Portneuf Medical Center
Medical Staff Bylaws Part IV
Organization & Functions Procedures

______________________________________________ 05-05-11
Signature, Medical Staff President
Date

__________________________________________ 05-05-11
Signature, CEO
Date

__________________________________________ 05-05-11
Signature, Board Chairman
Date
# Part IV: Organization and Functions

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECTION 1. ORGANIZATION AND FUNCTIONS OF THE STAFF</td>
<td>3</td>
</tr>
<tr>
<td>1.1 Organization of the Medical Staff</td>
<td>3</td>
</tr>
<tr>
<td>1.2 Responsibilities for Medical Staff Functions</td>
<td>3</td>
</tr>
<tr>
<td>1.3 Description of Medical Staff Functions</td>
<td>3</td>
</tr>
<tr>
<td>1.4 Medical Staff President Duties</td>
<td>9</td>
</tr>
<tr>
<td>1.5 Responsibilities of Clinical Service Chiefs</td>
<td>9</td>
</tr>
<tr>
<td>SECTION 2. MEDICAL STAFF COMMITTEES</td>
<td>9</td>
</tr>
<tr>
<td>2.1 Medical Executive Committee</td>
<td>9</td>
</tr>
<tr>
<td>2.2 Credentials Committee</td>
<td>9</td>
</tr>
<tr>
<td>2.3 Medical Staff Quality Committee (See Medical Staff Quality Committee Charter)</td>
<td>9</td>
</tr>
<tr>
<td>2.4 Special Care Committee</td>
<td>9</td>
</tr>
<tr>
<td>2.5 Wellness Committee</td>
<td>10</td>
</tr>
<tr>
<td>SECTION 3. CONFIDENTIALITY, IMMUNITY, AND RELEASES</td>
<td>10</td>
</tr>
<tr>
<td>3.1 Confidentiality of Information</td>
<td>11</td>
</tr>
<tr>
<td>3.2 Immunity from Liability</td>
<td>11</td>
</tr>
<tr>
<td>3.3 Activities</td>
<td>11</td>
</tr>
<tr>
<td>SECTION 4. REVIEW, REVISION, ADOPTION, AND AMENDMENT</td>
<td>12</td>
</tr>
</tbody>
</table>
SECTION 1. ORGANIZATION AND FUNCTIONS OF THE STAFF

1.1 Organization of the Medical Staff

The Medical Staff of Portneuf Medical Center shall be organized as a non-departmental Medical Staff. Any clinical specialty or like group of specialties may ask the MEC to authorize that specialty as a clinical service. A clinical service chief shall head each clinical service with overall responsibility for the supervision and satisfactory discharge of assigned functions under the Medical Executive Committee (MEC). Clinical services may give input to appropriate Center and Medical Staff committees 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 lie with the MEC. Medical Staff officers, clinical service chiefs, and Center and Medical Staff committee chairs are responsible for working collaboratively to develop a process for communication of Medical Staff functions and activities by providing periodic reports as appropriate to the appropriate administrative and Medical Staff leaders, and to elevate issues of concern to Medical Staff Quality, Credentials, Wellness or Medical Executive Committees as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care. Activities of the Medical Staff are intended to monitor the quality of patient care by encouraging peer collaboration and are entitled to peer review protection to the extent permitted by law.

Where appropriate, Medical Staff officers may appoint designated physician leaders (DPLs) to help fulfill Medical Staff functions and identify other medical and administrative resources needed to adequately fulfill these functions.

1.3 Description of Medical Staff Functions

The responsible individual leader or committee 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 evaluations from clinical services, and recommendations from committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities (MEC and other Medical Staff Committee(s));

b. Account to the Board and the Medical Staff by written recommendations for the overall quality and efficiency of patient care at the Center (Medical Staff President and MEC);

c. Take reasonable steps to ensure professional and ethical conduct, initiate investigations, and pursue corrective action of Medical Staff members when warranted (Medical Staff President and MEC);

d. Make recommendations on medico-administrative and Center clinical and operational matters (Medical Staff President and MEC);

e. Inform the Medical Staff of the accreditation program and the accreditation and state licensure status of the Center (Medical Staff President and MEC);

f. Act on all matters of Medical Staff business, and fulfill any state and federal reporting requirements (MEC and other Medical Staff and Center committees);
g. Oversee, develop, and plan continuing medical education (CME), programs, and activities designed to keep the staff informed of significant new developments and new skills in medicine related to the findings of performance improvement activities (MEC, Center CME Committee and DPL);

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, Center Ethics Committee and DPL);

i. Provide oversight concerning the quality of care provided by residents, interns, and medical students, and ensure they act within approved guidelines established by the Medical Staff and Board (MEC, Graduate Medical Education (GME) Committee);

j. Ensure effective, timely, and adequate comprehensive communication between Medical Staff members and leaders as well as between Medical Staff leaders and Center administration and the Board. (Medical Staff President)

k. Oversee Medical Staff involvement with and selection of the physician(s) who best exhibit the attributes of the Center service excellence program. (DPL)

1.3.2 Oversee medical care evaluation/performance improvement/patient safety activities (Medical Staff Quality 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 Center;

d. Communicate findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the Board, 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. Participate in implementation of an integrated patient safety program throughout the Center;

g. Ensure that an ongoing, proactive program for identifying risks to patient safety and reducing medical/health care errors is 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: (Medical Executive Committee and Medical Staff Quality 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 Center 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;
j. Use of developed criteria for autopsies;
k. Sentinel event data;
l. Coordination of care, treatment, and services with other practitioners and Center personnel, as relevant to the care, treatment, and services of an individual patient; and
m. Patient safety data;

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

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

1.3.4 **Credentials Review** (see Part III: Credentials Procedures)

1.3.5 **Information Management** (MEC and Center Health Information Management Director)

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 Center.

b. Develop, review, enforce, and maintain surveillance at least quarterly over enforcement of Medical Staff and Center 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. (Medical Staff Quality Committee for review and enforcement of timeliness rules, policy, etc.);

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

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

1.3.7 **Planning** (Medical Staff President, MEC, Clinical Service Chiefs)

a. Advise the Center by participating in the evaluation of existing programs, services, and facilities of the Center and Medical Staff and evaluating continuation, expansion, abridgment, or termination of each;
b. Advise the Center 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 Part I: Governance, Part II: Investigation, Corrective Action, Hearing and Appeal Plan, Part III: Credentials Procedures, Part IV: Organization and Functions and Medical Staff rules and regulations;

b. Conduct periodic review of clinical policies which affect physicians or their extenders, rules; and


1.3.9 Nominating (MEC)

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 Medical Staff, the MEC, Board and administration concerning the qualifications and acceptability of prospective nominees.

1.3.1 Medical Staff Leadership Development (MEC)

a. Medical Executive Committee will ensure effective Medical Staff leadership and continuity by selecting members of the Medical Staff who are committed to fulfilling the responsibilities of their leadership positions as defined in the appropriate position description and contained within these Bylaws. (Refer to Leadership Development Policy 7900.706)

1.3.1 Infection Control Oversight (MEC, Center Infection Control Committee and DPL, and the Medical Staff Quality Committee)

a. The Medical Staff oversees the development and coordination of the Center-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 all 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 every two years.

1.3.12 Pharmacy and Therapeutics Functions (MEC, Center Pharmacy and Therapeutics Committee and DPL, and the Medical Staff Quality Committee)

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

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 the Joint Commission.

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

g. Approve policies and procedures related to the Joint Commission Care of Patient Standards: 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 Center;

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 Center 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.
m. 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 Center.

1.3.13 **Cancer Committee**

a. Maintain certification by the American College of Surgeons Commission on Cancer as a Community Hospital Cancer Program. (Center Cancer Committee and DPL)

b. **Composition:** The Cancer Committee shall be a multi-disciplinary committee, consisting of physicians representing the following clinical specialties: Surgery, Medical Oncology, Pathology, Radiology, Pediatrics, Obstetrics and Gynecology, and Radiation Oncology. Other disciplines may also be included as appropriate. Other members of the Committee shall include the Cancer Liaison Physician and the Cancer Registrar, who shall provide staff services to the Committee in coordinating the Cancer Program. Representatives of the following hospital departments shall also serve as members of the Committee: Administration, Nursing, Social Services, and Quality Management. The Chairman shall be appointed annually by the Medical Staff President.

**Duties:** The duties of the Cancer Committee shall be to:

1. oversee, in an advisory capacity, the entire spectrum of care for all cancer patients admitted to the hospital and/or Radiation Oncology, including diagnosis, treatment, follow-up, and consultative services. In addition, this Committee shall oversee the evaluation of the quality of care, including documentation and reporting of outcome;
2. sponsor monthly multi-disciplinary conferences which are educational and consultative and include all major sites of cancer seen at the Center;
3. appoint a member of the Committee to supervise the Cancer Registry quality control activities, including abstracting, staging, follow-up, and reporting (Aside from this supervision, the Registry is otherwise an autonomous unit of the Center, accountable directly to administration);
4. plan and complete a minimum of two patient care evaluation studies annually, one of which shall include survival data and, if available, comparison data;
5. evaluate the effectiveness of the patient care evaluation program; and
6. publish and distribute an annual report which includes the following:
   a) statement of purpose
   b) reports of the two annual PCE studies, Cancer Registry activities, educational conferences, the five major cancer sites seen at the Center, and Cancer committee activities

c. Collaborate and report to the system Study Oversight Committee as appropriate, the review, evaluation, monitoring, and approval, of research projects and clinical investigations to be conducted at the Center. The Idaho State University Human Subjects Committee will oversee compliance with written protocols and develop criteria for reviewing and monitoring studies and observing all requirements of the appropriate regulatory authorities applicable to any given study. (Study Oversight Committee Guidelines, Memorandum of Understanding between Idaho State University and Portneuf Medical Center)

1.3.14 **Study Oversight Committee**

The Portneuf Medical Center Institutional Review Board will be called the Study Oversight Committee and is established to consider whether a clinical trial is appropriate for the Center. At all times the primary purpose of the Study Oversight Committee is to protect the rights and welfare of human subjects. Refer also to Study Oversight Committee Guidelines.
1.4 Medical Staff President Duties

1.4.1 The Medical Staff President is the primary elected officer of the Medical Staff and is the Medical Staff’s advocate and representative in its relationships to the Board and the administration of the Center. The Medical Staff President, 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 Parts I through IV of these Bylaws and the Medical Staff rules and regulations.

1.5 Responsibilities of Clinical Service Chiefs

a. Formulate continuing education and encourage discussion of patient care issues pertinent to that clinical specialty and other related clinical specialties;
b. Conduct grand rounds as desired by physicians in the clinical service;
c. Discuss policies and procedures and report same to other appropriate clinical service chiefs and foster cross-specialty communication;
d. Discuss equipment needs pertinent to that clinical service;
e. Develop reports and evaluations for a specific issue at the request of another clinical service chief, the MEC or other Center or Medical Staff committee;
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 an annual report detailing the clinical service activities to the MEC.

SECTION 2. MEDICAL STAFF COMMITTEES

2.1 Medical Executive Committee

Description of the MEC is in Part I: Governance, Article VI

2.2 Credentials Committee

Description of the credentials committee is in Part III: Credentials Procedures, Section I

2.3 Medical Staff Quality Committee (See Medical Staff Quality Committee Charter)

2.4 Critical Care Committee

2.4.1 Composition: The Critical Care Committee shall consist of not less than three (3) members of the Medical Staff and one member of the nursing staff.

2.4.2 Responsibilities: The Committee has the responsibility for continuing professional supervision of coronary care, intensive care, and post critical care units. The Committee will review the treatment of individual cases, and may suggest that attending physicians seek consultations when appropriate. The Committee will establish an in-service teaching program for Center personnel and Medical Staff associated with these special care units.
2.5 Wellness Committee

2.5.1 Composition: The Wellness Committee shall consist of, whenever possible, at least one (1) past Medical Staff President who retains privileges at the Center, one (1) member of the Active Medical Staff, a member of the Medical Staff Quality Committee, and a physician with a previous history of impairment whose impairment has been successfully treated (if feasible), and other members of the Medical Staff selected by the Medical Staff President to bring the total complement to five (5) physician members. The chair shall be appointed by the Medical Staff President. Other credentialed practitioners may also be assigned.

2.5.2 General Description: The committee shall be responsible for addressing problems dealing with impaired professional performance among practitioners. Issues related to impaired practitioners shall be referred to the Medical Staff President, who will determine the need for referral to the Wellness Committee. Guidelines for this Committee, including its stated purpose, function, membership and the process for consultation shall be maintained in the Medical Staff Office and shall be redistributed to members of the Medical Staff at two (2) year intervals.

2.5.3 Responsibilities:

a. To recommend to the MEC 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 Medical Staff President, the impaired practitioner's clinical service chief, the residency program director, and the CEO of the Center as applicable when the committee feels the impaired practitioner's actions could endanger patients. The existence of the Wellness Committee does not alter the primary responsibility of the clinical service chief, if applicable for clinical performance within that chief’s clinical service; and

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

e. Refer also to Centerwide policies on Practitioner Health and Conduct.

2.5.4 Operational Authority: The Wellness Committee shall have the authority to perform the duties of the committee as outlined. Deliberations of the Committee are to remain confidential subject only to the reporting mechanism previously outlined. The Committee shall report to the MEC at least two times per year.

2.6 Medical Leadership Committee

Medical Leadership Committee (MLC) shall be a standing committee of the Medical Executive Committee. MLC shall be composed of current officers and the immediate past Medical Staff President. The CEO, Medical Staff Services Director, Quality Chief, and Wellness Committee Chair may also attend at the discretion of the MLC. The purpose of this Committee is to address time limited or specialized tasks. The Medical Staff President or designee will report MLC activities to the Medical Executive Committee as needed.

**SECTION 3. CONFIDENTIALITY, IMMUNITY, AND RELEASES**
3.1 Confidentiality of Information

3.1.1 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 Center 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

3.2.1 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 or her duties as an official representative of the Center 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

3.3.1 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:

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

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

c. Corrective or disciplinary actions;

d. Hearings and appellate reviews;

e. Quality assessment and performance improvement activities;

f. Utilization review and improvement activities;

g. Claims reviews;

h. Risk management and liability prevention activities; and

i. Other Center, committee, 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 may be amended or repealed in accordance with the procedure outlined in Part I: Governance, Article IX, Section 3.