North Hospital

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Tag:	
Applicability:	*Indiana University Health North Hospital*

Organization Policy

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ARTICLE 1
GENERAL
A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Credentials Policy.

B. TIME LIMITS

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated.

C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

ARTICLE 2
CLINICAL SECTIONS
A. LIST OF SECTIONS

The Medical Staff shall be divided into the following Sections, with possible Subsections (but not necessarily limited to) listed in parentheses:

a. Obstetrics and Gynecology;(including General Obstetrics/Gynecology, Gynecological Oncology, Gynecology, Maternal Fetal Medicine, Reproductive Endocrinology/Infertility, and Urogynecology);
b. Pediatrics (including Adolescent Medicine, Allery, Cardiology, Critical Care, Developmental Pediatrics, Endocrinology, Gastroenterology, Hematology/Oncology, Infectious Disease, Neonatology, Nephrology, Neurology, Pulmonary and Rheumatology);
c. Surgery (including General Surgery, Bariatric Surgery, Cardiovascular Surgery, Gynecological & Urogynecological Surgery, Musculoskeletal Surgery, Neurosurgery, Oral/Maxillofacial and Dentistry, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pediatric Surgery, Plastic & Reconstructive Surgery, Urological Surgery, and Vascular Surgery);
d. Medicine (including Internal Medicine, Allergy/Immunology, Clinical Pharmacology (physician only), Occupational Medicine, Endocrinology-Metabolic Disease,Geriatrics,Infectious Disease, Pulmonary/ Intensivists, Dermatology, Emergency Medicine, Cardiology, Gastroenterology, Hematology/Oncology, Neurology, Nephrology, Physical Medicine, and Psychiatry);
e. Family Medicine (including Level 1 Obstetrics);
f. Anesthesiology; (including Pain Management);
g. Radiology; (including Radiation Oncology and Interventional Radiology); and
h. Pathology.

B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND DIVISIONS

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

ARTICLE 3
MEDICAL STAFF COMMITTEES

A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

1. This Article outlines the Medical Staff committees of Indiana University Health North Hospital that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.
2. Procedures for the appointment of committee chairs and physician members of the committees are set forth in Article 5 of the Medical Staff Bylaws.
3. Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the President of the Hospital or designee, in consultation with the Medical Staff as appropriate.

B. MEETINGS, REPORTS AND RECOMMENDATIONS

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

C. CREDENTIALS COMMITTEE

1. **Composition**:
   The President of the Medical Staff shall appoint at least five (5) Active Staff members representing major clinical sections to serve as the Credentials Committee of the Medical Staff. The Chief Medical Officer may be one of the five (5) members and will have voting rights. The Credentials Committee shall consist of an appropriate number of members of the Active Staff representing the major clinical sections. Particular consideration is to be given to Past Presidents of the Medical Staff, past section chairs, and other physicians knowledgeable in the credentialing and quality improvement processes.
2. **Duties**:
   The Credentials Committee shall:
   a. in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff and Allied Health Professionals appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;
   b. review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Professionals and, as a

result of such review, make a written report of its findings and recommendations; and

c. review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital.

3. **Meetings**:
   The Credentials Committee shall meet monthly or at the call of the chair.

4. **Specialty Advisors**
   The Chair of the Credentials Committee has the authority to select specialty advisors for the purpose of assessing and reviewing applications for appointment and reappointment to the Medical and Allied Health Practitioner Staffs.

D. MEDICAL EXECUTIVE COMMITTEE (MEC)

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

E. PERFORMANCE ASSESSMENT AND IMPROVEMENT COMMITTEE

1. **Composition**
   The MEC will name members to the PA&I Committee on recommendation of the PA&I Chair, the President of the Medical Staff, or the chair of a clinical section. The President of the Medical Staff shall appoint the chair of the Performance Assessment and Improvement Committee from among the members of the committee.

2. **Duties**

   a. GENERAL RESPONSIBILITIES.
      The general responsibilities of the Performance Assessment and Improvement Committee shall include the following:

      1. Identify, evaluate and where appropriate, make recommendations concerning the issues affecting the quality of care provided and the appropriate utilization of resources;
      2. Assume responsibility for assuring systematic and ongoing reviews of patient care by each department and/or clinical service;
      3. Ensure that the quality assurance requirements of external, regulatory accrediting bodies are met;
      4. Determine from the results of reviews the need for educational activities or other appropriate action when necessary; and
      5. Review pertinent results from hospital clinical department Quality programs.
      6. Consistent with quality of care concerns, when requested by the CMO or President of the Medical Staff, address Medical Staff and AHP health issues to determine the appropriate steps to protect patients and to help the individual practice safely and competently.

   b. RESPONSIBILITIES AS A MEDICAL RECORDS & INFORMATION MANAGEMENT COMMITTEE
      Acting as Medical Records & Information Management Committee, the Performance Assessment and Improvement Committee shall oversee the quality, pertinence and legibility of patient information, and ensure timely completion of medical records; and establishment of appropriate and consistent documentation standards.

3. **Meetings**
   The Performance Assessment and Improvement Committee meetings may be called by the Chair of the committee, as often as deemed necessary, and at such intervals as may be set in the Rules of the Medical Staff.

F. SURGICAL SERVICES STEERING COMMITTEE

1. **Composition**:
   a. The Committee shall consist of the following: The Surgical Services Medical Director, who shall serve as the Chair of the committee, the Surgery Section Chair, and various representatives appointed by the President of the Medical Staff.
   b. Other members shall include the President of IU Health North Hospital, the Chief Medical Officer, the Chief Nursing Officer for IU Health North Hospital, the Director of Surgical Services; the Manager of Surgical Services; a representative of the Quality Program of IU Health North Hospital; and Director of Risk Management and Patient Safety.
2. **Duties**:
   The Surgical Services Steering Committee shall:
   a. provide high quality standards for Surgical Services;
   b. develop and maintain policies and procedures that are derived from evidence-based literature, supportive of regulatory guidelines and recommendations, and reflective of national standards of care;
   c. participate in quality improvement activities and make recommendations based on the same;
   d. address issues that pertain to the operations of Perioperative Sections; and
   e. identify educational needs of physicians and perioperative staff.
3. **Meetings**:
   The Surgical Services Steering Committee shall meet at least quarterly or at the call of the chair.

G. PHARMACY AND THERAPEUTICS COMMITTEE

1. **Composition**:
   a. The Pharmacy and Therapeutics Committee shall be composed of an appropriate number of Active Members of the Medical Staff.
   b. Other members shall include the Directors of Pharmacy, a pharmacist with content expertise, and representatives from Hospital Administration, Nursing Services, Performance Improvement and other disciplines deemed appropriate by the committee chair.
   c. The majority of the members of the Pharmacy and Therapeutics Committee shall be members of the Active Staff and shall include both adult and pediatric representatives.
2. **Duties**:
   The Pharmacy and Therapeutics Committee shall:
   a. be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital;
   b. 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;

c. advise the Medical Staff and the pharmaceutical department on matters pertaining to the choice of available drugs;

d. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

e. develop and review periodically a formulary or drug list for use in the Hospital;

f. evaluate clinical data concerning new drugs or preparations requested for use in the Hospital;

g. recommend education programs for staff regarding drugs and their appropriate therapeutic use;

h. Act as a peer review body in the monitoring and evaluation of medication issues related to quality and safety of patient care;

i. establish guidelines for pharmaceutical representatives; and

j. facilitate communication between the committee and the Institutional Review Boards.

3. **Meetings**:
The Pharmacy and Therapeutics Committee shall meet at least ten months each year.

H. TISSUE REVIEW COMMITTEE

1. **Composition**:
The Tissue Review Committee shall consist of an appropriate number of members, the majority of which shall be members of the Active Staff.

2. **Duties**:
The Tissue Review Committee shall:

a. review and evaluate surgery performed in the Hospital when there is a disagreement among the preoperative, postoperative, and pathological diagnoses, or where a question of the acceptability of the procedure has been raised. Written reports shall be maintained reflecting the results of all evaluations performed and actions taken;

b. establish a process to determine the appropriateness of procedures in which a clinically relevant discrepancy with the potential to change the course of therapy exists between the preoperative (clinical) diagnosis and postoperative (pathological) diagnosis; and

c. consider the practice related to the review of pathology specimens diagnosed at outside institutions prior to internal clinical interventions.

3. **Meetings**:
The Tissue Review Committee shall meet at least quarterly or at the call of the chair.

I. NOMINATING/LEADERSHIP DEVELOPMENT COMMITTEE

1. **Composition**:

a. The Nominating/Leadership Development Committee shall be comprised of the following members:

1. President of the Medical Staff, who shall serve as chair;

2. Immediate Past President of the Medical Staff; and

3. up to five additional members of the Medical Staff appointed by the President of the Medical

Staff with consultation from the MEC.

b. The Chief Medical Officer shall serve as an *ex officio* member, without vote.

c. Except for the President of the Medical Staff and the Immediate Past President, the members of the Nominating/Leadership Development Committee shall serve as needed at the request of the current President of the Medical Staff.

2. **Duties**:

The Nominating/Leadership Development Committee shall be responsible for the following:

a. identifying a slate of qualified individuals to serve as Medical Staff Officers in accordance with Article 3 of the Medical Staff Bylaws;

b. appointing Medical Staff members to serve as chairs and members of all Medical Staff Committees, unless otherwise provided in the Medical Staff Bylaws or Organization Policy; and

c. developing and overseeing a physician leadership educational process funded by the Medical Staff dues to promote effective and successful Medical Staff Leaders at present and in the future.

ARTICLE 4
AMENDMENTS

This Policy may be amended in accordance with Article 8 of the Medical Staff Bylaws.

ARTICLE 5
ADOPTION

This Medical Staff Organization Policy is adopted and made effective upon approval of the Medical Staff and the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Organization Policy of Indiana University Health North Hospital

Adopted by the Medical Staff:	**April 4, 2014**
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K. Alicia Schulhof, FACHE
President, Indiana University Health North Suburban Area

Charles E. Schalliol
Chair, Board of Directors Indiana University Health North Hospital

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
IU Health North President	Kristy Schulhof: President-IUH North Sub Area	02/2019
President, Medical Staff	Sean Trivedi: Staff Physician-EM-Faculty	01/2019
CMO	Paul Calkins: Chief Medical Officer	01/2019
	Louise Lawson: Speclst-Credentialing	01/2019

Applicability

Indiana University Health North Hospital