SECTION 18.1 - DESIGNATION AND SUBSTITUTION

There shall be a Medical Executive Committee (MEC) and such other standing or special committees delegated certain duties by the Medical Executive Committee as deemed necessary and desirable to perform medical staff functions listed in these bylaws. Those functions requiring Medical Staff participation rather than direct oversight by the medical staff may be discharged by medical staff representation on such hospital committees as are established to perform such functions.

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to the Medical Executive Committees or a department, but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

Committees shall be standing and special to carry out the assigned responsibilities of the Medical Staff, including but not limited to those functions required by regulatory and accrediting agencies and deemed advisable by the clinical departments and/or Medical Executive Committee. Staff committees shall be appointed by the Chief of Staff and the Chairman and Vice Chairman indicated, with the exception of the Medical Executive Committee and Departmental Committees. Each Chairperson shall be responsible to see that the functions and duties are fulfilled and completely discharged. Each committee will record the attendance and transactions of all meetings, and may submit an annual report to the General Staff at the Annual Meeting.

To the extent that a standing committee performs a peer review function under this Article XVIII, the Mercy Health Muskegon (Mercy Health Muskegon will hereinafter be referred to as HOSPITAL) Board hereby deems the standing committee a duly appointed peer review committee for purposes of MCL §331.531 et. seq., §333.20175, and §333.21515, as amended, especially for the purpose of immunity from civil and criminal liability and all other immunities available under Michigan and federal law. Peer review bodies also include the HOSPITAL Board and any committee of the HOSPITAL Board.

Special committees shall be appointed from time to time as may be required to carry out properly the duties of the Medical Staff. Such committees shall confine their work to the purposes for which they were appointed, and shall report to the Medical Executive Committee. They shall not have the power of action unless such is specifically granted by the motion which created the committee.

No special committee shall be formed for a peer review function unless it is formed by the Medical Executive Committee with the specific intent to operate exclusively for a peer
review function, the nature of that peer review function shall be clearly and specifically stated in the minutes of the Medical Executive Committee. Where time is of the essence, the Medical Executive Committee may retroactively ratify the formation of such a peer review special committee. For purposes pursuant to MCL §331.531, et. seq., §333.20175, and §333.21515 as amended, especially for the purpose of immunity from civil and criminal liability, all special committees formed for a peer review function are hereby deemed to be duly appointed by the HOSPITAL Board. Once a special committee completes the peer review function for which it was formed, it shall immediately and automatically cease to exist.

The committees that perform peer review are outlined below. The committees include, but are not limited to the following: Cancer, Credentials, Cardiovascular Surgery Quality Review, Continuing Medical Education, Ethics, Infection Prevention and Control, Institutional Review Board, Medical Education, Medical Executive Committee, Medical Library, Medical Review, Osteopathic Principles & Medical Records, Pharmacy and Therapeutics, Surgical Review, Trauma Morbidity & Mortality Committee, Trauma Operations Process Improvement Committee, Utilization Management, and the investigative, hearing and appeal bodies described in these Bylaws. Peer review functions are also performed in the clinical departments and sections of the Medical Staff, by the Medical Staff Officers, and by the participants in the investigations, hearings and appeals described in these Bylaws, all of whom are assigned peer review functions. Employees of the HOSPITAL are assigned and perform professional practice review functions by providing information, records, data and knowledge to, gathering information for, and otherwise assisting, individuals and committees in the performance of their professional practice review functions.

All records, data, and knowledge collected by or for individuals and committees assigned peer review functions shall be confidential, shall be used only for carrying out such functions, and shall be made available only to other persons and entities that have been assigned such functions for the HOSPITAL or the "review entity” described in Section 6.1.1. Such records, data and knowledge shall be entitled to the protection of the Michigan laws cited in this Section.

A. **CANCER COMMITTEE**

1. The Cancer Committee shall be a standing committee of the HOSPITAL Medical Staff.

2. The Cancer Committee shall monitor the quality of all oncology services provided to HOSPITAL cancer patients.
3. The Cancer Committee composition shall be multidisciplinary and will include physicians from the diagnostic and treatment specialties representative of our facility, including Diagnostic Radiology, Pathology, General Surgery, Medical Oncology, Radiation Oncology, Pain Management, and others as deemed necessary. The Cancer Committee must include a physician as chair, along with the designated Cancer Liaison Physician. Non-physician members will include representatives from Administration, Oncology Nursing, Social Work, Quality Management, and a Certified Tumor Registrar, along with others as deemed appropriate and as outlined in the requirements of the most current Commission on Cancer, Cancer Program Standards: Ensuring Patient-Centered Care, for a Comprehensive Community Cancer Program (CCCP).

4. The Cancer Committee shall meet at least quarterly. The meeting schedule shall be expected to fulfill overall program needs and may require the committee to meet more frequently or establish subcommittees as needed to fulfill its goals.

5. The Cancer Committee, under the leadership of the Committee Chair, shall be responsible for the development and evaluation of annual goals and objectives for the clinical, educational, and programmatic endeavors related to cancer care at HOSPITAL. The Cancer Committee Chair shall be responsible for guiding the Committee through the development and evaluation of the annual goals, setting time frames for evaluation and completion, assigning coordinators, and overseeing the responsibilities of other Committee members.

6. The Cancer Committee shall promote team involvement and shared responsibilities by designated one member of the Cancer Committee to coordinate each of the six major areas of program activity. An individual cannot fulfill more than one coordinator role. The Coordinators are as follows:
   - Cancer Conference Coordinator
   - Cancer Registry Quality Coordinator
   - Quality Improvement Coordinator
   - Community Outreach Coordinator
   - Clinical Research Representative or Coordinator
   - Psychosocial Services Coordinator
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The Cancer Committee shall be responsible for defining the responsibilities of each role, and these shall be documented in the Policies and Procedures of the HOSPITAL Cancer Program Manual and shall include procedures for each member’s role in contribution, monitoring, reporting, and recommending improvement if activity falls below requirements or goals.

7. The Cancer Committee shall establish and monitor the cancer conference frequency, format, attendance requirements, clinical responsibilities and evaluation of same annually. Conferences will include prospective case presentations, encourage multidisciplinary involvement, contribute to patient management and outcomes, and provide education by being made available to the entire medical staff and others. A minimum of 15% of the annual analytical case load will be presented at cancer conference, at least 80% of these will be prospective, and AJCC or other appropriate stage will be discussed and documented.

8. The Cancer Committee shall establish and implement a plan to evaluate the quality of cancer registry data and activity annually. This will include procedures to monitor case finding, accuracy of data collection (including collaborative stage), abstracting timeliness, follow-up, and data reporting.

9. The Cancer Committee shall perform clinically meaningful analyses of the HOSPITAL patient diagnosis, treatment, and outcomes to ensure that quality care is administered to cancer patients. Specific oversight responsibilities and duties for monitoring activity related to the quality improvement program are addressed in the Policies and Procedures of the HOSPITAL Cancer Program Manual.

B. CONTINUING MEDICAL EDUCATION COMMITTEE

There shall be a CME Committee with the focus of enhancing physician competence and performance to provide a healthier community. The membership of the core committee will include the Director of Medical Education, medical librarian, two family practice physicians and the Medical Activity Directors from the major Regularly Scheduled Series (RSS). Other members will be chosen to represent collaborative relationships with Quality, Patient Safety, Risk Management, Pharmacy, and the County Health Department.

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1. The CME Committee shall meet as often as necessary but at least three times annually to oversee the CME program.

2. Major functions shall be to:
   a. Guarantee the CME program meets the Accreditation Council for Continuing Medical Education (ACCME) Essential Areas and their Elements;
   b. Monitor compliance with all Michigan State Medical Society (MSMS) Committee on CME accreditation requirements;
   c. Monitor compliance with the Council on CME of the American Osteopathic Association (AOA) accreditation requirements;
   d. Establish and continually revise Policies and Procedures that comply with ACCME guidelines;
   e. Guarantee the CME Director and Coordinator attend regional and national CME Conferences as required.

C. CREDENTIALS COMMITTEE

There shall be an Integrated Credentials Committee with membership appointed by the Chief of Staff with cross-departmental representation to include representation from the HOSPITAL/MHLC/AHN.

1. The Credentials Committee shall meet as often as necessary but at least quarterly.

2. Major Functions shall be to:
   a. Adhere to guidelines as set forth in Bylaws, Article VI;
   b. Process all initial applications for Medical Staff membership and privileges;
   c. Process all reapplications for Medical Staff membership and privileges at least every two years which includes reports on quality of care issues from all Medical Staff committees; and
   d. Make recommendation on initial appointment, reappointment, and clinical privileges to Medical Executive Committee in a timely fashion.

D. ETHICS COMMITTEE

Statement of Purpose: As a faith-based, mission-driven organization founded on the traditions of our Catholic sponsors, Mercy Health Muskegon is committed to differentiating itself as a recognized leader in the area of healthcare ethics. The
Office of the Chief Executive Officer (“CEO”) is responsible for ensuring that the organization achieves this commitment, and oversees initiatives that assure consistent and collaborative attention to the integration, delivery and practice of healthcare ethics throughout Mercy Health Muskegon.

To effectively fulfill this role, the CEO has chartered the Ethics Committee as an administrative body responsible for fostering a culture mindful of the role of intentional ethical reflection in the healthcare environment, offering leadership and expertise in the area of healthcare ethics and ethical deliberation, and carrying out the practice of ethics respectful of the dignity of every person, attentive to the commitment to care for the body, mind and spirit of our patients, residents, families and colleagues, and our community.

Membership: The Ethics Committee is a multidisciplinary committee of the Medical Staff and is composed of attending physicians drawn from a variety of specialties and representatives from nursing, mission integration, social work, hospital administration, pastoral care, law, and psychiatry. The VP and Chief Medical Officer serves as the Chair of the Ethics Committee.

There should be at least one community member who is not a member of the medical staff or hospital employee and one member from the Trinity Home office Ethics Department. Members should have an interest in clinical and organizational ethics and show effort in continuing education.

A quorum consists of voting members present at each meeting. The Chief Medical Officer, in consultation with the Vice President of Mission Services will appoint members and serve as the executive sponsor of the Ethics Committee. The office of Mission Services will be responsible for meeting schedules, agendas, minutes, and the arrangement of appropriate staff support for committee activities.

Focus and Responsibilities: The Ethics Committee will focus on developing practices and initiatives that serve to integrate healthcare and organizational ethics into the culture of Mercy Health Muskegon. To this end, the committee will be responsible for:

**EDUCATION:** In cooperation with hospital administration, its various departments, and medical, nursing, and allied health staffs, the committee will undertake educational efforts in clinical and organizational ethics. Depending on the availability of resources, the committee will develop or assist others in the development of lectures, seminars, rounds, in-service programs, or online content
that advance ethics education at Mercy Health Muskegon. The purpose of these educational efforts is to provide participants with access to the ethical concepts, language and principles they need to address the complex ethical dimensions of medicine and the hospital organization.

**POLICY DEVELOPMENT AND REVIEW:** The committee will work with hospital administration to develop policies and procedures regarding ethical issues, questions, or problems that arise in the care of patients. The committee may provide analysis of the ethical aspects of existing or proposed policy or assist in the development of new policy when indicated. Policy development will be guided by evidence-based medicine, current organizational and business development principles, and take into consideration our Catholic identity as articulated in the Ethical and Religious Directives for Catholic Healthcare Services.

**CASE REVIEW/CONSULTATION:** The committee will provide a forum for the analysis of ethical questions that arise in the care of patients and their families. The goal of the committee is to respect the rights and promote the interests of the patient, clarify the issues, promote mutual education and support all individuals involved in the care encounter. In this role, the committee will provide support and counsel to those responsible for treatment decisions including health care providers, patients, surrogates, and members of the patient's family, acting in an advisory capacity, not as a decision-maker, but attempting to support/assist those who do have this responsibility.

Case review/consultation is recommended for these categories:
- Decisions regarding significant ethical ambiguity and perplexity in which case review might provide insight into complex ethical issues.
- Decision involving disagreement between health care providers or between providers and families/surrogates/patients regarding the ethical aspects of a patient's care.
- Decision that involve withdrawal of or with-holding of life-sustaining treatments which are not adequately addressed in hospital policies.

**Communication:** Communication will be accomplished through meetings, program documents, email, and the use of internet collaboration technologies.

**Meetings:** The Ethics Committee will meet every other month.

If necessary, subcommittees can be formed to address what is required to successfully develop, implement, and sustain a specific initiative or committee activity. Subcommittees will appoint a Chair and be responsible for scheduling, minutes, and the development of any related deliverables.
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The agenda for each Ethics Committee meeting and any related materials will be distributed a week in advance of each meeting. Members will be responsible for bringing their own printed or electronic copies of the meeting materials to each meeting.

Minutes: Minutes of each meeting will be taken by the Executive Administrator for the Vice President of Mission Services and distributed to team members. Review and approval of meeting minutes will be included as a standing item on the next meeting agenda. Minutes will be archived in the Mission Services Department.

E. GRADUATE MEDICAL EDUCATION COMMITTEE

There shall be a Graduate Medical Education Committee (GMEC) comprised of, at a minimum: the Designated Institutional Official (DIO), a representative sample of Program Directors, a minimum of 2 peer-elected residents, and one of the Quality Directors. Additional members may be nominated as necessary to carry out the function of the GMEC and its subcommittees. The Chair shall be the DIO.

1. The Graduate Medical Education Committee shall meet as often as necessary but at least 6 times per year and subsequently submit an annual written report to the Medical Executive Committee as well as to the Board of Trustees.

2. Major functions shall be to:
   a) Monitor and advise the institution on all aspects of residency education;
   b) Establish and implement institutional policies and procedures for the selection, evaluation, promotion, and dismissal of residents;
   c) Assure appropriate and equitable funding for resident positions, including benefits and support services;
   d) Oversee curriculum (both institutional and program specific) to ensure that all graduate medical education is compliant with the respective Program Requirements;
   e) Establish and implement institutional policies and procedures for discipline and the adjudication of complaints and grievances relevant to the GME programs. These policies and procedures must satisfy the requirements of fairness and due process;
   f) Monitor and oversee appropriate supervision, working conditions, and work hours for residents;
   g) Oversee and review the Medical Library functions;
h) Ensure that all participants in professional Graduate Medical Education Programs shall be supervised in his/her patient care responsibilities at Mercy Health Muskegon by a licensed practitioner who has been granted clinical privileges through the Medical Staff Credentialing process;

i) Maintain oversight of ACGME accreditation of both the Institution and each accredited Program;

j) Review and approve each Program and the Institution Annual Reviews;

k) Review and approve any major changes to any accredited program including, but not limited to: closure, change in resident compliment, change in Program accreditation status, changes in the Sponsoring Institution or its affiliations;

l) Review and approve:
   1) Institutional GME policies and procedures;
   2) Annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits;
   3) Applications for ACGME accreditation of new programs;
   4) Requests for permanent changes in resident/fellow complement;
   5) Major changes in each of its ACGME-accredited programs' structure or duration of education;
   6) Additions and deletions of each of its ACGME-accredited programs' participating sites;
   7) Appointment of new program directors;
   8) Progress reports requested by a Review Committee;
   9) Responses to Clinical Learning Environment Review (CLER) reports;
   10) Requests for exceptions to duty hour requirements;
   11) Voluntary withdrawal of ACGME program accreditation;
   12) Requests for appeal of an adverse action by a Review Committee; and
   13) Appeal presentations to an ACGME Appeals Panel.

m) The GMEC must demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review (AIR) and must identify institutional performance indicators for the AIR which includes:
   - Results of the most recent institutional self-study visit;
   - Results of ACGME surveys of residents/fellows and core faculty members; and
• Notification of each of its ACGME-accredited programs' accreditation statuses and self-study visits.

The AIR must include monitoring procedures for action plans resulting from the review. The DIO must submit a written annual executive summary of the AIR to the Governing Body; and

n) The GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process. The Special Review process must include a protocol that establishes criteria for identifying underperformance and results in a report that describes the quality improvement goals, the corrective actions and the process for GMEC monitoring outcomes.

F. INFECTION PREVENTION AND CONTROL COMMITTEE

Composition: The IPC shall consist of a minimum of four (4) members of the Medical Staff, including representation from Medicine, Emergency Services and Surgery. Infection Prevention and Control staff and a representative for each Nursing Service (Medical, Surgery, OB, Critical Care and ED), representative for Laboratory Microbiology Section, Administration, Sterile Processing Dept. and Environmental Services. Representatives from other clinical service departments of the hospital shall be available at least on a consulting basis as the need arises. The IPC shall meet at least quarterly or more often as necessary.

Functions: The Infection Prevention and Control Committee shall be responsible for:

• The development, maintenance and surveillance of an active house wide Infection Prevention and Control Program based on the Infection Control risk assessment which is included in the Infection Prevention and Control Plan.
• Make recommendations of actions concerning prevention and control of infectious diseases.
• Responsible for the development, maintenance and review of specific written infection prevention and control policies and procedures for the hospital and for all services throughout the hospital.

Meetings/Records/Reporting: The committee shall meet quarterly, maintain a record of its minutes, recommendations and activities, and shall report thereon to the Executive Committee quarterly.
G. **INSTITUTIONAL REVIEW BOARD**

There shall be an Institutional Review Board with the purpose of assuring, both in advance and by periodic review, that appropriate steps are taken to protect the rights and welfare of human subjects participating as subjects in research.

The IRB is comprised of no less than five persons with a diversity of backgrounds, professions, and genders. Specifics of IRB composition are outlined in the Administrative Manual, Section: Pharmacy, Institutional Review Board, Policy #1.

1. The Institutional Review Board shall meet as often as necessary, but at least quarterly.
2. Major functions shall be to:
   a. Receive, review and approve new research protocols for use in patients at HOSPITAL.
   b. Receive, review and approve ongoing research protocols as often as necessary, but at least annually for use on patients at HOSPITAL.
3. The IRB actions are subject to review by the Medical Executive Committee, Board Quality Committee, and the Board of Trustees of Mercy Health Muskegon.
4. Minutes of the IRB meetings shall be forwarded to the Medical Executive Committee for review.
5. Further information may be found in the Administrative Manual, Section: Pharmacy, Institutional Review Board, Policy #1.

H. **MEDICAL EXECUTIVE COMMITTEE** – See Bylaws Section 18.2

I. **MEDICAL LIBRARY**

**Composition:** The Medical Library Committee shall consist of at least three members of the Medical Staff, appointed by the Chief of Staff. The Medical Librarian shall be a member ex-officio of this committee.

**Functions:** The Medical Library Committee shall be responsible for developing and maintaining a comprehensive Medical Library, to review the Library policies and procedures; to evaluate the effectiveness of the Library in meeting the informational and educational needs of its users; and to establish priorities in the selection of new
texts, the selection or renewal of journals, and the acquisition of other Library materials.

Meetings/Records/Reporting: The Medical Library Committee shall meet at least semi-annually or more often as called by the Chairman of the committee. It shall maintain a record of its proceedings and report to the Executive Committee.

J. MEDICAL REVIEW COMMITTEE

There shall be a Medical Review Committee chaired by the Chief of the Department of Medicine with representation from the department, sections, and services, the Board Quality Committee, and the Chief Medical Officer, and the Medical Director(s) of Quality and Safety, or appropriate designees.

1. The Medical Review Committee shall meet as often as necessary but at least ten times annually.

2. Major Functions shall be to:
   a. Develop, monitor, and implement clinical performance measures and clinical indicators to identify opportunities to improve patient care;
   b. Measure and assess the care provided in the Department of Medicine;
   c. Conduct peer review and provide oversight of the peer review and ongoing monitoring performed within the Department of Medicine;
   d. Review care and management of all mortality cases including results of autopsy pertinent to the Department of Medicine;
   e. Review the appropriateness of operative, invasive, and non-invasive procedures pertinent to the Department of Medicine;
   f. Review the correlation among preoperative, postoperative, and tissue diagnoses by assessing major discrepancies or patterns of discrepancy pertinent to the Department of Medicine;
   g. Analyze important single events, levels of performance, and patterns or trends that vary significantly and undesirably from the expected;
   h. Analyze comparative peer review performance data; and
   i. Provide routine reports and recommendations on medical staff quality activities to the Medical Executive Committee and Credentials Committee as appropriate.
K. OSTEOPATHIC PRINCIPLES/MEDICAL RECORDS COMMITTEE

There shall be an Osteopathic Principles/Medical Records Committee and it shall include the subcommittees listed below. The Osteopathic Principles Committee shall provide routine reporting on quality activities and peer review to the Medical Review Committee, Surgical Review Committee, and Medical Executive Committee.

1. Osteopathic Methods Subcommittee

The Osteopathic Methods Subcommittee shall meet at least quarterly or as often as needed. The subcommittee may have representatives from the Departments of Medicine and Surgery. The subcommittee chairperson shall be an osteopathic physician.

   a. Major functions shall be to:
      1) Develop recommendations to improve the utilization of osteopathic principles and practice, the documentation of the osteopathic findings, the description of osteopathic manipulative treatment, and the application of such modalities as part of the comprehensive care received by patients;
      2) Develop retrospective and concurrent audits of patient charts relating the application of osteopathic principles and practice to patient diagnosis and treatment; and
      3) Share patient chart evaluations done by the committee with osteopathic physicians to improve utilization of osteopathic principles and practices.

2. Utilization Management Subcommittee

The Utilization Management Subcommittee shall consist of two or more practitioners, of which at least two must be doctors of medicine or osteopathy. Committee membership shall represent a cross section of clinical departments and services.

   a. The HOSPITAL medical records administrator shall be an advisor to this committee.

   b. Utilization reviews may not be conducted by any individual who has financial interest in the cases being reviewed or was professionally
involved in the cases being reviewed.

c. The functions of this subcommittee shall be development and implementation a utilization management plan for HOSPITAL.

d. The subcommittee shall meet at least quarterly; part of its function shall be to render assistance to the professional staff to ensure that all required subcommittee functions are carried out.

e. The Utilization Management Plan shall provide for review for Medicare and Medicaid patients with respect to the medical necessity of:
   1) Admissions to HOSPITAL facilities;
   2) The duration of stays; and
   3) Continuum of care.

f. Review of admissions may be performed before, at, or after HOSPITAL admission.

3. **Medical Records Subcommittee**

   a. The Medical Records Subcommittee shall assure accurate and timely completion of medical records. The Medical Records Subcommittee shall meet at least quarterly. The subcommittee shall be composed of at least two physicians representing a cross section of the Medical Staff.

   b. Major Functions shall be to:
      1) Review clinical pertinence;
      2) Recommend major changes to forms and formats of the medical record;
      3) Approve the abbreviation list;
      4) Develop the policy and procedures for the maintenance of the medical record; and
      5) Develop the policy and procedures for release of information.

L. **PHARMACY AND THERAPEUTICS COMMITTEE**

   The Pharmacy and Therapeutics Committee shall be a multidisciplinary committee. The medical staff membership is appointed by the Chief of Staff
utilizing representation from the Departments of Medicine and Surgery.

Composition: The committee shall consist of at least (6) physicians, one who shall serve as the chairperson, the Medication Safety Officer of the Hospital, the Nurse Executive and/or his/her representatives, the Medical Director or his/her representative, representative from Nutritional Services, pharmacist, Quality/Safety Risk Manager.

Scope: The Pharmacy & Therapeutics Committee exists as part of the hospital medical staff and the overall patient safety program. This committee is selected under the guidance of the medical staff, and it is also a policy and procedure recommending body to the medical staff and administration of the hospital on all matters related to the use of medication.

Purpose:
- Policy: The committee adopts and assists in the formulation of broad professional policies regarding evaluation, selection, procurement, distribution, safe use practices and other matters pertinent to drugs in the hospital. This committee refers issues regarding the effect of medications of the patient(s) to the Medical Review Committee, or other Medical Staff Committees as indicated.
- Educational: The committee recommends or assists in the formulation of programs designed to meet the needs of the professional staff (physicians, nurses and pharmacists) for complete knowledge on matters related to drugs and drug practice.

Functions: This committee shall perform the following specific functions:

1. The Pharmacy and Therapeutics Committee shall meet as often as necessary but at least eight times annually.
2. Recommendations of the Pharmacy & Therapeutics Committee shall be presented to the Executive Committee.
3. To serve in an advisory capacity to the hospital and medical staff, in all matters pertaining to the use of medications.
4. To serve in an advisory capacity to the medical staff and the Pharmacy, in the selection or choice of drugs which meet the need in relation to the diseases treated in this institution. Selection of drugs for facility use is based on criteria which encompass the effectiveness of the drugs, the risks associated with the drugs (i.e., medication errors, abuse potential, and sentinel events) and the costs of financial impact.
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5. To prevent unnecessary and costly duplication of identical chemical entities or combinations of drugs in the formulary.

6. The committee shall be responsible for the development of a basic drug list or formulary of accepted medications to be used in the hospital which will be continually reevaluated and revised to ensure the distribution of the most effective, newest, safest, and most economical therapeutic agents available.

7. To recommend policies regarding the safe use of drugs in the hospital including such matters as investigational drugs, hazardous drugs and others.

8. To make recommendations for the solutions of problems involved in the appropriate preparing, labeling distribution and administration of medications for inpatients and outpatients.

9. To review all reported adverse reactions (both significant and minor) to drugs administered to the patients.

10. To evaluate the drug therapy component of the patient’s medical records.

11. To present recommendations of the committee to the medical staff for decisions regarding medical procedures and problems. The Executive Committee has final authority regarding the administrative responsibilities in carrying out the recommendations of the medical staff.

12. To monitor implementation of the written Pharmacy and all drug related policies and procedures and make recommendations for improvement. The Pharmacist in consultation with other appropriate health professionals and administration shall be responsible for the development and implementation of procedures. Policies and procedures shall be reviewed and/or revised at least annually.

13. To annually evaluate all services provided and make recommendations to the Executive Committee of the medical staff, administration, and the Governing Body.

14. To make recommendations concerning drugs to be stocked in hospital patient care units or services.

15. To plan suitable educational programs for the professional staff or pertinent matters related to drugs and their use.

16. To study problems related to the administration of medications.

17. To approve and review protocol orders for drugs used for specified patients and physicians.

18. To review and approve limiting durations of drug therapy.

19. To review and approve all emergency and override (Pyxis) medications stocked in the hospital.

20. To review Blood and Blood Component data on a quarterly basis.
M. **SURGICAL REVIEW COMMITTEE**

There shall be a Surgical Review Committee chaired by the Chief of the Department of Surgery with representation from the department, sections, and services, the Board Quality Committee, and the Chief Medical Officer, and the Medical Director(s) of Quality and Safety, or appropriate designees.

1. The Surgical Review Committee shall meet as often as necessary but at least ten times annually.

2. Major Functions shall be to:
   a. Develop, monitor, and implement clinical performance measures and clinical indicators to identify opportunities to improve patient care;
   b. Measure and assess the care provided in the Department of Surgery;
   c. Conduct peer review and provide oversight of the peer review and ongoing monitoring performed within the Department of Surgery;
   d. Review care and management of all mortality cases including results of autopsy pertinent to the Department of Surgery;
   e. Review the appropriateness of operative, invasive, and non-invasive procedures pertinent to the Department of Surgery;
   f. Review the correlation among preoperative, postoperative, and tissue diagnoses by assessing major discrepancies or patterns of discrepancy pertinent to the Department of Surgery;
   g. Analyze important single events, levels of performance, and patterns or trends that vary significantly and undesirably from the expected;
   h. Analyze comparative peer review performance data; and
   i. Provide routine reports and recommendations on medical staff quality activities to the Medical Executive Committee and Credentials Committee as appropriate.

N. **TRAUMA MORBIDITY AND MORTALITY (M&M) COMMITTEE**

The Trauma M&M Committee is a multi-disciplinary peer review committee functioning under the auspices of the Medical Executive Committee.

**Scope:** The charge of the committee is to evaluate the care of trauma patients who have been admitted to the hospital for observation/full admission/surgical procedure, as well as mortalities and transfers to another facility. Trauma M&M
will also discuss quality issues forwarded for tertiary review and participate in identification of improvement opportunities to improve patient outcomes.

Membership: Membership includes all trauma surgeons, trauma medical director, trauma program manager, trauma registrar, quality support staff, and liaisons from orthopaedic surgery, anesthesia, emergency medicine, radiology, and neurosurgery. Additional attendees will be invited ad hoc.

Meetings: Committee meets monthly no less than ten times annually with 50% or greater attendance of peer review representatives and core surgical staff.

O. TRAUMA OPERATIONS PROCESS IMPROVEMENT COMMITTEE

The Trauma Operations Process Improvement Committee (TOPIC) is a multi-disciplinary systems review committee functioning under the auspices of the Medical Executive Committee.

Scope: The charge of the committee is to evaluate care of the trauma patients who have been admitted to the hospital for observation/full admission/surgical procedure, as well as mortalities and transfers to another facility. All care including pre-hospital through to rehab, death, or discharge shall be reviewed. TOPIC will also discuss quality issues forwarded for tertiary review and participate in identification of improvement opportunities to improve patient outcomes.

Membership: Membership includes representatives from the Emergency Department, Perioperative Services (OR), Emergency Medical Service (EMS), laboratory, radiology, blood bank, North-4, Intensive Care Unit (ICU), Pediatrics, Obstetrics, security, emergency preparedness, quality, rehab, and respiratory. Other attendees will be invited ad hoc.

Meetings: Committee meets every other month, no less than 5 times annually.