

**SANTA ROSA  
MEMORIAL HOSPITAL**

**MEDICAL STAFF  
ORGANIZATION MANUAL**

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## ARTICLE 1

### GENERAL

#### 1.A. DEFINITIONS

Definitions detailed in the Bylaws shall apply to this Manual.

#### 1.B. DELEGATION OF FUNCTIONS

1. Unless otherwise specified in this or another Medical Staff document, when a function discussed in this document is to be carried out by a member of the Medical Center Administration, by a Medical Staff Officer, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.
2. When a Medical Staff Member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual. However, a Medical Staff Member's duty to appear at a meeting to discuss matters related to the Medical Staff Member's clinical competence, performance, or conduct or other concern may not be delegated.

## ARTICLE 2

### CLINICAL SERVICES

#### 2.A. SERVICES

The Medical Staff will be organized into the following Services:

Cardiovascular Medicine & Surgery Services

Consultative Services

Medical Services

Operative Services

Women & Children's Services

#### 2.B. FUNCTIONS AND RESPONSIBILITIES OF SERVICES AND SERVICE CHAIRS

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

#### 2.C. CREATION AND DISSOLUTION OF CLINICAL SERVICES AND DIVISIONS

1. Clinical services 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 service 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 service (this number must be sufficiently large to enable the service to accomplish its functions as set forth in Section 4.A of the Bylaws);
  - b. the level of clinical activity that will be affected by the new service is substantial enough to warrant imposing the responsibility to accomplish service functions on a routine basis;
  - c. a majority of the voting members of the proposed service vote in favor of the creation of a new service;
  - d. it has been determined by the Medical Staff leadership and the President that there is a clinical and administrative need for a new service; and

- e. the voting Medical Staff members of the proposed service have offered a reasonable proposal for how the new service 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 service is warranted:
- a. there is no longer an adequate number of members of the Medical Staff in the clinical service 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 service;
  - c. the service 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 service; or
  - e. a majority of the voting members of the service vote for its dissolution.

## ARTICLE 3

### MEDICAL STAFF COMMITTEES

#### 3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

1. This Article outlines the Medical Staff standing committees that carry out the Medical staff's functions, including ongoing and focused professional practice evaluations and other performance improvement, with the exception of the Medical Executive Committee, which is detailed in the Medical Staff Bylaws.
2. Procedures for the appointment of committee chairs, appointment of committee members, and terms of appointment are set forth in Section 5.A of the Medical Staff Bylaws.
3. This Article details the standing members of each Medical Staff committee. However, other individuals 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 Medical Staff members.

#### 3.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

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

1. be willing to serve, 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, which includes reviewing 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 record of its findings, proceedings, and actions that, unless otherwise specified below, the Medical Staff Administration will maintain in accordance with its policies and procedures. 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

Committee shall consist of sufficient members broadly representative of the various departments and sections.

#### 3.D.2. DUTIES

1. Conduct an annual review of the Medical Staff bylaws, policies and procedures and rules and regulations.
2. Submit recommendations to the Medical Executive Committee for changes as necessary to reflect current law and/or Medical Staff practices.

3. Evaluate and make recommendations to the Medical Executive Committee regarding changes proposed by other Medical Staff members, services or committees.

### 3.D.3 MEETINGS

The Committee meets as often as is necessary as determined by the chairperson but at least once a year and reports to the Medical Executive Committee.

### 3.E. CANCER COMMITTEE

#### 3.E.1. Composition:

1. The Cancer Committee will consist of Medical Staff members from the diagnostic and therapeutic specialties who are involved in the care of cancer patients. There will be at least one physician from each of the following clinical specialties:
  - a. diagnostic radiology;
  - b. medical oncology;
  - c. pathology;
  - d. radiation oncology; and
  - e. surgery (including sub-specialties).
2. Allied Health Staff members who work with cancer patients may also be appointed as members of the Cancer Committee.
3. The Cancer Liaison Physician will also serve as a member of this committee.
4. The Cancer Committee will also include:
  - a. cancer program administrator (responsible for the administrative oversight or who has budget authority for the cancer program);
  - b. certified tumor registrar;
  - c. oncology nurse;
  - d. palliative care team member (if these services are provided at the Hospital);
  - e. performance improvement or quality management representative;
  - f. social worker or case manager; and

- g. at least one representative from Administration, Clinical Education, Home Care/Hospice, Pharmacy, and Rehabilitation.
5. The Chief of Staff will have the authority to appoint other individuals to serve on the committee and is expected to select representatives from both the community and the Hospital. The Chief of Staff will appoint any other individuals as needed to comply with the accreditation requirements of the American College of Surgeons.

### 3.E.2. Duties:

The Cancer Committee will perform the following functions:

1. develop and evaluate annual goals and objectives for clinical, educational, and programmatic activities related to cancer;
2. promote and coordinate a multidisciplinary approach to patient management;
3. support educational and consultative cancer conferences on major sites and related issues;
4. assist in providing an active support care system for patients, families, and staff;
5. monitor quality and conduct quality management studies;
6. promote clinical research under the auspices of the Institutional Review Board;
7. supervise the Cancer Registry and check for accurate and timely abstracting, staging, and follow-up reporting;
8. perform quality control of registry data;
9. encourage data usage and regular reporting;
10. evaluate whether the content of the annual report meets accreditation requirements;
11. publish the annual report the end of the first quarter of the following year;
12. uphold medical ethical standards; and
13. monitor, assess, and identify changes that are needed to maintain compliance with the eligibility criteria of the American College of Surgeons Commission on Cancer.

### 3.E.3. Meetings and Reports:

The Cancer Committee will publish an annual report to the Medical Executive Committee by the first quarter (of the following year) and will publish other reports on an as-needed basis.

### 3.F. CME COMMITTEE

#### 3.F.1. Composition:

1. The CME Committee will consist of at least five Active Staff members, selected to be broadly representative of the clinical specialties on the Medical Staff.
2. The CME Committee will include the chair of the PPEC, the CME Coordinator, and the Performance Improvement Coordinator.
3. The CME Committee chair may invite other representatives from Administration, pharmacy and infection prevention as necessary.

#### 3.F.2. Duties:

The CME Committee will perform the following functions:

1. assist the Administration by providing the Medical Staff and guests of the Hospital with a high-quality, evidence-based, unbiased Continuing Medical Education program;
2. promote compliance with the Institute for Medical Quality/California Medical Association criteria for accreditation in Continuing Medical Education (including compliance with cultural and linguistic competency requirements);
3. establish long-range plans for various education offerings by:
  - a. reviewing institution-wide gap analysis and needs assessments;
  - b. formulating and approving learner appropriate outcomes;
  - c. evaluating CME activities to determine if improvement in learner competence, performance, or patient care outcomes; and
  - d. recommending policies and procedures for CME programs.

#### 3.F.3. Meetings and Reports:

The CME Committee will meet at least quarterly and when deemed necessary by the chair.

### 3.G. CREDENTIALS COMMITTEE<sup>1</sup>

#### 3.G.1. Composition:

1. The Credentials Committee will consist of at least five members of the Active Staff appointed by the Chief of Staff (in consultation with the Chief Medical Officer). Members will be selected based on their interest or experience in credentialing matters.
2. Members of the committee will be appointed for an initial three-year term and will be replaced on a rotating basis to promote continuity. Members may be reappointed for subsequent terms.
3. The chair of the committee may appoint a representative(s) 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:

1. 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;
2. collaborate with the Interdisciplinary Practice Committee on matters pertaining to the current clinical competence of individuals currently appointed to the Allied Health Staff and make a written report of its findings and recommendations;
3. recommend to the Medical Executive Committee the numbers and types of cases to be reviewed as part of the initial competency evaluation;
4. review and recommend to the Medical Executive Committee specialty-specific criteria for ongoing professional practice evaluation, and specialty-specific triggers that are identified by each department; and
5. 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.

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<sup>1</sup> CAL. CODE REGS. tit. 22, 70703(d) requires that the “credentialing” function be assigned to a committee. It does not necessarily have to be the Credentials Committee, but that is the most natural fit.

### 3.G.3. Meetings and Reports:

The Credentials Committee will meet at least ten times per year 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 Medical Officer, and any other persons that the chair of the Credentials Committee has authorized to be present.

### 3.H. ENDOVASCULAR COMMITTEE

#### 3.H.1. Composition:

1. The Endovascular Committee will consist of four surgeons, two radiologists, and two cardiologists.
2. The committee chair will be appointed by the Chief of Staff.

#### 3.H.2. Duties:

The Endovascular Committee will perform the following functions:

1. monitor quality issues related to endovascular procedures;
2. review credentialing criteria and make recommendations to the Credentials Committee;
3. coordinate with the PPEC (as appropriate) and CME Committee to arrange for educational sessions; and
4. communicate relevant findings to the PPEC and to departments.

#### 3.H.3. Meetings and Reports:

The Endovascular Committee will meet at least annually and when deemed necessary by the chair.

### 3.I. INFECTION PREVENTION COMMITTEE<sup>2</sup>

#### 3.I.1. Composition:

1. The Infection Prevention Committee will consist of the hospital's infection control officer and at least three members, including representatives from the Medical Staff, Administration, nursing, and infection control personnel.

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<sup>2</sup> CAL. CODE REGS. tit. 22, 70703(d) requires that the "infection control" function be assigned to a committee.

2. It may include non-voting consultants in microbiology and non-voting representatives from relevant hospital services.<sup>3</sup>

### 3.I.2. Duties:

The Infection Prevention Committee will:

1. develop a hospital-wide infection prevention program and maintain surveillance over the program;
2. develop a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;
3. develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;
4. develop written policies defining special indications for isolation requirements;
5. coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics;
6. act upon recommendations related to infection prevention received from the Chief of Staff the Medical Executive Committee, services and other committees; and
7. review sensitivities of organisms specific to the facility.

### 3.I.3. Meetings and Reports:

The Infection Prevention Committee will meet at least quarterly and when deemed necessary by the chair.<sup>4</sup> Minutes of the Infection Prevention Committee will be maintained on file in the administrative offices of the Hospital.<sup>5</sup>

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<sup>3</sup> CAL. CODE REGS. tit. 22, 70739(b) states: "The oversight of the infection surveillance, prevention and control program shall be vested in a multi-disciplinary committee which shall include representatives from the medical staff, administration, nursing department and infection control personnel. This committee shall provide advice on all proposed construction and shall be responsible for the provision of current, updated information on infection control policy and procedures for the facility."

<sup>4</sup> CAL. CODE REGS. tit. 22, 70703 indirectly requires this committee to meet quarterly.

<sup>5</sup> CAL. CODE REGS. tit. 22, 70733(a) requires hospitals to "maintain copies of [minutes and reports of the hospital Infection Control Committee] on file in the administrative offices of the hospital...."

### 3.J. INTERDISCIPLINARY PRACTICE COMMITTEE

#### 3.J.1. Composition:

The Interdisciplinary Practice Committee will consist of, at a minimum, the director of nursing, the administrator or designee, and an equal number of physicians appointed by the medical executive committee and registered nurses appointed by the director of nursing. In addition, one or more clinical psychologists shall be appointed by the medical executive committee. If physician assistants are granted privileges, then physician assistants shall be included in the committee. These members shall all be voting members. The committee may also include other licensed or certified health professionals.

#### 3.J.2. Duties:

The Interdisciplinary Practice Committee will perform the following functions:

1. establish written policies and procedures for the conduct of its business;
2. in collaboration with the Credentials Committee, act as the credentialing body for Allied Health Staff members, making recommendations regarding appointment and clinical privileges to the Credentials Committee;
3. establish and administer standardized procedures for registered nurses as follows:
  - a. prescribe a required form for standardized procedures, including the subject to be covered;
  - b. identify the nursing functions that require the adoption of standardized procedures and ensure that registered nurses perform them only in accordance with standardized procedures;<sup>6</sup>
  - c. establish a method for the review and approval of all proposed standardized procedures;
  - d. review and recommend approval of all proposed standardized procedures

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<sup>6</sup> CAL. CODE REGS. tit. 22, § 70706.2 makes the Committee of Interdisciplinary Practice “responsible for:  
(1) Identifying functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the facility, and initiating the preparation of such standardized procedures in accordance with this section.  
(2) The review and approval of all such standardized procedures covering practice by registered nurses in the facility.  
(3) Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee on Interdisciplinary Practice or by delegation to the director of nursing.”

covering registered nurses;

- e. ensure that the Chief Nursing Executive 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
  - f. 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 Executive or at some other designated place;
4. oversee the Allied Health Staff as follows:
- a. identify specific categories of Allied Health Professionals to practice at the hospital and make appropriate recommendations;
  - b. make recommendations concerning the minimum standards of practice applicable to Allied Health Professional categories;
  - c. make recommendations concerning the supervision required for Allied Health Professionals;
  - d. review applications for practice authorizations and privileges and renewal of practice authorizations and privileges granted to practitioners from accepted categories in accordance with applicable Medical Staff bylaws, rules/regulations and policies;<sup>7</sup> and
  - e. 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
5. review and recommend approval of standardized procedures under which Registered Nurses practice in expanded roles.

### 3.J.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 Credentials Committee.

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<sup>7</sup> CAL. CODE REGS. tit. 22, § 70706.1(a) states that “The Committee on Interdisciplinary Practice shall be responsible for recommending policies and procedures for the granting of expanded role privileges to registered nurses, whether or not employed by the facility, to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of a patient in a licensed health facility. These policies and procedures will be administered by the Committee on Interdisciplinary Practice which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges.”

### 3.K. INSTITUTIONAL REVIEW COMMITTEE

The Medical Staff delegates authority for Institutional Review Committee to the PSJH System IRC, led by representatives who are sufficiently qualified through the experience and expertise of its members throughout the system to ensure the rights and welfare of human subjects are safeguarded.

#### 3.K.1. Composition

The composition of the Institutional Review Committee is dictated by Federal Policy for the Protection of Human Subjects (45 CFR Part 46) and shall at all times conform to these federal requirements. The system charter shall identify the composition of the committee.

#### 3.K.2. Duties

1. To assure the protection of human subjects of research, and to assure compliance with all state and federal laws pertaining to such research, by reviewing, evaluating, and approving or disapproving all research prior to initiation at this institution. Research, which is to be conducted outside this institution, may also be considered and acted upon by the committee, if it is voluntarily proposed by a qualified investigator and consistent with the interests of the institution.
2. To formulate and implement written procedures for conducting its initial and continuing review of research and for reporting its findings and actions.

#### 3.K.3. Meetings and Reports

This System Committee shall meet as defined by the System Charter. The Committee shall report to both the Medical Executive Committee and the Board of Trustees any information pertinent to studies to be conducted at this facility.

### 3.L. JOINT CONFERENCE COMMITTEE

#### 3.L.1 Composition

The Joint Conference Committee shall be composed of an equal number of members of the Board of Trustees and the Medical Executive Committee, but the Medical Staff members shall at least include the Chief of Staff and Immediate Past Chief of Staff. The Hospital President shall be a non-voting ex-officio member. The chairmanship of the Committee shall alternate yearly between the Board of Trustees and the Medical Staff.

#### 3.L.2 Duties

The Joint Conference Committee shall continue a forum for the discussion of matters of Hospital and Medical Staff policy, practice and planning, and a forum for interaction between the Board of Trustees and the Medical Staff on such matters as may be referred by the Medical Executive Committee or the Board of Trustees. The Joint Conference Committee shall exercise other responsibilities set forth in these Bylaws.

### 3.L.3 Meetings and Reports

The Joint Conference Committee shall meet as often as necessary at the call of the Chief of Staff, and shall transmit written reports of its activities to the Medical Executive Committee and to the Board of Trustees.

### 3.M. LEADERSHIP COUNCIL

#### 3.M.1. Composition:

1. The Leadership Council will consist of the following voting members:
  - a. Chief of Staff, who will serve as chair;
  - b. Chief of Staff-Elect;
  - c. Chair of the PPEC; and
  - d. Immediate Past Chief of Staff.
2. The following individuals will serve as *ex officio* members, without vote, to facilitate the Leadership Council's activities:
  - a. Chief Medical Officer; and
  - b. PPE Support Staff representative(s).
  - c. Director, Medical Staff Administration
3. 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.M.2. Duties:

The Leadership Council will perform the following functions:

1. review and address concerns about practitioners' professional conduct as outlined in the Medical Staff Professionalism Policy;
2. review and address possible health issues that may affect a practitioner's ability to practice safely as outlined in the Practitioner Health Policy;

3. review and address issues regarding practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy ("PPE Policy");
4. meet, as necessary, to consider and address any situation involving a practitioner that may require immediate action;
5. serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;
6. 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
7. perform any additional functions as may be requested by the PPEC, the Medical Executive Committee, or the Board.

### 3.M.3. Meetings and Reports:

The Leadership Council will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The Leadership Council will report to the PPEC, the Medical Executive Committee, and others as described in the Policies noted above.

## 3.N. MEDICAL ETHICS COMMITTEE

### 3.N.1 Composition

The Committee shall consist of the following:

Medical Staff members who have shown a strong interest in ethical matters and who represent various groups of the hospital staff, and Other non-medical members of this committee and of the Ethics Coordinating Council (an administrative committee) shall consist of physicians, nurses, social workers, palliative care staff, case managers, clergy, and administrators who shall be appointed by the Chair of the Ethics Resource Service and/or Ethics Coordinating Council.

Appointments from the Medical Staff Medical Ethics Committee shall be made by the Chief of Staff after consultation with the Chair of the Ethics Committee.

### 3.N.2 Duties:

1. The Committee's mission is to respond in a timely way to clinical ethical concerns raised by patients' families, nursing and the Medical Staff.

## 2. Vision

- a. Focus on the recruitment and training of physicians and staff to respond to emergency requests for clinical ethical issues.
- b. Provide ethical case consultations to assist in clarifying confusion or conflicts that have not been resolved in the normal course of problem resolution.
- c. Refer areas for improving patient care to Ethics Coordinating Council for follow-up and development.

### 3.N.3. Meetings & Reporting

The Committee meets at least quarterly. The Ethics Committee reports to the Medical Executive Committee and is linked to the Ethics Coordinating Council, Physician Well Being Committee, and Risk Management.

### 3.O. MEDICAL EXECUTIVE COMMITTEE

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

### 3.P. MEDICAL RADIATION SAFETY COMMITTEE

#### 3.P.1. Composition:

1. The Medical Radiation Safety Committee will consist of members from Cardiology, Radiology, and Radiation Oncology
2. The Radiation Safety Officer, who will be a voting member
3. Administration representative
4. A physician will serve as chair of the committee

#### 3.P.2. Duties:

The Medical Radiation Safety Committee will perform the following functions:

1. establish criteria to guide the Hospital in setting proper safety standards for the use of radioactive materials and radiation machines;
2. promote compliance with duties and responsibilities described by the Department of Health Services and other relevant regulatory bodies; and

3. as relevant to its mission and expertise, promote an emphasis on continual improvement of quality.

### 3.P.3. Meetings and Reports:

The Medical Radiation Safety Committee will meet at least quarterly, and more often if deemed necessary by the chair. It reports to the PPEC.

### 3.Q. MEDICAL RECORDS COMMITTEE

#### 3.Q.1 Composition:

The Medical Records Committee shall consist of:

1. At least five (5) members of the Active Medical Staff from different clinical specialties, including at least one hospitalist
2. Medical Director of Utilization Management
3. The Director of the Health Information Management Department
4. Non-physician representatives from Health Information Management and Patient Care Services.
5. The committee chair shall be a member of the Medical Staff
6. Active Medical Staff members are the only voting members of the committee.

#### 3.Q.2. Duties:

The duties and responsibilities of the medical records committee shall be:

1. Ensure patient safety through accurate documentation and timeliness completion of the medical record.
2. Implement changes to the medical record to assure patient safety, high quality care, while maintaining compliance with applicable laws, regulations, and accreditation standards.
3. Ensure the medical record reflects the continuum of care through a patient centered model.
4. Ongoing continuous improvement of system integration through process improvement and availability of information.
5. Provide feedback and make recommendations to the St. Joseph Health - Northern California Region Physician Advisory Committee, and medical staff membership on matters germane to the electronic medical record.

6. Implement changes to the medical record to assure safe, high quality patient care and compliance with applicable laws, regulations, and accreditation standards.
7. Manage and resolve concerns and conflicts regarding the content and completion of the medical record.
8. Manage deficiencies in individual medical staff members' responsibilities for medical record completion.
9. Educate the medical staff membership and medical executive committee on current and future medical record documentation requirements in conjunction with the Utilization Management Committee.

### 3.Q.3 Meeting and Reports:

The Committee meets as often as is necessary as determined by the chairperson, but at least quarterly. The committee reports to the Performance Monitoring Committee. It will also report to the MEC on a quarterly basis, or as requested by the MEC.

## 3.R. MULTI-SPECIALTY PRIVILEGES COMMITTEE

### 3.R.1 Composition

1. The committee shall be specially constituted to deal with each disputed matter, and shall cease to function after its conclusions are forwarded to the Credentials Committee.
2. In each instance, the committee shall consist of the two (2) members from each of the departments involved in the disagreement, to be appointed by the respective department chairmen, plus three (3) neutral members appointed by the Chief of Staff from uninvolved departments. One (1) of these three (3) will be appointed as chair.

### 3.R.2. Duties:

1. Seek to resolve differences between departments in regard to recommendations for the granting of clinical privileges.
2. Make recommendations regarding the jurisdiction of particular departments with respect to specific privileges.
3. Make recommendations to the Credentials Committee with a copy to the Chief of Staff. The Credentials Committee will forward these recommendations with its own recommendations to the Medical Executive Committee.

### 3.R.3 MEETINGS AND REPORTING

The Multi-Specialty Privileges Committee will meet when deemed necessary by the chair. It reports to the Credentials Committee.

### 3.S. NEW TECHNOLOGY COMMITTEE<sup>8</sup>

#### 3.S.1. Composition:

1. The New Technology Committee will consist of representatives from the Medical Staff, Administration, and purchasing department.
2. Invitations may be extended to representative physicians if specialty-specific issues are reviewed.

#### 3.S.2. Duties:

The New Technology Committee will:

1. assess the costs and benefits of new technology on patient care;
2. promote responsible stewardship of available resources; and
3. Monitor new programs and services for the initial period of implementation until the program has matured to ensure the program goals are met, ensure outcomes and credentialing criteria are appropriate, and promote patient safety and quality of care.

#### 3.S.3. Meetings and Reports:

The New Technology Committee will meet as requested by the chair, Chief of Staff or MEC. The New Technology Committee reports to the Credentials Committee.

### 3.T. NOMINATING COMMITTEE

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

### 3.U. PERFORMANCE MONITORING COMMITTEE

#### 3.U.1. Composition:

The Committee is multidisciplinary. Members shall include the Chief of Staff Elect, sufficient members of the Medical Staff broadly representative of the various departments and sections, the Hospital President or designee, the Chief Operating

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<sup>8</sup> Please let us know if you would prefer to combine this with your Credentials Committee.

Officer/Chief Nursing Officer or designee, the Performance Improvement Director, and other members as designated by the Chief of Staff.

3.U.2. Duties:

1. Identify opportunities for improvement.
2. Prioritize improvement activities.
3. Identify educational needs for medical and hospital staff.
4. Communicate improvement activities within the organization.
5. The PMC receives reports from Hospital Committees for appropriate transmittal of information to the Medical Executive Committee as well as from the following Medical Staff committees:
  - a. Cancer
  - b. Endovascular
  - c. Infection Prevention
  - d. Medical Radiation Safety
  - e. Pharmacy & Therapeutics
  - f. Regional Referral Quality Improvement
  - g. Trauma Quality Improvement
  - h. Utilization Management

3.U.3. Meetings and Reports

The Performance Monitoring Committee meets monthly or as often as needed, as determined by the Committee's chairperson. The Committee reports to the MEC and transmits all sub-committee reports to the MEC.

**3.V. PHARMACY & THERAPEUTICS COMMITTEE**

The Medical Staff delegates authority for formulary decision-making to the PSJH System P&T Committee, led by representatives of experts in medicine, pharmacy, and nursing throughout the system and continuum of care, that ensures patients of Providence St. Joseph Health and its affiliates are provided with safe, high-quality, and affordable medications throughout the continuum of care.

### 3.V.1. Composition

The System and Regional Committees shall members as defined by the System Charter.

The Local Committee shall consist of at least one Physician, who will act as chair, one Pharmacist, one Dietitian, the Executive VP of Patient Care Services or designee and the Hospital President or designee.

### 3.V.2. Duties:

#### 1. System P & T

- a. Decision making body for all formulary initiatives
- b. Decision making body for clinical practice initiatives, and dosing protocols
- c. Decision making body for order set changes as outlined by formulary and utilization management initiatives
- d. Determines metrics to drive clinical performance
- e. Directs contracting for all medications
- f. Develops education toolkits when appropriate

#### 2. Regional P & T

- a. Forwards and approves requests to add/remove medications from formulary and appeals to decisions to System P&T
- b. Aggregates region recommendation for System P&T consideration
- c. Participates in development of clinical strategic plan, informing system of region and local needs
- d. Executes on System P&T decisions in the region; developing toolkits when appropriate
- e. Ensures flow of information, decisions, and rationale is communicated within their regions
- f. Region utilization management and formulary compliance oversight
- g. Identification of local region opportunities

#### 3. Local P & T

- a. Submits requests to add/remove medications from formulary and appeals to decisions to Region P&T
- b. Local utilization management, formulary compliance, and medication safety oversight
- c. Engage local clinicians on initiatives for feedback and implementation
- d. Operationalize System P&T Decisions
- e. Ensures flow of information, decisions, and rationale is communicated to local stakeholders
- f. Predicts short term drug shortages and developing strategies to mitigate shortage

- g. Ensure best practice education and guideline based care are followed in the local ministry

### 3.V.3. Meetings and Reports:

The Pharmacy & Therapeutics Committees meet as necessary; but at least quarterly and will provide quarterly reports to the Performance Monitoring Committee.

### 3.W. PRACTITIONER WELL-BEING COMMITTEE<sup>9</sup>

#### 3.W.1. Composition:

1. The Practitioner Well-Being Committee will consist of at least five members of the Medical Staff. Members should be selected based on their experience, expertise, and willingness to serve.
2. The chair will be a physician.
3. A majority of the committee's members must be physicians.
4. Members of this committee shall not simultaneously serve as active participants on other peer review or quality assurance committees.

#### 3.W.2. Duties:

The Practitioner Well-Being Committee will perform the following functions:

1. serve as an identified resource within the Hospital to receive information and concerns about the health and behavior of individual practitioners related to physical, emotional, or drug dependency related conditions, whether from third parties or upon self-referral from the practitioners themselves;
2. provide assistance to service 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;
3. facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from physical, emotional, drug-related or other potentially impairing conditions;
4. provide advice, recommendations and assistance to any practitioner who is referred and to the referring source;
5. aid practitioners with regaining or retaining optimal professional functioning consistent with protection of patients, and with re-entry issues;

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<sup>9</sup> CAL. CODE REGS. tit. 22, 70703(d) requires one or more committees to participate in "assisting...medical staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services."

6. monitor practitioners for compliance with monitoring agreements, treatment programs, or other conditions of continued practice;
7. assess and determine appropriate outside assistance resources and programs for practitioners;
8. 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
9. 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.W.3. Meetings and Reports:

The Practitioner Well-Being 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).

## 3.X. PROFESSIONAL PRACTICE EVALUATION COMMITTEE (“PPEC”)

### 3.X.1. Composition:

1. The PPEC will consist of the following voting members:
  - a. Immediate Past Chief of Staff;
  - b. Another Past Chief of Staff;
  - c. Additional Medical Staff members who are:
    - (i) broadly representative of the clinical specialties on the Medical Staff;
    - (ii) interested or experienced in credentialing, privileging, PPE/peer review, or other Medical Staff affairs;
    - (iii) supportive of evidence-based medicine protocols; and
    - (iv) appointed by the Leadership Council.

2. The following individuals will serve as *ex officio* members, without vote, to facilitate the PPEC's activities:
  - a. the Chief Medical Officer; and
  - b. PPE Support Staff representative(s).
3. The Leadership Council will designate one voting member of the PPEC as the PPEC chair.
4. 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, service chair, or committee chair) who is experienced in credentialing, privileging, PPE/peer review, or Medical Staff matters.
5. 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.
6. 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.
7. 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.X.2. Duties:

The PPEC will perform the following functions:

1. 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;
2. 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;

3. 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;
4. review, approve, and periodically update the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;
5. 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;
6. review cases referred to it as outlined in the PPE Policy;
7. develop, when appropriate, Performance Improvement Plans for practitioners, as described in the PPE Policy;
8. monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;
9. work with service 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
10. 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.X.3. Meetings, Reports, and Recommendations:

The PPEC will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The PPEC will submit reports of its activities to the Medical Executive Committee and the Board on a regular basis.

## 3.Y. REGIONAL REFERRAL QUALITY REVIEW COMMITTEE

### 3.Y.1. Composition:

1. The Regional Referral Quality Improvement Committee will consist of Medical and Hospital staff from all areas of the Hospital who are involved in the Regional Referral system. Members shall include:
  - a. RRP Medical Director Co- Chair
  - b. Co-Chair, designated by Chief of Staff
  - c. Current Chief of Staff
  - d. Chief Medical Officer
  - e. Chief Nursing Officer

- f. Medical Director, Hospitalist Program
- g. Medical Director, Critical Care
- h. Medical Director or Assistant Medical Director, Trauma and Acute Care Surgery
- i. Medical Director, Pediatric Hospitalist Program
- j. Medical Director, Cardiac Cath Lab
- k. Medical Director, Emergency Department
- l. Medical Director or Department Chair, GI Inpatient
- m. Performance Improvement Department Representative
- n. RRP Administrative Director
- o. Medical Director of Integrated Delivery System
- p. Ad hoc as requested:
  - i. Medical Director, Neurosurgery
  - ii. Department Chair, or Section Leader of Orthopedics
  - iii. Medical Director, Neurology

2. The chair of the committee will be a member of the Active Staff.

3.Y.2. Duties:

The Regional Referral Quality Review Committee will:

- 1. Provide timely and credible quality overview of patient care and services related to the transfer process and patient disposition for those patients referred to SRMH
- 2. conduct case reviews of select patients who meet the co-chair criteria for review or request made by other physicians to conduct a case review
- 3. focus will be to evaluate workflow and hospital operations/ systems related to the transfers.

Determine if further discussion is needed related to physician decision; if so, a referral will be made to the appropriate service chair/s.

3.Y.3. Meetings and Reports:

The Regional Referral Quality Improvement Committees meet as necessary; but at least quarterly and will provide quarterly reports to the Performance Monitoring Committee.

3.Z. TRAUMA MULTIDISCIPLINARY TEAM

### 3.Z.1. Composition:

1. The Trauma Multidisciplinary Team will consist of Medical and Hospital staff from all areas of the Hospital who are involved in the care of trauma patients, including registered nurses.<sup>10</sup>
2. The chair of the committee will be a member of the Active Staff.

### 3.Z.2. Duties:

The Trauma Committee will:

1. facilitate revision, development and approval of integrated trauma care policies and procedures;
2. coordinate review of trauma charts, the care of trauma patients and the utilization of trauma services;
3. conduct preliminary peer review for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to trauma patients. The committee will routinely collect information about important aspects of patient care provided to trauma patients, periodically assess this information, and develop objective criteria for use in evaluating patient care provided to trauma patients;
4. provide a forum for review and evaluation of performance improvement and ongoing quality of trauma care provided within the Hospital;
5. plan and provide continuing medical education programs;
6. address regulatory standards/requirements and facilitate compliance;
7. provide leadership for future community trauma needs; and
8. appoint a subcommittee to handle the peer review process for trauma related cases, providing a report on the same to the PPEC and the Medical Executive Committee on a regular basis.

### 3.Z.3. Meetings and Reports:

The Trauma Multi-Disciplinary Team will meet as necessary; but at least quarterly and will provide quarterly reports to the Performance Monitoring Committee.

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<sup>10</sup> CAL. CODE REGS. tit. 22, § 70211(c)(2) mandates that all Medical Staff committees “that address issues affecting nursing care shall include registered nurses, including those who provide direct patient care.”

### 3.AA. UTILIZATION MANAGEMENT COMMITTEE<sup>11</sup>

#### 3.AA.1. Composition:

1. The Utilization Review Committee will consist of at least three physicians. Other members shall include representatives from Case Management, Clinical Informatics, and Clinical Documentation Improvement as appointed by the Chief of Staff.
2. Members of the Utilization Review Committee must recuse themselves from discussion in instances where they have provided professional care for a patient whose case is under review, or have a potential conflict of interest.

#### 3.AA.2. Duties:

The Utilization Review Committee will perform the following functions:

1. review the medical necessity of admissions, appropriateness of the setting, medical necessity of extended stays, and medical necessity of professional services;
2. communicate the results of its studies (and other pertinent data) to the Performance Monitoring Committee; and where appropriate, the Medical Executive Committee or the entire Medical Staff;
3. make recommendations for the optimum utilization of Hospital resources and facilities (commensurate with quality care and safety); and
4. formulate a written utilization review plan for the Hospital, subject to approval by the Medical Executive Committee and Board.

#### 3.AA.3. Meetings and Reports:

The Utilization Review Committee will meet at least quarterly and when deemed necessary by the chair. The Committee will report routinely to the PMC.

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<sup>11</sup> CAL. CODE REGS. tit. 22, 70703(d) requires the “utilization review” function to be assigned to a committee.

ARTICLE 4

AMENDMENTS

This Manual will be amended in the manner described in Article 8 of the Bylaws for the amendment of the Medical Staff Organization Manual.

ARTICLE 5

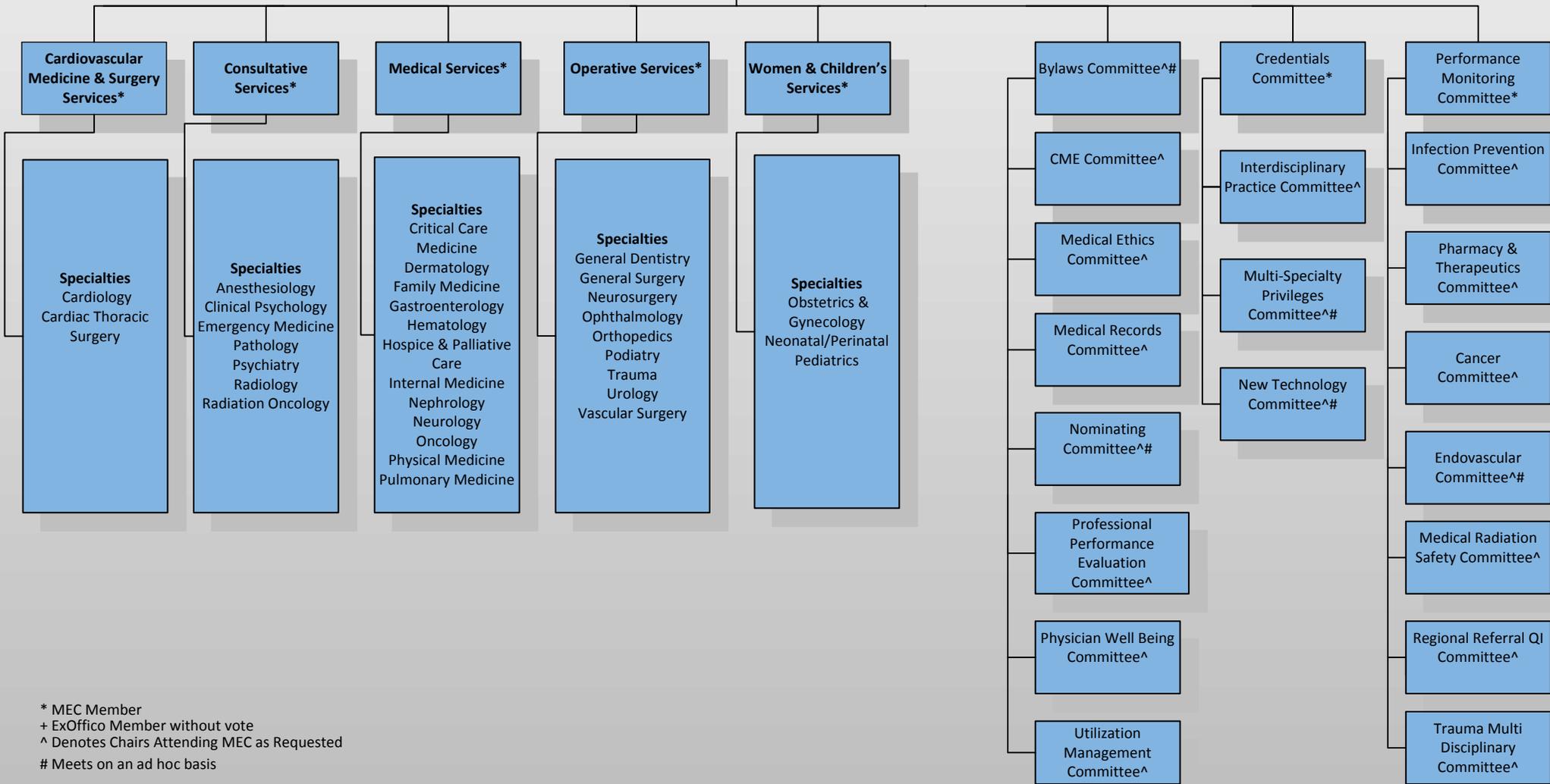
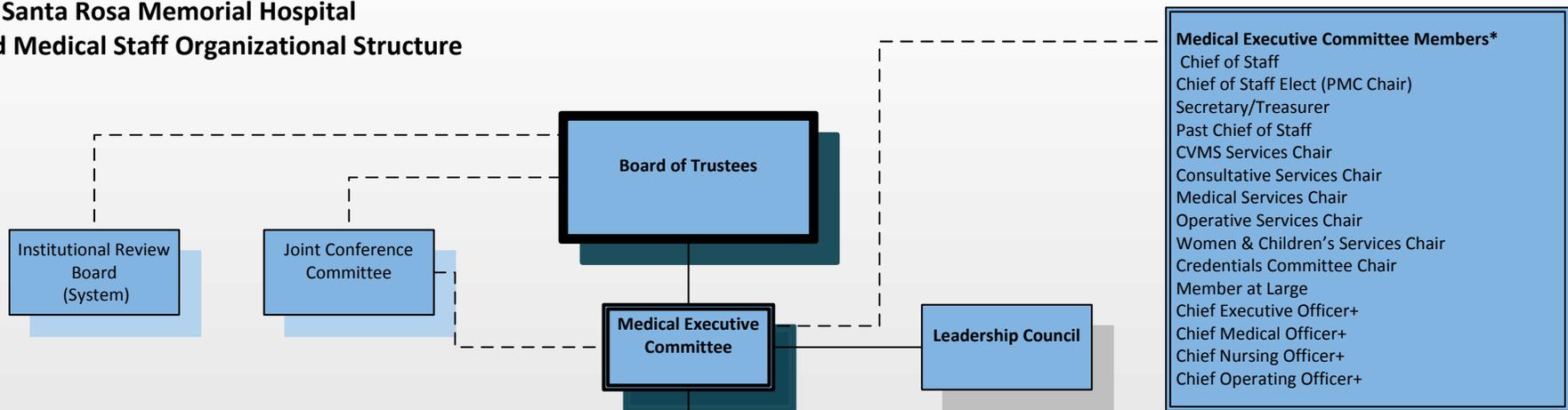
ADOPTION

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:            May 8, 2018

Approved by the Board:                 June 26, 2018, eff September 1, 2018

# Santa Rosa Memorial Hospital Proposed Medical Staff Organizational Structure



\* MEC Member  
 + ExOfficio Member without vote  
 ^ Denotes Chairs Attending MEC as Requested  
 # Meets on an ad hoc basis