

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
INDIANA UNIVERSITY HEALTH WEST
HOSPITAL**



ORGANIZATION MANUAL

**November 11, 2013-Adopted
November 28, 2017 – Revision
November 1, 2018- Revision**

TABLE OF CONTENTS

	<u>PAGE</u>
1. GENERAL.....	1
1.A. DEFINITIONS.....	1
1.B. TIME LIMITS	1
1.C. DELEGATION OF FUNCTIONS	1
2. CLINICAL SECTIONS	2
2.A. LIST OF SECTIONS.....	2
2.B. FUNCTIONS AND RESPONSIBILITIES OF SECTIONS	2
3. MEDICAL STAFF COMMITTEES.....	3
3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS	3
3.B. MEETINGS, REPORTS AND RECOMMENDATIONS.....	3
3.C. BYLAWS COMMITTEE.....	3
3.D. CANCER COMMITTEE	4
3.E. CODE COMMITTEE.....	4

3.F.	CREDENTIALS COMMITTEE	5
3.G.	ETHICS COMMITTEE.....	5
3.H.	INFECTION CONTROL COMMITTEE.....	6
3.I.	MEDICAL EXECUTIVE COMMITTEE	7
3.J.	MEDICAL STAFF QUALITY ASSESSMENT AND UTILIZATION REVIEW COMMITTEE.....	8
3.K.	PHARMACY AND THERAPEUTICS COMMITTEE.....	9
3.L.	TRANSFUSION COMMITTEE	10
4.	AMENDMENTS	11
5.	ADOPTION.....	12

ARTICLE 1

GENERAL

1.A. DEFINITIONS

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

1.B. TIME LIMITS

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

1.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

2.A. LIST OF SECTIONS

The following clinical sections are established for the Hospital:

- Medicine Section
- Surgery Section
- Obstetrics and Gynecology Section
- Pediatrics Section

2.B. FUNCTIONS AND RESPONSIBILITIES OF SECTIONS AND COMMITTEES

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

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

- (1) This Article outlines the Medical Staff committees of Indiana University Health West 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 chair 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 or designee.

3.B. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual 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 Manual.

3.C. BYLAWS COMMITTEE

3.C.1. Composition:

The Bylaws Committee shall be composed of an appropriate number of Active Members of the Medical Staff.

3.C.2. Duties:

The Bylaws Committee shall:

- (a) meet as needed, at least annually, to review, draft and recommend corrections, changes and amendments to the Medical Staff Bylaws, Rules and Regulations, manuals and other applicable Medical Staff policies;
- (b) ensure that the Bylaws and related documents reflect the current practice and structure of the Medical Staff and comply with changes which are required by state or federal law, Joint Commission ("JC") accreditation standards, and Centers for Medicare & Medicaid Services ("CMS") Conditions of Participation; and
- (c) recommend changes and amendments as appropriate to the MEC per Article 8 of the Medical Staff Bylaws.

3.D. CANCER COMMITTEE

3.D.1. Composition:

- (a) The Cancer Committee shall be multidisciplinary with required members as appropriate to the institution to maintain accreditation by the American College of Surgeons, Commission on Cancer,
- (b) The breast center services shall be multidisciplinary with required members as appropriate to the institution to maintain accreditation by the National Accreditation Program for Breast Centers. The Breast Program Leadership will report to the Cancer Committee.

3.D.2. Duties:

- (a) The Cancer Committee provides program leadership with duties as described in the Standards of the Commission on Cancer. (b) The Breast Program Leadership provides program leadership with duties as described in the Standards of the National Accreditation Program for the Breast Centers and will report to the Cancer Committee.

3.D.3. Meetings:

The Cancer Committee shall meet at least quarterly or at the call of the chair. Subcommittees will meet as needed for the completion of cancer committee and Breast Program Leadership activities.

3.E. CODE BLUE COMMITTEE

3.E.1. Composition:

- (a) The Code Committee shall be a multidisciplinary committee that consists of members from sections who participate in critical care roles.
- (b) Other members shall include a representative from Nursing, Respiratory Therapy and Pharmacy

3.E.2. Duties:

The Code Blue Committee shall:

- (a) Recommend policies and procedures related to cardiopulmonary resuscitation and the calling of codes in the Hospital;
- (b) Recommend standards for code responses with a mechanism for systematic, ongoing monitoring to provide improved patient care to cardiac arrest victims, and develop a methodology for the collection, collation, and analysis of performance and outcomes data of cardiopulmonary resuscitation in the Hospital;
- (c) Review personnel roles, procedures, and practices for code responses;
- (d) Identify educational needs of staff involved in cardiopulmonary resuscitation events and coordinate basic and advanced life support teaching and testing; and
- (e) Recommend standardized equipment and medications for code responses.

3.E.3. Meetings:

The Code Committee shall meet at least quarterly or at the call of the chair.

3.F. CREDENTIALS COMMITTEE

3.F.1. Composition:

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 chairmen, and other physicians knowledgeable in the credentialing and quality improvement processes.

3.F.2. Duties:

The Credentials Committee shall:

- (a) in accordance with the Credentials Manual, 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, including specifically as set forth in Section 4.A.4 ("Clinical Privileges for New Procedures") and Section 4.A.5 ("Clinical Privileges That Cross Specialty Lines") of the Credentials Manual.

3.F.3. Meetings:

The Credentials Committee shall meet monthly or at the call of the chair.

3.G. ETHICS COMMITTEE

3.G.1. Composition:

The Ethics Committee shall be a multidisciplinary committee and shall consist of an appropriate number of members of the Active Staff. At least one representative each from Nursing, Social Services, Clergy, Legal, and Administration shall also serve on the committee. The chair may appoint individuals to temporary ad hoc positions on the committee when it is determined that their expertise may be necessary or of assistance for a particular issue.

3.G.2. Duties:

The Ethics Committee shall:

- (a) serve as a resource for the Medical Staff, Hospital staff, and the community in regard to ethics information and education;

- (b) facilitate communication and aid in conflict resolution between concerned parties by assisting in the identification of options available to the patient, the patient's family, and the physician;
- (c) be responsible for ongoing internal education of committee members and for the development of educational programs for the Hospital, patients and their families, and the community;
- (d) be responsible for the review and development of policies for the Hospital in the area of ethical principles and their application and for the revision of these policies as needed; and
- (e) be responsible for developing procedures for responding to requests for consultations and be available for case consultation upon request of any member of the patient's health care team, the patient, or the patient's family.

3.G.3. Meetings:

The Ethics Committee shall meet at least quarterly or at the call of the chair.

3.H. INFECTION CONTROL COMMITTEE

3.H.1. Composition:

The Infection Control Committee shall consist of an appropriate number of members of the Active Staff, representing the medical and surgical sections. The individual employed by the Hospital for management of the infection control program, such as an infection control nurse, and at least one representative each from Nursing s and Hospital administration shall also serve on the committee. These three representatives shall have voting privileges as well. The chair may appoint individuals to temporary ad hoc positions on the committee when it is determined that their expertise may be necessary or of assistance for a particular issue.

3.H.2. Duties:

The Infection Control Committee shall:

- (a) develop and maintain a Hospital wide infection control program and maintain surveillance over the program;
- (b) develop a system for identifying, analyzing, and reporting the incidence and cause of nosocomial infections in the Hospital;
- (c) monitor infection surveillance data to uncover epidemics, cluster infections and unusual pathogens, and report such data and educate the Medical Staff and involved Hospital services on appropriate prevention and treatment protocols;
- (d) review the surveillance and infection control policies related to all phases of the Hospital's activities and recommend opportunities for improvement to the particular department or section; and
- (e) collaborate with the Pharmacy and Therapeutics Committee on the selection of antibiotics and antiviral agents for the Hospital formulary.

3.H.3. Meetings:

The Infection Control Committee shall meet at least quarterly or at the call of the chair.

3.I. MEDICAL EXECUTIVE COMMITTEE

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

3.2 MEDICAL STAFF QUALITY AND PEER REVIEW COMMITTEE

Composition:

(a) The Medical Staff Quality and Peer Review Committee (QPRC) shall consist of at least four voting members of the Medical Staff, including the President of the Medical Staff along with a standing chair and physicians representing the Hospital-based sections: Medicine, Pediatrics, Surgery, and Obstetrics. Members appointed to this committee shall be appointed for terms of two to five years to ensure continuity.

(b) Other members shall include the following, who shall serve without a vote: President, Chief Medical Officer, Vice President of Patient Care Services, Medical Staff Office Supervisor, representatives from Legal Services and ad-hoc consulting members may be assigned as needed.

Duties:

The Medical Staff Quality and Performance Review Committee shall:

- (a) Serve as the clearinghouse for all services gathering and reporting provider quality at either the individual practitioner or service line level;
- (b) provide oversight of peer review activities conducted at the section level through examination of aggregate peer review data, including review of recommendations to adjust practitioner clinical privileges, based on investigations conducted at the section level;
- (c) Ensure that identified system improvement opportunities are referred to the proper authorities;
- (d) Ensure that identified practitioner improvement opportunities are addressed;
- (e) Oversee the ongoing and focused professional practice evaluation processes and ensure that the information is communicated both to the practitioner and to the Credentialing Committee as per policy;
- (f) Monitor patient quality and safety through evaluation of physician performance;
- (g) Review investigation of serious complaints and allegations of unethical, unprofessional or incompetent medical practice in conjunction with peer review activities that are conducted by the clinical sections.

With respect to matters involving individual Medical Staff members, the committee may provide such advice, counseling, or referrals as it may deem appropriate. Such advice, counseling or referrals may be confidential; however, in the event that information received by the committee demonstrates that the health or condition of a Medical Staff member may pose an undue risk of harm to patients or colleagues or in the event the committee recommends that action be taken pursuant to Article VI of the Credentials Manual, the committee shall notify and may make appropriate recommendations to the President of the Medical Staff or the MEC.

The committee shall consider matters relating to the health and well-being of the Medical Staff and shall act as a liaison between impaired physicians and the Indiana State Medical Association-Physician Assistance Committee (“ISMA-PAC”). The committee shall act as a physician advocate as follows:

- (a) be available to receive reports of potentially impaired physicians;
- (b) refer reports regarding potentially impaired physicians to the ISMA-PAC;
- (c) assist in gathering information on potentially impaired physicians and assist the ISMA-PAC in intervention, as appropriate; and
- (d) assist the ISMA-PAC in rehabilitation efforts and/or monitoring.

Pursuant to Article I of the Credentials Policy, all activities of the committee shall be activities of a peer review committee under Indiana and federal law.

Meetings:

The Medical Staff Quality and Peer Review Committee shall meet at least bi-monthly each year or at the call of the chair.

3.J. MEDICAL STAFF QUALITY ASSESSMENT AND UTILIZATION REVIEW COMMITTEE

3.J.1. Composition:

- (a) The Medical Staff Quality Assessment and Utilization Review Committee shall consist of at least six voting members of the Medical Staff. The committee shall have a chair and co-chair,) Section chief, and physicians representing the Hospital-based departments.
- (b) Other members shall include the following, who shall serve without a vote: President, CNO, CMO, Clinical Excellence representative, Nursing Quality, Director of Integrated Care Management, and ad-hoc consulting members may be assigned as needed.

3.J.2. Duties:

The Medical Staff Quality Assessment and Utilization Review Committee shall:

- (a) Review the organizational improvement activities and the priorities concerning the same: develop an annual plan for performance improvement activities and set priorities concerning the same;
- (b) Encourage interdisciplinary approach to performance improvement activities;
- (c) Review findings from patient satisfaction data;
- (d) Ensure that identified system improvement opportunities are referred to the proper authorities;
- (e) Ensure that identified practitioner improvement opportunities are addresses;
- (f) Utilization Management issues will be reported at least quarterly or more frequently as deemed appropriately to this committee. The committee may appoint physician/dentist outside of the committee to perform concurrent or retrospective chart reviews for utilization management. Peer review privilege applies in accordance with Indiana Peer Review Statute I.C. 34-4-12.6.1.

3.J.3. Meetings:

The Medical Staff Quality Assessment and Utilization Review Committee shall meet at least quarterly each year or at the call of the chair. A quorum will be defined as those in attendance at the meeting. Agreement of a decision is a majority consensus of votes.

3.K. PHARMACY AND THERAPEUTICS COMMITTEE

3.K.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 Director of Pharmacy, Manager, 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.

3.K.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 Section 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) oversee Drug Specialty Panels;
- (i) establish guidelines for pharmaceutical representatives; and
- (j) facilitate communication between the committee and the Institutional Review Boards.

3.K.3. Meetings:

The Pharmacy and Therapeutics Committee shall meet at least ten months each year.

3.L. TRANSFUSION COMMITTEE

3.L.1. Composition:

- (a) The Transfusion Committee shall consist of an appropriate number of members.
- (b) Other members shall include the Medical Director of Transfusion Services and representatives from sections which are high-volume users of blood components, including Surgery, Anesthesia, and Hematology/Oncology, and a medical staff representative.
- (c) The majority of the members of the Transfusion Committee shall consist of members of the Active Staff and shall include both adult and pediatric representatives.

3.L.2. Duties:

The Transfusion Committee shall:

- (a) develop and monitor policies and procedures for the ordering, distribution, handling, use and administration of whole blood and blood components;
- (b) review the adequacy of transfusion services for patient needs;
- (c) review actual or suspected transfusion reactions and sentinel events related to transfusion practice; and
- (d) evaluate blood usage, including the review of the amount of blood requested, the amount of blood used and the amount of blood wasted.

3.L.3. Meetings:

The Transfusion Committee shall meet at least quarterly or at the call of the chairman.

ARTICLE 4

AMENDMENTS

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

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual 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.

Adopted by the Medical Staff:

Approved by the Board:

Revision by the Medical Staff:

Approved by the Board: