) monitor practitioners for compliance with monitoring agreements, treatment programs, or other conditions of continued practice;

(g) assess and determine appropriate outside assistance resources and programs for practitioners;

(h) maintain the confidentiality of the practitioner seeking referral or referred for assistance subject to the requirements of law, ethical obligation, the bylaws, or the protection of patients (however, in the event information received by the committee clearly demonstrates that the health or known or suspected impairment of a practitioner poses or might pose an unreasonable risk of harm to hospitalized patients, that information may be referred for appropriate action); and

(i) consider general matters related to the health and well-being of the Medical Staff and, with the approval of the Medical Executive Committee, develop educational programs or related activities.

3.T.3.Meetings and Reports:

The Wellbeing Committee meets at least quarterly and when deemed necessary by the chair. It will provide quarterly reports to the Medical Executive Committee regarding its general activities (e.g., number of self-referrals, number of interventions, and number of physicians undergoing monitoring). These quarterly reports will not include specific or sensitive information. As appropriate, the Wellbeing Committee may also report to the Leadership Council.

ARTICLE 4

AMENDMENTS

This Manual will be amended as 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 11, 2018

Approved by the Board: November 14, 2018

PERIPHERAL VASCULAR COMMITTEE (PVC)

A. COMPOSITION

The Committee shall consist of all members of the Medical Staff who hold privileges to perform peripheral vascular procedures, including the Wound Care Medical Director who is a non-voting member of the Committee. Other members may be assigned by the Chief of Staff. A quorum shall consist of at least three voting members to include at least one cardiologist, one radiologist and one vascular surgeon. {Changed by MEG 12/20/04, MEG, Gen Medical Staff 1/11/05, Board 2/9/05)

B. DUTIES

The duties of the PVC will include:
1. Assisting the Departments of Surgery, Medicine and Radiology in performing quality review of peripheral vascular cases. The review may include evaluation of individual cases based on pre- established criteria, focused studies and statistical analysis.

2. Referring all cases with quality of care concerns to the Surgery, Medicine, and Radiology Committees for final peer review.

3. Making recommendations to the Departments of Surgery, Medicine and Radiology regarding policies, procedures, standard of practice and equipment.

4. Assisting the Departments of Surgery, Medicine and Radiology in reviewing the credentials of practitioners requesting privileges for peripheral vascular procedures. All credentialing and peer review recommendations will be made by the appropriate Departmental Committee.

5. If proctorship is instituted for members requesting additional privileges, the number of proctors and the length of the proctorship period and/or the number of cases to be proctored, is at the discretion of the department chair, with consideration for the recommendation of the Peripheral Vascular Committee. (Changed by MEG 12/20/04, MEG, Gen Medical Staff 1/11/05, Board 2/9/05)

C. MEETINGS

The Committee shall meet at least quarterly or more often as necessary according to the volume of cases and credentials files requiring review. Attendance at 50% of meetings is mandatory for the members holding peripheral vascular procedures. The Committee is responsible to the Medical Executive Committee through the Departments of Surgery, Medicine, and Radiology.