MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF MUNSON MEDICAL CENTER

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 Credentials Policy.

1.B. DELEGATION OF FUNCTIONS

(1) When an administrative function under this Manual 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 a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee is bound by all the terms, conditions and requirements of this Manual. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Manual.

(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. LIST OF DEPARTMENTS AND SECTIONS

The following clinical departments and sections are established:

AMBULATORY CARE DEPARTMENT
Encompassing providers in Family Medicine, Internal Medicine, and other non-hospital based ambulatory specialties, (i.e., Dermatology, Allergy)

- Section of Urgent Care Medicine

ANESTHESIOLOGY DEPARTMENT

CARDIOVASCULAR DISEASE DEPARTMENT

EMERGENCY MEDICINE DEPARTMENT

FAMILY MEDICINE DEPARTMENT

MEDICINE DEPARTMENT

- Section of Endocrinology, Diabetes and Metabolism
- Section of Gastroenterology
- Section of Hematology & Medical Oncology
- Section of Hospice and Palliative Medicine
- Section of Hospital Medicine
- Section of Infectious Disease
- Section of Nephrology
- Section of Neurology
- Section of Occupational Medicine
- Section of Physical Medicine and Rehabilitation
- Section of Pulmonary Disease & Critical Care Medicine
- Section of Sleep Medicine

OBSTETRICS AND GYNECOLOGY DEPARTMENT

ORTHOPAEDIC SURGERY DEPARTMENT

- Section of General Orthopaedic Surgery
- Section of Hand Surgery

PATHOLOGY DEPARTMENT

RADIOLOGY DEPARTMENT
- Section of Radiation Oncology

PEDIATRICS DEPARTMENT
- Section of Neonatal-Perinatal Medicine

PSYCHIATRY DEPARTMENT

SURGERY DEPARTMENT
- Section of Cardiothoracic Surgery
- Section of Plastic Surgery
- Section of General Surgery
- Section of Neurological Surgery
- Section of Ophthalmology
- Section of Oral and Maxillofacial Surgery
- Section of Otolaryngology – Head and Neck Surgery
- Section of Podiatric Foot and Ankle Surgery
- Section of Urological Surgery
- Section of Vitreoretinal Surgery

VASCULAR DEPARTMENT

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND SECTIONS

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

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

(1) As set forth below, the MEC and the Board, acting jointly, may create, eliminate and combine clinical departments.

(a) Creation of Departments. The following factors will be considered by the MEC and the Board in determining whether a clinical department should be created:

(i) 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);

(ii) 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;

(iii) a majority of the voting members of the proposed department vote in favor of the creation of a new department;

(iv) it has been determined by the Medical Staff leadership that there is a clinical need for a new department; and/or

(v) 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.

(b) Dissolution of Departments. The following factors will be considered by the MEC and the Board in determining whether the dissolution of a clinical department is warranted:

(i) there is no longer an adequate number of members of the Medical Staff in the department to enable it to accomplish the functions set forth in the Bylaws and related policies;

(ii) 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;

(iii) the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

(iv) no qualified individual is willing to serve as department chair; and/or

(v) a majority of the voting members of the department vote for its dissolution.

(2) The MEC may create, eliminate, or combine sections, keeping in mind the factors outlined in (1)(a) and (1)(b) above.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of the Hospital that carry out peer review 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.

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) have the willingness and ability to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent on 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 off-topic 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 committee plans are in alignment with the strategic goals of the Hospital and 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 written report after each meeting to the MEC and to other committees and individuals as may be indicated in this Manual.

3.D. BIOETHICS RESOURCE COMMITTEE

The Bioethics Resource Committee is a joint committee of the Medical Staff and Hospital that was established to ensure the quality of medical ethical decisions as they relate to patient care at the Hospital. The composition and duties of the Bioethics Resource Committee are set forth in the Bioethics Resource Committee Policy.

3.E. BYLAWS COMMITTEE

3.E.1. Composition:

The Bylaws Committee will consist of at least three members of the Medical Staff with experience in Medical Staff issues and administrative representatives, as necessary.

3.E.2. Duties:

The Bylaws Committee will perform the following duties:

(a) conduct a periodic review of the Medical Staff Bylaws and associated documents, at least every two years;

(b) submit recommendations to the Medical Executive Committee for changes to these documents; and

(c) review matters in connection with the Medical Staff Bylaws, the Credentials Policy, and associated policies referred by the Board, the Medical Executive Committee, the departments, the President of the Medical Staff, the MMC CMO, and committees of the Medical Staff.

3.F. CANCER COMMITTEE

3.F.1. Composition:

The composition of the Cancer Committee will meet the accreditation requirements of the American College of Surgeons.

3.F.2. Duties:

The duties of the Cancer Committee are to plan, initiate, stimulate, monitor, and assess the results of cancer programs and identify changes that are needed to maintain compliance at the Hospital through the following functions:

(a) arrange, publicize, conduct, and evaluate educational and consultative cancer conferences which must be multidisciplinary, case-oriented, and hospitalwide;

(b) assure consultative services are available to patients;

(c) perform an audit role regarding patient care; and

(d) supervise tumor registry database for quality control of abstracting, staging, and reporting.

3.G. CONTINUING MEDICAL EDUCATION COMMITTEE

3.G.1. Composition:

The Continuing Medical Education Committee will consist of representatives of the Medical Staff, administration, library staff, and other clinicians (i.e., pharmacy, nursing, etc.).

3.G.2. Duties:

The Continuing Medical Education Committee will:

(a) evaluate the effectiveness of CME educational programs;

(b) act on recommendations for continuing education from the MEC, departments, sections, or other committees; and

(c) maintain a permanent record of CME education activities and submit reports to the MEC concerning such activities, as requested.

3.H. CREDENTIALS COMMITTEE

3.H.1. Composition:

(a) The Credentials Committee will consist of at least five members of the Medical Staff who will be selected based on their interest or experience in credentialing matters.

(b) Members of the committee will serve three-year terms, with appointment of new members staggered to provide for the continuity of the committee.

(c) An Advanced Practice Provider will also be appointed to the committee.

3.H.2. Duties:

The Credentials Committee will:

(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 written reports of its findings and recommendations;

(b) in accordance with the Policy on Advanced Practice Providers and Allied Health Professionals, review the credentials of all applicants seeking to practice as Licensed Independent Practitioners and Advanced Practice Providers, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(c) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff and/or granted clinical privileges and, as a result of such review, make a written report of its findings and recommendations;

(d) review and approve specialty-specific data elements for ongoing professional practice evaluation and specialty-specific triggers for focused professional practice evaluation that are identified by each department; 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.I. HEALTH INFORMATION MANAGEMENT COMMITTEE

3.I.1. Composition:

The Health Information Management Committee will include a multidisciplinary group of physicians, clinical care providers, representatives from Information Systems and Performance Improvement, the Health Information Management ("HIM") manager and others identified by the committee. A physician in good standing on the Medical Staff will chair the committee.

3.I.2. Duties:

The Health Information Management Committee will:

(a) ensure medical record compliance in accordance to CMS and Joint Commission regulations as well as Hospital and Medical Staff policy by auditing medical record components post patient discharge;

(b) maintain medical record compliance data and make such data available for inspection;

(c) take appropriate action to address issues of noncompliance to assist it in performance improvement;

(d) review and approve forms (paper forms for the legal medical record);

(e) recommend updates to the Medical Staff Medical Record Completion Policy, as applicable;

(f) develop, review, enforce and maintain surveillance over enforcement of Medical Staff and Hospital policies, rules, and regulations relating to medical records, including timely completion, preparation, forms, format, and recommend methods of enforcement thereof and changes therein;

(g) provide liaison with Hospital Administration, nursing services, and HIM professionals on matters relating to medical records practices; and

(h) other duties as they relate to the documentation and use of medical records.

3.J. INTENSIVE CARE UNIT COMMITTEE

3.J.1. Composition:

The Intensive Care Unit Committee will consist of Medical Staff members actively practicing in the ICU and the nurses providing care there. The President of the Medical Staff will appoint a chair along with all physician members. These members may include individuals from the following specialties: general surgery, neurosurgery, internal medicine, hospitalist, anesthesia, gastroenterology, infectious disease, and cardiology. The committee will also include an appointed MMC Administrative Representative, the ICU Unit Manager, and the Apache Coordinator.

3.J.2. Duties:

The Intensive Care Unit Committee will be expected to meet on an ad hoc basis to review protocol development, ICU policies, quality review, Apache data, and Information System issues as they relate to the ICU. The Medical Director will forward summaries and physician outlier metrics to the physician's file in the Medical Staff Services Department as part of the ongoing physician performance evaluation ("OPPE"). Apache data will be presented annually to the Quality and Patient Safety Council ("QPSC").

3.K. MEDICAL EXECUTIVE COMMITTEE

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

3.L. MEDICAL STAFF PERFORMANCE IMPROVEMENT COMMITTEE ("MSPIC")

3.L.1. Composition:

The MSPIC will consist of the following:

(a) Medical Director of Quality;

(b) MMC CMO;

(c) Director of Medical Services and Director of Surgical Services;

(d) Manager of Clinical Quality;

(e) Clinical Quality RN Data Specialists;

(f) Risk Management representative;

(g) Chairs of Medical, Surgical Department, and Cardiology Department Peer Review Committees;

(h) Chair of Trauma Performance Improvement Committee;

(i) Chief Medical Informatics Officer;

(j) Medical Director, Clinical Documentation Integrity/Health Information Management; and

(k) At-large Medical Staff representatives (to include Licensed Independent Practitioners other than physicians) who are:

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

(ii) interested or experienced in credentialing, privileging, PPE/peer review, or Medical Staff matters; and

(iii) supportive of evidence-based medicine protocols.

3.L.2. Duties:

The MSPIC will perform the following functions:

(a) perform executive peer review as referred by Medical Staff peer review committees;

(b) perform periodic review of Level 1 and Level 2 Peer Review Cases;

(c) address performance improvement opportunities identified through peer review;

(d) recommend new initiatives related to quality and patient safety to the Quality and Patient Safety Council;

(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) examine referrals from Quality and Patient Safety Council regarding physician-specific concerns;

(g) clinical Information Technology performance improvement;

(h) develop physician-specific scorecards;

(i) oversee the implementation of the ongoing professional practice evaluation ("OPPE") process and ensure that all components of the process receive appropriate training and support;

(j) review reports showing the number of cases being reviewed through the OPPE process, by department or specialty, in order to help ensure consistency and effectiveness of the process;

(k) review, approve, and periodically update quality data elements that are identified by departments and sections, and adopt Medical Staff-wide data elements;

(l) review and approve the specialty-specific quality indicators that will trigger the professional practice evaluation/peer review process;

(m) review and approve order sets and pathways deemed to be mandatory by departments and sections;

(n) receive reports of system or process concerns that have been referred to the appropriate Hospital department or to the Medical Staff/PPE Support Staff, and keep those system or process issues on its agenda until notification is received that the issue has been successfully resolved;

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

(p) periodically review the effectiveness of the OPPE process and recommend revisions or modifications as may be necessary.

3.M. MEDICAL AND SURGICAL DEPARTMENTS PEER REVIEW COMMITTEE ("MSDPRC")

3.M.1. Composition:

(a) The MSDPRC will consist of at-large members of the Medical Staff who are:

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

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

(3) supportive of evidence-based medicine protocols.

(b) The Medical Director of Quality will serve as an *ex officio* member, without vote, to facilitate the MSDPRC's activities.

(c) The President of the Medical Staff shall designate two voting members of the MSDPRC as its co-chairs.

(d) Other Medical Staff members or Hospital personnel may be invited to attend a particular MSDPRC meeting (as guests, without vote) in order to assist the MSDPRC 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 MSDPRC.

3.M.2. Duties:

The MSDPRC will perform the following functions:

(a) review cases referred to it through the OPPE and FPPE processes; and

(b) perform any additional functions as may be requested by the MSPIC, the MEC or the Board.

3.M.3. Additional Medical Staff Committees Engaged in Peer Review:

In addition to other committees established by this Manual, the following Medical Staff committees also may function as "peer review committees" when they are engaged in "peer review" as such terms are defined by Michigan law:

(a) Trauma Peer Review; and

(b) Cardiology Department Peer Review.

3.N. PHARMACY AND THERAPEUTICS COMMITTEE

3.N.1. Composition:

(a) The Pharmacy and Therapeutics Committee will consist of representatives of the Medical Staff who represent a broad range of specialty areas. The committee will also include representatives from administration, nursing, and pharmacy.

(b) Quorum requirements for a meeting of the Pharmacy and Therapeutics Committee are the following:

(1) 50% of provider membership;

(2) one Clinical Pharmacy Manager to serve as co-chair;

(3) one Clinical Utilization Specialist representative;

(4) one Medical Safety Pharmacist representative;

(5) two Registered Nurse representatives; and

(6) one Administrative representative.

3.N.2. Duties:

The Pharmacy and Therapeutics Committee will perform the following duties:

(a) approve appropriate policies/procedures related to pharmaceutical therapeutics to include protocols, standing orders, guidelines, and electronic/paper order sets involving pharmaceuticals;

(b) approve and maintain a safe and cost-effective medication formulary;

(c) approve criteria for use of pharmaceuticals when appropriate using evidence-based best practices to improve the use of pharmaceuticals and resolve problems;

(d) monitor and evaluate use of drugs to assure appropriate, safe and effective use;

(e) periodically review Medication Optimization Review Committee Reports and provide oversight and input for safe medication practice;

(f) review, recommend, and/or approve drug information resources utilized in the institution;

(g) serve as a resource related to drug shortages, including mitigation, utilization and alternative strategies;

(h) serve in an evaluative, educational, and advisory capacity to the Medical Staff and organizational administration in all matters pertaining to the use of mediation; and

(i) assure compliance with standards and requirements of outside governing agencies (i.e., CMS, State of MI-LARA, the State Board of Pharmacy, the Joint Commission, and others) as it relates to medication/drug therapy processes and utilization.

3.N.3. Meeting Frequency:

The Pharmacy and Therapeutics Committee will meet monthly and not less than ten times per year.

3.O. PHYSICIAN WELL BEING COMMITTEE

3.O.1. Composition:

The Physician Well Being Committee will consist of at least three members of the Medical Staff who are selected based on their knowledge, skills and expertise in identification and management of practitioner health issues.

3.O.2. Duties:

The Physician Well Being Committee will:

(a) recommend education for all Medical Staff members and Hospital staff regarding practitioner health issues, including how to identify and report potential issues;

(b) develop and recommend policies for practitioner health issues, including self-referral, referral by others, evaluating credibility of a reported concern, resources for evaluation, diagnosis and treatment, maintaining confidentiality, monitoring practitioners under rehabilitation, intervening when patient safety is at risk and taking appropriate actions;

(c) evaluate self-referrals and third-party reports regarding potential practitioner health issues;

(d) make recommendations for treatment and rehabilitation regarding practitioner health issues;

(e) monitor individuals under treatment and rehabilitation for practitioner health issues; and

(f) make recommendations for reinstatement of clinical privileges following an individual's treatment and rehabilitation for practitioner health issues.

3.P. PROFESSIONAL STANDARDS COMMITTEE

3.P.1. Composition:

(a) The Professional Standards Committee will be comprised of the following voting members:

(1) President of the Medical Staff, who will serve as Chair;

(2) President-Elect;

(3) Chair of the Department of Medicine; and

(4) Chair of the Department of Surgery.

(b) The following individuals will serve as *ex officio* members, without vote, to

facilitate the Professional Standards Committee's activities:

(1) MMC CMO; and

(2) Medical Staff/Quality Support staff representatives.

(c) Other Medical Staff members or Hospital personnel may be invited to attend a particular Professional Standards Committee meeting (as guests, without vote) in order to assist the Professional Standards Committee 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 Standards Committee review process and are bound by the same confidentiality requirements as the standing members of the Professional Standards Committee.

3.P.2. Duties:

The Professional Standards Committee 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 and refer cases to the Physician Well-Being Committee as appropriate;

(c) review and address issues regarding practitioners' clinical practice which includes, but is not limited to, oversight of performance improvement plans and FPPEs;

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

(e) perform any additional functions as may be requested by the MSPIC, the MEC, or the Board.

3.Q. SECURITY BREACH ADVISORY COMMITTEE

The composition, duties and meeting requirements of the Security Breach Advisory Committee will be established in accordance with the Munson Healthcare Confidentiality and Systems Usage Breach Policy.

ARTICLE 4

AMENDMENTS AND ADOPTION

(a) The amendment process for this Manual is set forth in the Bylaws.

(b) This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations of the Medical Staff or Hospital policies pertaining to the subject matter herein, and henceforth all department and committee activities of the Medical Staff and of each individual serving as a member of a department or staff committee will be undertaken pursuant to the requirements of this Manual.

Adopted by the Medical Staff: _____

Approved by the Board: _____