Lovelace
Women's Hospital

Medical Staff Bylaws
Part IV: **Organization and Functions Manual**

9-12-05

Part IV: Organization and Functions Manual

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SECTION 1. ORGANIZATION AND FUNCTIONS OF THE STAFF

1.1 **Organization of the Medical Staff**

The medical staff of Women's Hospital shall be organized as a non-departmentalized staff. The following are the currently recognized Clinical Services: Medicine, Obstetrics and Gynecology, Pediatrics, and Surgery. A Clinical Service Chief shall head each clinical service with overall responsibility for the coordination of clinical service activities. Individual Clinical Services are advisory only, with no binding authority, but may adopt internal policies to facilitate their work, subject to the authority of the MEC.

1.2 **Responsibilities for Medical Staff Functions**

The ultimate responsibility and authority for the medical staff functions outlined in Section 1.3 lies with the MEC. The Medical Staff Officers, Clinical Service Chiefs, Hospital and medical staff committee Chairs, are responsible for working collaboratively to develop a process for communication of medical staff function activities by providing periodic reports as appropriate to the medical staff and any Clinical Services and to elevate issues of concern to MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care. Activities of the medical staff are intended to improve the quality of patient care by encouraging peer collaboration and are entitled to peer review protections to the extent permitted by law.

The Chief of Staff and the Chief Medical Officer will appoint physician advisors to act as liaisons with hospital personnel and committees to facilitate important medical staff performance improvement activities.

1.3 **Description of medical staff functions:**

The responsible medical staff party is listed in parentheses following each activity outlined below:

1.3.1 Governance, direction, coordination, and action:

a. Receive, coordinate and act upon, as necessary, the reports and recommendations from Clinical Services, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities (MEC and medical staff committee(s));

b. Account to the Governing Board and to the staff by written recommendations for the overall quality and efficiency of patient care at Women's Hospital (Chief of Staff and MEC);

c. Take reasonable steps to obtain professional and ethical conduct and initiate investigations, and pursue corrective action of medical staff members when warranted (Chief of Staff and MEC);

d. Make recommendations on medico-administrative and hospital clinical and operational matters (Chief of Staff and MEC);

e. Inform the medical staff of the accreditation program and the accreditation and state licensure status of Women's Hospital (Chief of Staff and MEC);

f. Act on all matters of medical staff business, and fulfill any state and federal reporting requirements (MEC and medical staff committees);

g. Oversee, develop and plan programs and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities (MEC);

h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution (MEC, Bioethics Physician Liaison or Subject Matter Expert);

i. Provide oversight concerning the quality of care provided by any residents, interns, or students who may work at the hospital, and ensure that the same act within approved guidelines established by the medical staff and governing body (MEC); and

j. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and hospital administration and the Governing Board. (Medical Staff Officers and MEC)

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities **(MEC, Medical Staff Peer Review Committee,**)

a. Set expectations, develop plans, educate members, and manage processes to measure, assess, and improve the quality of clinical activities;

b. Understand the adopted approach to and methods of performance improvement;

c. Ensure that important processes and activities are measured, assessed, and improved systematically across all disciplines throughout the hospital;

d. Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body, and define in writing responsibility for acting on recommendations for improvement;

e. Participate in ensuring that the processes are defined and implemented for identifying and managing sentinel events and events that warrant intensive analysis;

f. Ensure implementation of an integrated patient safety program throughout the hospital;

g. Ensure that an ongoing, proactive program for identifying risks to patient safety and reducing medical/health care errors are defined and implemented;

h. Provide for mechanisms to measure, analyze, and manage variation in the performance of defined processes that affect patient safety; and

i. Measure and assess the effectiveness of contributions to improving performance and patient safety.

1.3.3 Monitoring activities should include but not be limited to the following (MEC, Medical Staff Peer Review Committee):

a. Medical assessment and treatment of patients;

b. Use of medications;

c. Use of blood and blood components;

d. Use of operative and other procedures;

e. Education of patients and families;

f. Coordination of care with other practitioners and hospital personnel;

g. Accurate, timely, and legible completion of patients' medical records;

h. Appropriateness of clinical practice patterns;

i. Significant departures from established patterns of clinical practice;

k. Use of developed criteria for autopsies;

l. Sentinel event data;

m. Patient safety data;

n. Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient; and

o. Findings of the assessment process relevant to individual performance.

1.3.4 Credentials review (see Part III of these bylaws, the Credentials Procedure Manual)

1.3.5 Information Management (MEC, Medical Records Physician Liaison)

a. Review and evaluate medical records to determine that they*:*

1. Properly describe the condition and progress of the patient, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and

2. Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.

b. Develop, review, enforce, and maintain surveillance at least quarterly over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein. (MEC, Medical Record Physician Liaison, Peer Review Committee for review and enforcement of timeliness rules, forms, policy, etc.); and

c. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

1.3.6 Emergency Preparedness: Assist the hospital administration in developing, periodically reviewing, and implementing a crisis management program that addresses disasters both external and internal to the hospital (MEC).

1.3.7 Planning (Chief of Staff, MEC)

a. Advise the hospital by participating in the evaluation of existing programs, services, and facilities of the hospital and medical staff and recommending continuation, expansion,

abridgment, or termination of each;

b. Advise the hospital by participating in the evaluation of the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and

c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members.

1.3.8 Bylaws review (MEC)

a. Conduct periodic review of the Medical Staff Bylaws, Organization and Functions Manual, Credentials Procedure Manual, and medical staff rules and regulations;

b. Conduct periodic review of the clinical policies and rules; and

c. Submit written recommendations to the MEC and to the Governing Board for amendments to the Medical Staff Bylaws, Credentials Procedure Manual, Organization and Functions Manual, and rules and regulations.

1.3.9 Nominating (MEC, Nominating Committee)

a. Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure; and

b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.10 Infection Control Oversight (MEC, Medical Staff Peer Review Committee, Infection Control Physician Liaison)

a. The medical staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection.

b. Develop and approve policies describing the type and scope of surveillance activities including:
   - Review of cumulative microbiology recurrence and sensitivity reports;
   - Determination of definitions and criteria for nosocomial infections;
   - Review of prevalence and incidence studies, as appropriate; and
   - Collection of additional data as needed;

c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

d. Evaluate and revise the type and scope of surveillance annually;

e. Develop a surveillance plan for sampling of personnel and environments;

f. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

g. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;

h. Report nosocomial infection findings on a day-to-day basis to the attending physician and

appropriate clinical or administrative leader; and

i. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

1.3.11 Pharmacy and Therapeutics functions (MEC, Pharmacy & Therapeutics Physician Liaison, and Medical Staff Peer Review Committee)

a. Maintain a formulary of drugs approved for use by the hospital;

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff;

c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);

d. Perform drug usage evaluation studies on selected topics;

e. Perform medication usage evaluation studies as required by this facility's accrediting agency.

f. Perform blinded practitioner profile analysis related to medication use;

g. Approve policies and procedures related to the care of patients, to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the health system;

h. Develop and measure indicators for the following elements of the patient treatment functions:
    - Prescribing/ordering of medications;
    - Preparing and dispensing of medications;
    - Administrating medications; and
    - Monitoring of the effects of medication.

i. Analyze and profile data regarding the measurement of the patient treatment functions by service and practitioner, where appropriate;

j. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

k. Serve as an advisory group to the health system and medical staffs pertaining to the choice of available medications; and

l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.12 All quality, patient safety and performance related functions mentioned above shall be reported through the Medical Staff Peer Review Committee to the MEC or directly to the MEC. All minutes and records reviewed will be maintained as a permanent record and will be kept in compliance with the confidentiality policies of the medical staff and Women's Hospital.

1.4 **Responsibilities of Chief of Staff:**

Note: The Duties of Officers and of Chief of Staff are listed in Part I of the Medical Staff Bylaws, Article V, Section 6, Duties of Officers.

1.4.1 The Chief of Staff is the primary elected officer of the medical staff and is the medical staff's advocate and representative in its relationships to the Governing Board and the administration of the hospital. The Chief of Staff, jointly with the MEC, provides direction to and oversees medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the Medical Staff Bylaws, Credentials Procedure Manual, Organization and Functions Manual, and the medical staff rules and regulations. Specific responsibilities and authority are to:

a. Call and preside at all general and special meetings of the medical staff;

b. Serve as chair of the MEC and as ex-officio member of all other medical staff committees without vote, and to participate as invited by the Governing Board and the hospital administrator on hospital or Governing Board committees;

c. Enforce the Medical Staff Bylaws (Parts I through IV) and medical staff and hospital policies;

d. Unless as provided for elsewhere in the Bylaws, appoint committee chairpersons and all members of the medical staff standing and ad hoc committees; appoint Physician Liaisons/Advisors; in consultation with hospital administration, appoint medical staff members to appropriate hospital committees; and in consultation with the chair of the Governing Board, appoint medical staff members to appropriate Governing Board committees when those are not designated by position or by specific direction of the Governing Board or otherwise prohibited by state law;

e. Support and encourage medical staff leadership and participation on the interdisciplinary clinical performance improvement activities;

f. Report to the Governing Board the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners or allied health professionals who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

g. Continuously evaluate and periodically report to the hospital, MEC, and the Governing Board regarding the effectiveness of the credentialing and privileging processes;

h. 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 Governing Board, hospital management, other professional and support staff, and the community the hospital serves;

i. Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Governing Board;

j. Attend Governing Board meetings and Governing Board committee meetings as invited by the Governing Board;

k. Ensure that the decisions of the Governing Board are communicated and carried out within the medical staff; and

l. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.

1.5 **Responsibilities of Clinical Service Chiefs**: All of the following functions shall be performed in an advisory capacity to the MEC only, and the MEC shall not be required to wait for any particular reports or recommendations from Clinical Services or Clinical Service Chiefs prior to taking action:

a. Formulate continuing education as desired by the membership of the Clinical Service and encourage discussion of patient care issues pertinent to that clinical specialty or specialties;

b. Conduct Grand rounds as desired by physicians in the Clinical Service;

c. Discuss policies and procedures and make recommendations to the MEC as desired by the members of the Clinical Service;

d. Discuss equipment needs pertinent to that Clinical Service, if requested by the members of the Service, and make recommendations to appropriate hospital parties;

e. Develop recommendations on a specific issue at the request of the MEC;

f. Encourage participation in the development of criteria for clinical privileges and give input on an application or reapplication, when requested by the Credentials Committee or MEC; and

g. Submit a written annual report detailing the Clinical Service activities to the MEC if requested by the MEC or Chief of Staff.

SECTION 2. MEDICAL STAFF COMMITTEES AND PHYSICIAN LIAISONS/ADVISORS

All physician advisors/liaisons and committees other than the MEC act solely in an advisory capacity to the MEC.

2.1 **Medical Executive Committee:**

Description of the MEC is in Article VII, Section 2 of Part I of the Medical Staff Bylaws

2.2 **Credentials Committee:**

Description of the Credentials Committee is in Section I of Part III of the Medical Staff Bylaws (Credentials Procedure Manual)

2.3 **Medical Staff Peer Review Committee:**

2.3.1 **Composition**: the Medical Staff Peer Review Committee includes:

a. A minimum of seven (7) active members of the medical staff; and

b. Other hospital staff without vote to present data or reports, as requested by the chair.

2.3.2 **Responsibilities**: The Medical Staff Peer Review Committee is responsible to:

a. Obtain case reviews and recommendations from specialists/subject matter experts when deemed appropriate and make recommendations to the MEC regarding the need for external peer review.

b. Regularly review of aggregated results of physician performance representing all dimensions of care to identify individual or system opportunities for improvement.

c. Communicate individual improvement opportunities to the appropriate medical staff leader;.

d. Communicate system improvement opportunities to the Quality Council.

e. Track staff member responses to recommendations for improvement and compliance with all improvement plans.

f. Report to the MEC regularly regarding recommendations to improve care.

g. Communicate and collaborate with any hospital Quality Committee to address system issues at Women's Hospital.

2.4 **Cancer Committee:**

2.4.1 **Composition**: The Cancer Committee shall be multidisciplinary with required members as appropriate to maintain certification by the American College of Surgeons Commission on Cancer as a Community Hospital Cancer Program.

2.4.2 **Responsibilities**: The Cancer Committee provides program leadership with duties as described in the Standards of the ACS Commission on Cancer.

2.5 **Pharmacy and Therapeutics Physician Liaison:**

2.5.1 **Responsibilities**: The Pharmacy & Therapeutics Physician Liaison shall be responsible for assisting in the development and surveillance of all drug utilization policies and practices within the hospital in collaboration with the hospital's director of pharmacy and the pharmacy staff. The Physician Liaison shall assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety, procedures, and all other matters relating to drugs in the hospital. The Physician Liaison, in collaboration with the Director of Pharmacy, shall be charged with implementation of a regular review of the clinical use of antibiotics, including prophylactic use of antibiotics.(revised 11/12)

2.6 **Infection Control Physician Advisor:**

2.6.1 **Responsibilities**:

The Physician Liaison for Infection Control shall collaborate with the hospital Infection Control Coordinator and other appropriate hospital personnel to develop and maintain protocols that will insure constant surveillance of all potential sources of hospital infections. In collaboration with hospital personnel and appropriate clinical experts, the Physician Liaison will review and analyze infections occurring in the hospital. The Physician Advisor may consult with representatives from dietary, environmental services, central supply, and nursing services. A report of infections, their outcomes and recommendations shall be made to the MEC through the Quality Council and/or the Medical Staff Peer Review Committee..

2.7 **Biomedical Ethics Physician Advisor:**

2.7.1 **Responsibilities**: The Physician Advisor will with work with any established hospital ethics committee or any system wide Biomedical Ethics Committee to establish policies relating to issues of medical ethics, engage in case reviews or solicit appropriate members of the medical staff for such involvement, promote educational programs relating to medical ethics, and serve as a resource to members of the medical staff facing challenging medical ethics dilemmas.

2.8 **Practitioner Health Committee:**

2.8.1 **Composition:** The Practitioner Health Committee shall consist of the members of the MEC acting to address matters of physician health and well-being.

2.8.2 **General Description:** The MEC, acting as the Practitioner Health Committee, shall be responsible for addressing problems dealing with impaired professional performance among practitioners. Issues related to impaired practitioners shall be referred to the Chief of Staff, who will determine whether to bring the matter before the MEC.

2.8.3 **Responsibilities:** This committee shall be responsible for addressing problems dealing with impaired professional performance among practitioners at Women's Hospital. In particular, the committee will focus on clinical performance adversely affected by a practitioner's substance abuse, physical or mental health. The committee will seek to find ways to assist practitioners that provide an alternative to the corrective action mechanisms articulated elsewhere in these bylaws. The committee will collaborate with organizations recognized by the state medical board to assist physicians with health or substance abuse problems. The committee is charged with the following tasks:

a. To recommend practitioners to a program for identifying and contacting practitioners who have become professionally impaired in varying degrees because of drug dependence including alcoholism or because of mental, physical or aging problems. The committee is to offer rehabilitative help to such practitioners to the extent of its ability;

b. To establish programs for educating staff practitioners to prevent substance dependence;

c. To notify the impaired practitioner's Clinical Service Chief, and the hospital CEO if the committee believes that an impaired practitioner's actions could endanger patients;

d. To create opportunities for referral (including self referral) while maintaining confidentiality to the greatest extent possible.

2.8.4 **Operations**: Deliberations of the MEC, when serving as the Practitioner's Health Committee, are to remain confidential subject only to the reporting mechanism outlined in 2.9.3 above.

2.8.5 **Patient Safety**: It at any time during the process described in this section it is determined that a medical staff member cannot safely perform the clinical privileges that he or she has been granted, regardless of whether he or she is participating in a program sponsored by the Practitioner's Health Committee, the matter shall be referred to the MEC for appropriate corrective action in accordance with the medical staff bylaws. The committee and/or MEC shall also strictly comply with any applicable federal or state reporting requirements. Nothing in this section shall be deemed to limit any of the provisions in the medical staff bylaws for corrective action or disciplinary action against a medical staff member or for the suspension of that medical staff member's clinical privileges.

2.9 **Lovelace Albuquerque Credentials and Peer Review Sharing Committee:** (added 11/12)

2.9.1 **Composition:** The Lovelace Albuquerque Credentials and Peer Review Sharing Committee shall be composed of one physician member of the Governing Board and either one member of the MEC or one member of the Credentials Committee of each of Lovelace Medical Center, Lovelace Westside Hospital, and Lovelace Women's Hospital.

2.9.2 **General Description:** The purpose of the committee shall be to facilitate the sharing of credentialing, peer review, and quality review information among three facilities under common ownership: Lovelace Medical Center, Lovelace Westside Hospital, and Lovelace Women's Hospital. Any credentialing and peer review information may be shared among these facilities upon request of the CEO, Chief of Staff, or Credentials Committee chair of these facilities. Additionally, any reports generated by the peer review or quality review processes at any of these hospitals shall promptly be forwarded to the Lovelace Albuquerque Credentials and Peer Review Sharing Committee. The disclosure of information via this committee is not intended to waive any applicable privilege.

2.9.3 **Responsibilities:**

a. To promote the sharing of credentialing, peer review, and quality review information among Lovelace Medical Center, Lovelace Westside Hospital, and Lovelace Women's Hospital.

b. To perform the committee's functions in strict compliance with HIPAA regulations.

SECTION 3. CONFIDENTIALITY, IMMUNITY, AND RELEASES

3.1 **Confidentiality of Information**: Information submitted, collected, or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of: assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of health care provided; evaluating current clinical competence and qualifications for staff appointment/affiliation, or clinical privileges or specified services; contributing to teaching or clinical research; or determining that health care services were indicated or were performed in compliance with an applicable standard of care shall, to the fullest extent permitted by law, confidential. This information will not be disseminated to anyone other than a representative of the hospital or to other health care facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed. Such confidentiality shall also extend to information that may be provided by third parties. Each practitioner expressly acknowledges that violations of the confidentiality provided here are grounds for immediate and permanent revocation of staff appointment and/or clinical privileges or specified services or other disciplinary or corrective action as the MEC might recommend.

3.2 **Immunity From Liability**: No representative shall be liable to a practitioner for damages or other

relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or for providing information, opinion, counsel, or services to a representative or to any health care facility or organization of health professionals concerning said practitioner. Immunity protections afforded in these Bylaws are in addition to those prescribed by applicable state and federal law.

3.3 **Activities:** The confidentiality and immunity provided by this article applies to all information or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

3.3.1 Applications for appointment/affiliation, clinical privileges, or specified services;

3.3.2 Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;

3.3.3 Corrective or disciplinary actions;

3.3.4 Hearings and appellate reviews;

3.3.5 Quality assessment and performance improvement activities;

3.3.6 Utilization review and improvement activities;

3.3.7 Claims reviews;

3.3.8 Risk management and liability prevention activities; and

3.3.9 Other hospital, committee, [service/clinical service], or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

SECTION 4. REVIEW, REVISION, ADOPTION, AND AMENDMENT

This medical staff Organization and Functions Manual may be amended or repealed in accordance with the procedure outlined in Article XI, Section 2 of Part I of these Bylaws.

Adopted by:

Chief of Staff	Date:
Chief Executive Officer	Date:
Chairman, Governing Board	Date: