Medical Staff Bylaws

Part IV: Organization and Functions Manual

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SECTION 1. ORGANIZATION AND FUNCTIONS OF THE STAFF

1.1 Organization of the Medical Staff

The medical staff shall be organized as a non-departmentalized staff with the following clinical services: anesthesia, dental services, emergency medicine, family practice, pediatrics, medicine, obstetrics and gynecology, optometry, orthopaedic surgery, pathology, podiatry, psychiatry, psychology, radiology, and surgery. A clinical service chief shall head each clinical service with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

1.2 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in the Practitioner Excellence Committee (PEC) documents with the ultimate responsibility lying with the MEC. The medical staff officers, clinical service chiefs (if applicable), health center and medical staff committee chairs, are responsible for working collaboratively to develop a process for communication of medical staff function activities by providing periodic reports as appropriate to the committee and to elevate issues of concern to MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care.

Additionally, medical staff officers may appoint designated physician leaders to serve on health center committees to help fulfill medical staff functions.

1.3 Description of Medical Staff Functions

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

1.3.1 Governance, direction, coordination, and action:

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

b. Account to the board and to the staff with written recommendations for the overall quality and efficiency of patient care at the health center (chief of staff and MEC);

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

d. Make recommendations on medical, administrative, and health center clinical and operational matters (chief of staff, medical directors and MEC);

e. Inform the medical staff of the accreditation and state licensure status of the health center (chief of staff, Administrator and MEC);

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

b. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities (Grand Rapids Medical Education Partners, MEC and clinical service chiefs);

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, Health Center Ethics committee);

i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the medical staff and governing body (Grand Rapids Medical Education Partners, MEC);
j. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and health center administration and the board (chief of staff, MEC)

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities (PEC)

1.3.3 Monitoring activities of physician performance should include but not be limited to the following: (See medical staff peer review policy, VP Clinical Quality)

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. Accurate, timely, and legible completion of patients’ medical records to include the quality of medical histories and physical examinations;

g. Appropriateness of clinical practice patterns;

h. Significant departures from established patterns of clinical practice;

i. Use of developed criteria for autopsies;

j. Sentinel event data;

k. Patient safety data;

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

m. Findings of the assessment process relevant to individual performance;

n. Analyzing and improving patient satisfaction.

1.3.4 Credentials review (see Credentials Procedures Bylaws Part III)

1.3.5 Information Management (Director of HIM, PEC)

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

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

   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 health center.

b. Develop, review, enforce, and maintain surveillance at least quarterly the enforcement of medical staff members and all practitioner clinical documentation as specified by health center and medical staff policy or rules and regulations.

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

1.3.6 Emergency Preparedness (MEC, Health Center Director of Organization Integrity): Assist the health center administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the health center.

1.3.7 Planning (chief of staff, MEC, clinical service chiefs, medical directors, CMO, VP strategic planning)

a. Participate in evaluating existing programs, services, and facilities of the health center and medical staff; and recommend continuation, expansion, abridgment, or termination of each;

b. Participate in evaluating 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;
c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members.

1.3.8 Bylaws review (MEC)

a. Conduct periodic review of the medical staff bylaws, rules, regulations and policies;
b. Submit written recommendations to the MEC and to the Board for amendments to the medical staff bylaws, rules, regulations and policies.

1.3.9 Nominating (MEC Nominating subcommittee)

a. Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure;
b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.10 Infection Control Oversight (Hospital epidemiologist and practitioner)

a. The medical staff oversees the development and coordination of the health 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 healthcare acquired infections;
   • Review of prevalence and incidence studies, as appropriate;
   • Collection of additional data as needed;
c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;
d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;
e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;
f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;
g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader;
h. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

1.3.11 Pharmacy and Therapeutics functions (Pharmacy and Therapeutics committee)

1.3.12 Practitioner Health (PEC, MEC ad-hoc review subcommittee)

a. Evaluate the credibility of a complaint, allegation, or concern and establish 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. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;
b. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;
c. Notify the impaired practitioner’s applicable clinical service chief and the MEC whenever the impaired practitioner’s actions could endanger patients.
d. Create opportunities for referral (including self referral) while maintaining confidentiality to the greatest extent possible;
e. Report to the PEC/MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The health center shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the health center has confidence.

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1.4 Responsibilities of the Chief of Staff

1.4.1 The chief of staff is the primary elected officer of the medical staff and is the medical staff’s advocate and representative in its relationships to the Board and the administration of the health center. The chief of staff, jointly with the MEC, provides direction to and oversees medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the medical staff bylaws, rules, regulations and policies. Specific responsibilities and authority are to:

a. Call and preside at all general and special meetings of the medical staff;
b. Serve as chair of the MEC and as ex officio member of all other medical staff committees without vote, and to participate as invited by the Board and the health center administrator on health center or Board committees;
c. Enforce medical staff bylaws, rules, regulations and medical staff/health center policies;
d. Except as stated otherwise, appoint medical staff committee chairs and all members of medical staff standing and ad hoc committees; in consultation with health center administration, appoint medical staff members to appropriate health center committees; in consultation with the chair of the Board, appoint the medical staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;
e. Support and encourage medical staff leadership and participation on interdisciplinary clinical performance improvement activities;
f. Report to the Board the MEC’s recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners or allied health professionals who are applying for appointment or privileges, or who are granted privileges or providing services in the health center;
g. Continuously evaluate and periodically report to the health center, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;
h. Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the medical staff in their relations with each other, the Board, health center management, other professional and support staff, and the community the health center serves;
i. Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting health center operations to health center administration, the MEC, and the Board;
j. Attend Board meetings and Board committee meetings as invited by the Board;
k. Ensure that the decisions of the Board are communicated and carried out within the medical staff;
l. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the medical staff bylaws.

1.5 Responsibilities of the Clinical Service Chiefs (if applicable)

a. Formulate continuing education and encourage discussion of patient care issues pertinent to that clinical specialty;
b. Conduct grand rounds as desired by physicians in the clinical service;
c. Discuss policies and procedures and recommend same to the Medical Executive Committee;
d. Discuss facility and equipment needs pertinent to that clinical service;
e. Develop reports of a specific issue at the request of the MEC;
f. Encourage participation in the development of criteria for clinical privileges and give input on an application or reapplication, when requested by credentials committee or MEC;
g. Participate in peer review activities as determined by the Practitioner Excellence Committee;
h. Collaborate with all administrative leaders as appropriate on all activities that impact the clinical service;
i. Give input to the credentials committee regarding competency criteria for privileges and comment on each member’s and licensed independent practitioner’s request for clinical privileges;
j. Coordinate inter and intra clinical service communication.

1.6 Clinical service chiefs will be selected by their clinical service and a recommendation shall be made to the MEC and the Board.

(1) Process

a. At least three (3) months prior to an election, an announcement will be made to solicit nominations.
b. Any active staff member with privileges in that clinical service may be nominated.
c. Nomination needs to be supported by five (5) members or 25% of the clinical service, whichever is less (For example, in a clinical service of 12 members, the nomination would need to be supported by 3 members. In a clinical service of 100 members, the nomination would need to be supported by 5 members).
d. Nominees will receive a list of duties and responsibilities of the office. In order for the nominee’s name to be placed on the ballot, the nominee will sign a statement indicating an understanding of the duties and willingness to serve. They are encouraged to contact the incumbent for details.
e. At least one (1) month prior to the election, the list of nominees needs to be presented to the Medical Executive Committee for the purpose of ratification.
f. Voting shall be done by secret ballot and the candidate receiving the most affirmative votes cast shall be elected.
g. The MEC and the Board will ratify the winner.
h. If a clinical service chief leaves office with more than 50% of the term remaining, this process will be repeated at the earliest reasonable convenience (not to exceed 60 days) to elect a new clinical service chief. If less than 50% of the term remains, then the vice-chief will assume the position to complete the term, after affirmation by the MEC.

SECTION 2. MEDICAL STAFF COMMITTEES

2.1 General language governing committees

The following shall be the standing committees of the medical staff. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The chief of staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease upon the accomplishment of the purpose of the committee or upon a date set by the chief of staff when establishing the committee. The chief of staff and the PRESIDENT, or their designees, are ex officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the chief of staff or by action of the MEC for failure to remain a member of the medical staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

2.2 MEC

Description of the MEC is in Part I: Governance; Section 6.2.

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2.3 Credentials Committee

Description of the credentials committee is in Part III: Credentials Procedures; Section 1.

2.4 Practitioner Excellence Committee (PEC)

2.4.1 Composition: The practitioner excellence committee will be comprised of 7 to 12 active members of the medical staff with a balanced representation of the main specialty areas of the hospital. The Vice Chief of Staff is an ex-officio member with vote and is counted as one of the members. Practitioners from other specialties may be invited to the meeting as needed.

The CMO, the CQO, the Vice President for Patient Care Services and quality support staff as determined by the Chair are ex-officio members without a vote.

The Committee members will be appointed by the Chief of Staff based on the recommendations from the Committee Chair and clinical service chiefs and approved by the MEC. Members will serve for a three year term and the terms will be staggered over three years.

The Chair of the PEC will be appointed by the Chief of Staff, and approved by the MEC for a term of one year. To be eligible for appointment as Chair, the member must have served on the committee at some point in time for at least one year when possible. The Chair may serve an unlimited number of consecutive terms as long as he/she is eligible to be a committee member. The Chair will be a voting member of the MEC.

Committee members will be expected to attend at least 50% of the committee meetings over a twelve month period to maintain membership. Committee members will be expected to participate in appropriate educational programs provided by the Hospital or Medical Staff to increase their knowledge and skills in performing the Committee’s responsibilities.

2.4.2 Meetings and Reporting: The committee will meet at least 10 times per year. The PEC will report to MEC at least quarterly. No changes can be made to the PEC and policies without approval of the MEC. The PEC will report to the Board of Directors through the MEC at least quarterly.

2.4.2 Responsibilities:

a. Evaluation of Individual Cases
   • Initial review of all cases of sufficient complexity of management or seriousness of outcome requiring practitioner peer review based on cases identified by review indicators, ongoing departmental audits or through referrals to the Medical Staff Peer Review Coordinator.
   • Obtain reviews and recommendations from specialists on the medical staff or from external specialists when required.
   • Communicate with the practitioner involved with the case to obtain input prior to making determinations when opportunities for improvement may exist.
   • Make determinations regarding individual practitioner opportunities for improvement based on individual or multiple case reviews or make determinations that focused practice evaluation is needed to further define whether an improvement opportunity is present.
   • Identify potential hospital PI opportunities for improvement as a result of case review.

b. Evaluation of Aggregate Data
   • Perform ongoing review and evaluation of aggregate data and of adverse patterns, trends and outlier status. The purpose of this review is to determine if additional
analysis or focus professional practice evaluation are needed. This function may be
delegated to an individual member of the committee or to a subcommittee.

- Identify potential individual practitioner opportunities for improvement and determine
  if focused practice evaluation or additional analysis or focus studies are needed to
  further define whether an improvement opportunity is present.
- Identify potential medical staff or hospital PI opportunities for improvement as a
  result further analysis of aggregate data.
- Identify excellence in practitioner practice to determine best practices for
  dissemination.

c. Improvement Opportunities

- The role of the PEC is to assure when opportunities for improvement are identified,
  the appropriate individuals are notified of the issues and a reasonable improvement
  plan is developed. This will be accomplished through the following:

  - Communicate individual improvement opportunities to the appropriate clinical
    service chief, who, with the assistance of the PEC Chair, Chief Quality Officer
    (CQO) or designee, and if requested, the CMO, develops an improvement plan if
    necessary.
  - Communicate system improvement opportunities to the appropriate hospital
    committee.
  - Track responses and improvement plans
  - Report to the MEC regarding actions taken to improve care and any cases where
    action was not taken when requested or actions are perceived to be inadequate.

d. Measurement System Management

- Recommend to the MEC requests to the quality management department for
  additions or deletions to indicators, criteria or focused studies for evaluating
  practitioner performance.
- At least annually review the indicators, screening tools and referral systems for
  effectiveness in collaboration with the medical staff clinical service chiefs and
  recommend changes to the MEC.
- It is the expectation that all clinical services will participate in development of
  specialty-specific indicators in comparison with established benchmarks and norms
  (evidence-based medicine). If clinical services fail to provide recommendations, the
  PEC will have the authority to develop and implement specialty-specific indicators.
- It is understood that sub-specialty databases obtained using hospital resources
  belong to the medical staff and not individual clinical services or specialties. All data
  from these sources shall be shared with the PEC when requested.
- In coordination with the Credentials Committee, define the appropriate content and
  format for practitioner performance feedback reports.

e. Oversight of Other Medical Staff Practitioner Performance Evaluation Committees

- Although the vast majority of initial review of individual cases, along with aggregate
  data results, will be performed by the PEC, some medical staff clinical services or
  committees will continue to perform some of these functions either as a quality
  control mechanism or as a multi-disciplinary educational process. Such discussions
  will be considered part of the medical staff quality function and are protected from
  discovery as long as the appropriate policies and procedures of the MEC are
  followed. The PEC will have oversight of the process used to perform this review
  and the indicators selected by the specialty.

The following areas may perform this function as described below:

- Image Based Specialties (Pathology, Radiology, Cardiac Images): Image Based
  Specialties may perform routine quality reviews of diagnostic image interpretation by
  Practitioners (e.g. surgical pathology or cytology slides, radiological images).
- Trauma: The Trauma Committee will continue to perform its functions under the
  required ACS standards.
- Cancer: The Cancer Committee will continue to perform its functions under the
  required certification standards.
• Emergency Department: The Emergency Department may perform review of specific processes and outcomes as appropriate for departmental performance improvement and education.
• Anesthesia Department: The Anesthesia Department may perform review of the processes and outcomes of care provided in the Anesthesia Department.
• Neonatal Services: The Neonatal Service may perform review of the processes and outcomes of care in the NICU.
• Obstetrics (Obstetricians, Family Medicine physicians with core obstetric privileges, and certified nurse midwives): Obstetric Specialties may perform routine quality reviews of obstetric procedures by Practitioners (e.g., injury to neonate, elective delivery prior to 39 weeks completed gestation).

Cases resulting in significant adverse outcomes potentially related to Practitioner care as defined by review indicators will be referred to the quality office to initiate the PEC peer review process.

For those indicators determined by the MEC as reportable to the medical staff, the department will report the results to the PEC.

2.4.3 The committee shall be responsible for those functions described in 1.3.11 above and reports to the (MEC or medical staff quality committee).

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

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;

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. Approve policies and procedures related to the Joint Commission 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 and therapeutics use within the health center;

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

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

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

j. Serve as an advisory group to the health center and medical staff pertaining to the choice of available medications;

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

2.5 Cancer Committee

2.5.1 Composition: The cancer committee shall be multidisciplinary and comprised of the following members to maintain certification by the American College of Surgeons Commission on Cancer as a Community Health Center Cancer Program.

- Diagnostic Radiologist
- Oncologic Surgeon
- Pathologist
Medical Oncologist
Radiation Oncologist
Family Practice
Cancer Liaison Physician
Medical Director of the Cancer Program
Administrative Director of the Cancer Program
Cancer Registrar
Oncology Nurse
Nutrition Specialist
Pastoral Care
Palliative Care
Oncology Social Worker
Grand Rapids Clinical Oncology Program
American Cancer Society

2.5.2 Responsibilities: The cancer committee provides responsible, accountable program leadership for the Cancer Program activities as described in the Standards of the Commission on Cancer and reports to the MEC or PEC.

a. Develops and evaluates the annual goals and objectives for the endeavors related to cancer care.
b. Establishes the cancer conference frequency and format on an annual basis.
c. Establishes the multidisciplinary attendance requirements and attendance rate for cancer conferences on an annual basis.
d. Ensures that the required number of cases are discussed at the cancer conference on an annual basis and that at least 75% of the cases discussed are presented prospectively, and that AJCC or other appropriate stage of the case is discussed and documented for the five major sites seen at Mercy Health Saint Mary’s.
e. Monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis.
f. Establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis. The plan includes procedures to monitor case-finding, accuracy of data collection (especially the accuracy of collaborative stage), abstracting timeliness, follow-up, and data reporting.
g. Analyzes patient outcomes and disseminates the results of the analysis.

2.6 Pharmacy and Therapeutics Committee

2.6.1 Composition: The pharmacy and therapeutics committee shall consist of at least four (4) members of the medical staff. Representatives from pharmacy, nursing service, other disciplines and health center administration will serve as ex officio members.

2.6.2 Responsibilities: The committee shall be responsible for those functions described in 1.3.11 above and reports to the (MEC or medical staff quality committee).

a. Maintain a formulary of drugs approved for use by the health center;
b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;
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. Approve policies and procedures related to the Joint Commission 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 and therapeutics use within the health center;
g. Develop and measure indicators for the following elements of the patient treatment functions:
• Prescribing/ordering of medications;
• Preparing and dispensing of medications;
• Administrating medications;
• Monitoring of the effects of medication.

h. Analyze and profile data regarding the measurement of the patient treatment functions by service and practitioner, where appropriate;
i. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;
j. Serve as an advisory group to the health center and medical staff pertaining to the choice of available medications;
k. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

2.7 Trauma Coordinating Committee:

2.7.1 Composition:

The trauma services committee shall include the director of trauma program; chiefs of surgery and emergency medicine; medical director of Intensive Care Unit (SICU), or designee; chair of emergency preparedness committee; and medical staff representatives from the following: anesthesia, emergency medicine, neurosurgery, orthopedic surgery, pediatrics, and radiology; nurse managers from: emergency medicine, ICU, and surgery; trauma coordinator; trauma registrar; clinical nurse specialist.

2.7.2 Responsibilities:

The committee develops policies and procedures for the trauma service, oversees the on-call schedule, develops trauma-related educational programs based on the results of its evaluation of trauma care and programs on trauma prevention for the community, evaluates human and equipment resources and makes recommendations for capital expenditures, reviews the trauma registry, and reviews, evaluates, and discusses the quality of care in cases of adverse outcomes (complications and deaths) particularly focusing on those deaths statistically expected to survive, which were identified using outcome norms. Reviews monthly statistics based on injury severity score and revised trauma score as they relate to outcomes and provides a trend analysis of complications and reports to the (MEC or medical staff quality committee).

SECTION 3. CONFIDENTIALITY, IMMUNITY, AND RELEASES

4.1 Confidentiality of information

To the fullest extent permitted by law, the following shall be kept confidential: information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided; evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; contributions to teaching or clinical research; or determinations that healthcare services were indicated or performed in compliance with an applicable standard of care. This information will not be disseminated to anyone other than a representative of the health center or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

4.2 Immunity from liability:

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of
his/her duties as an official representative of the health center or medical staff or for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

4.3 Covered activities:

The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

- applications for appointment/affiliation, clinical privileges, or specified services;
- periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
- corrective or disciplinary actions;
- hearings and appellate reviews;
- quality assessment and performance improvement/peer review activities;
- utilization review and improvement activities;
- claims reviews;
- risk management and liability prevention activities;
- other health center, committee, clinical service, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

4.4 Releases:

Each practitioner shall, upon request of the health center, execute general and specific releases when requested by the chief of staff or his/her respective designees. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

Adoption and Approval

Adopted by:

______________________________  ________________________________
Chief of Staff  Date

______________________________  ________________________________
President, Mercy Health Saint Mary's  Date

______________________________  ________________________________
Chairperson, Board  Date

This electronic version is the official document as adopted and approved by the Chief of Staff, Chief Executive Officer, and Chairperson of the Board.