SAINT ALPHONSUS MEDICAL CENTER
ONTARIO

ORANIZATIONAL PLAN

Committees of Medical Staff

ORANIZATIONAL PLAN

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I. PURPOSE

This Organizational Plan has been prepared pursuant to the provisions of Article VIII, Part C, section 3(b). It is designed to reflect the composition, purpose, duties, and meetings of the following Standing Committees:

1. Quality and Safety Committee.
2. Credentials Committee.
3. Bylaws Committee.
4. Nominating Committee.

II. COMPOSITION, PURPOSE, DUTIES, AND MEETINGS OF STANDING COMMITTEES

PART A. Quality and Safety Committee.

1. The Quality and Safety Committee shall include the following:

   A. Four (4) selected physician members.

   B. Senior Leadership representative.

   C. Director, Center for Continuous Improvement.

   D. Risk Manager, ad hoc.

   E. Records Manager, ad hoc.

2. Duties and Purpose.

   The Duties and responsibilities of the Quality and Safety Committee shall be:

   A. To review and evaluate clinical practice in the hospital by means of routine reporting of activities of the Interdisciplinary Committee;

   B. To review and evaluate, quality of patient care within the hospital by routine reporting of risk management, safety, infection control, customer service and performance improvement issues.

D. To act as a liaison between hospital leadership and the Medical Staff to promote understanding of performance improvement and quality enhancements being implemented as understanding a result of isolated identified issues and/or strategically planned goals to improve quality of care.

E. To oversee that appropriate quality indicators are being reviewed by the medical staff service and selected committees and referred to further review if appropriate;

F. To oversee that medical staff documentation is appropriate within state and federal government requirements as well as other regulatory agency standards;

G. To assist in the prioritization and selection of performance improvement projects;

H. To approve plans relating to performance improvement and risk management.

3.Meetings, Reports, and Recommendations.

A. Meetings. Meetings meet as often as necessary to fulfill its duties, shall maintain a permanent record of its activities, and shall report its recommendations to the Executive Committee.
B. Reports. Reports shall be prepared following each meeting and directed to administration and the appropriate medical staff groups.

C. Recommendations. Recommendations shall be made base upon information developed and received during the meetings, and shall be made to:

1. The Medical Staff Executive Committee; and
2. The Board Performance Improvement Committee.

4.Delegation of Duties.

The functions of the Quality and Safety Committee may be performed by the Committee, a subcommittee, or by agents delegated by the Committee or such other individual or individuals as deemed appropriate by the chairman for the Committee.

PART B. Performance Improvement and Peer Review Committee

PURPOSE

Peer Review processes serve the following purposes:

1. PATIENT SAFETY AND QUALITY CARE. Assurance of patient safety and the quality of patient care by a review of medical staff performance, both individually and collectively;

2. COMPETENCY DETERMINATION. Provision of a reasonable method for determining the competency of medical staff members; and

3. PERFORMANCE IMPROVEMENT. Identification of individual, departmental and system opportunities for improvement and implementation of process improvements.

DEFINITIONS

1. PEER. For the purposes of this policy, a peer is defined as a practitioner, an MD or DO, privileged in this community, with appropriate subject matter expertise to evaluate the care provided in a particular case. In some cases, any practitioner experienced in caring for patients can provide the necessary level of subject matter expertise. In other cases, the appropriate level of subject matter expertise will require that those performing the review be privileged in the same specialty or department as the practitioner whose care is being evaluated.

2. PEER REVIEW. Peer review is the evaluation of the quality of care provided, including identification of opportunities to improve care, carried out by Active and Active Ambulatory members of the Medical Staff with appropriate subject matter expertise. Peer review is conducted using multiple sources of information, including, but not limited to:
    A. the review of individual cases;
    B. the review of physician-specific data, compared to aggregate data, for compliance with clinical standards of care and general rules of the medical staff; and
    C. use of rates in comparison with established benchmarks or norms.

3. COMMITTEE PEER REVIEW PLANS. The committee peer review plan describes the rule- based, rate-based, and case review indicators that will be used by the committee to identify opportunities for improvement.

4. RATE-BASED INDICATORS. Rate-based indicators are measurements (percentages or averages) of a particular aspect of performance that can be tracked over time. Circumstances requiring further analysis will be identified by defined triggers. These triggers may be based on protocol compliance levels, generally recognized professional guidelines for the practice of medicine, regulatory compliance standards, Trinity Health goals, national benchmarks, as available, and/or rates placing a physician outside established parameters from the department mean for the indicator. All indicator definitions will include a trigger, with deviations greater than two standard deviations from the department mean as the default. Examples: Timely completion of medical records, selected complication rates, readmission rates, and mortality rates.

5. CASE REVIEW INDICATORS. Case review indicators are events that require analysis by peers to determine the cause, effect, and severity of the outcome. Examples: unexpected death, significant post-procedure complication, sentinel event, referral (related to clinical competence), and self-referral.

6. ONGOING PROFESSIONAL PRACTICE EVALUATION. Ongoing Professional Practice Evaluation (OPPE) is an ongoing process that allows the medical staff to monitor and conduct ongoing evaluations of each practitioner's professional performance. This process allows any potential problems with a practitioner's performance or trends that impact quality of care and patient safety to be identified and resolved in a timely manner. The OPPE also fosters an efficient, evidence-based privilege renewal process. The information resulting from the ongoing professional practice evaluation may be used to determine whether to continue, limit, or revoke any existing privilege(s).

7. FOCUSED PROFESSIONAL PRACTICE EVALUATION. Focused Professional Practice Evaluation (FPPE) is a time-limited process that allows the medical staff to evaluate the privilege- specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at Saint Alphonsus Medical Center-Ontario. FPPE will occur in all requests for new privileges and when there are concerns regarding the provision of safe, high quality care by a medical staff member (may be identified through Ongoing Professional Performance Evaluations).

8. COMMUNITY STANDARD OF CARE. The determination of the community standard of care is a consensus-based process and necessitates the involvement of multiple peers. In rare instances, the medical staff also recognizes, particularly in controversial areas of medical care, that this determination may require the assistance of consultants from outside the S aint Alphonsus Medical Center-Ontario Medical Staff and a review of pertinent medical literature.

9. EXTERNAL PEER REVIEW. When an internal review cannot be unbiased, medical staff leaders may obtain external peer review from outside reviewers who are unbiased and likely of a similar training and experience. Other circumstances that may necessitate external peer review may include specialty review when there are limited or no medical staff members who can offer that review, and when requested by medical staff departments, other ad hoc medical staff panels, or standing committees of the medical staff.

10. CONFIDENTIALITY. All Peer Review activities are confidential and privileged as protected under Oregon Statutory 41.675. It is the policy of Saint Alphonsus' Medical Staff to fulfill its responsibility to conduct peer review in an effective manner and, at the same time, respect an individual practitioner's expectations of confidentiality and fair treatment. Confidentiality allows for full cooperation and participation of the individual practitioners, and the resultant benefits.

PERFORMANCE OF PEER REVIEW

1. MECHANISM. Peer review performs the following functions:
   A. collects data on processes and outcomes, assesses performance in relation to national or community standards of care, analyzes how processes function, identifies

opportunities for improvement, and reviews outcomes in relation to expectations;
B. evaluates individual practitioner performance; and
C. provides individual performance data to Credential Committee for the purposes of reappointment, renewal of privileges, or revision of clinical privileges.

2. DATA COLLECTION. Data will be collected continuously from a variety of sources. These sources include, but are not limited to, computer and manual log entries; incident reporting systems; analysis of performance in relation to procedures, DRGs, diagnoses, pathology reports, autopsy reports; other internal and external databases; self-referral; and complaints. Physician specific and other peer review data will be collected under the authority and direction of the MEC and in collaboration with the medical staff departments, using resources in the Office of Medical Affairs and the Quality and Safety Committee.

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

OPPE is an ongoing process that allows the medical staff to monitor and conduct ongoing evaluations of each practitioner's professional performance. At a minimum, each department OPPE plan should include the following:

1. OPPE will be performed for all practitioners on an ongoing basis, with data provided to the physician for review more frequently than every 12 months. Review of privileges will be evaluated at reappointment.

2. Data reports and information that comprise OPPE include inpatient data for the individual physician and comparison with the aggregate of physicians with similar risk-adjusted cases. Each department will include measures to evaluate, at a minimum, the following:
   1. Patient care
   2. Practice-based learning and improvement
   3. Interpersonal and communication skills
   4. Professionalism
   5. System-based practice
   6. Medical/clinical knowledge

3. The information gained by the review of the above information will be filed in provider's credentials file and incorporated into reappointment process.

4. If behavior is identified as a possible issue, the Medical Staff Conduct Policy will be followed as a component of the OPPE.

5. Relevant information obtained from the OPPE will be forwarded for inclusion into the performance improvement activities, at all times maintaining confidentiality.

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

An intensified review is done by the Peer Review committee, when indicated by trended data or a trigger. Triggers are defined in Departmental OPPE plans and describe criteria by which a focused review will occur. These triggers will include:

1. Review at the time of new appointment to the Medical Staff to ensure clinical competency;

2. Fallout data identified at the time of re-credentialing and not considered by the Peer Review Committee to be explainable and acceptable;

3. A performance issue identified in the course of peer review and considered to warrant further monitoring;

4. A performance issue identified by observation

This process will be initiated as rapidly as possible, but not longer than 30 days from identification of the problem, after notification of the practitioner. The review of the practitioner may include:

1. TRIGGERED REVIEW. A review of all cases identified by the specific indicator which triggered the review;

2. RANDOM SAMPLING. Review of a random sample of cases for a 24 month period;

3. PROSPECTIVE REVIEW. Review of all the practitioner's cases for the next 6 to 12 months; or

4. OTHER REVIEWS. Any other review as defined by the Medical Executive Committee and/or the department chair.

At the conclusion of the intensified review, the findings and recommendations are reported to the the MEC. The MEC may, as appropriate note and if circumstances require, take steps including but not be limited to, collegial intervention, education, or referral of the matter to the appropriate body for carrying out the Corrective Action Plan.

RESPONSIBILITIES AND ROLES

1. PHYSICIANS are expected to:
   A. Participate in peer review activities as defined by and maintained by their department.
   B. Be present when requested to attend a committee or department meeting to discuss a case in which they were involved.
   C. Review their regular OPPE reports, and discuss any questions or concerns with their Department Chair.
   D. Work with the Department Chair and/or Departmental Supervisory Committee to

resolve any performance issues identified through OPPE.

2. DEPARTMENT CHAIRS, in consultation with his/her department and in collaboration with the Peer Review & Quality Committee, are required to:
   A. Develop a specific peer review plan for his/her department every two years, for approval by the Peer Review and Quality Committee.
   B. Review OPPE reports for any members of their department who fall outside of established parameters in any category of the evaluation.
   C. Present a report on the fall-out data to the Departmental Committee for determination of further action.
   D. In collaboration with their Departmental Committee, meet with physicians if further action is deemed appropriate, to agree on an action plan.
   E. Communicate the result of these reviews and actions taken to the Peer Review Coordinator.

3. THE MEDICAL EXECUTIVE COMMITTEE will participate in the above processes by:
   A. Monitor and participate in peer review as set for in the Medical Staff Bylaws and this Policy.
   B. Determining appropriate steps in situations where an adequate action plan cannot be agreed upon by a physician, Department Chair, and Departmental Supervisory Committee.
   C. Providing intervention when an issue compromising patient safety is brought forward for immediate action.

The following people shall be included in Peer Review events: Chair or designee of Medical Staff Quality Committee and Medical Staff member from each service line.

Peer Review Committee will meet at least 6 times a year and adverse reviews will be directed to Medical Executive Committee.

PART C. Credentials Committee.

1. Composition:

   The Credentials Committee shall consist of Three (3) active staff members of the Medical Staff. Members shall service for a one year term. The Chief of the Medical Staff shall make appointment to this Committee. The Chairman shall also be appointed by the Chief of the Medical Staff and shall be selected from the membership of the Committee. Vacancies that occur shall be filled by the Chief of Staff for the remainder of the vacating member's term. A representative from hospital administration will be invited, but will not be a voting member.

2. Duties:

The duties of the Credentials Committee shall be:

A. to review the credentials and qualifications of all applicants, to make such investigations of and interview applicants as may be necessary, to obtain and consider the recommendations of the services in which an applicant seeks appointment, and to make recommendations for appointment, reappointment and delineation of clinical privileges in compliance with these Bylaws;

B. to make a report to the Executive Committee on each applicant for the Medical Staff appointment and clinical privileges, including recommendations with regard to the appointment or reappointment, staff status, department affiliation, clinical privileges and any special considerations or conditions;

C. To review, on their own motion or at the request of the Chief of Staff, the Executive Committee, the Quality Assurance Committee, or any other Medical Staff or Board Committee responsible for monitoring quality patient care, all questions regarding the professional and clinical competence of persons currently appointed to the Medical Staff, their care and treatment of patients and case management, their compliance with these Bylaws, or their ethical conduct, and as a result of such review, to make recommendations to the Executive Committee for the granting, reduction or withdrawal of clinical privileges or staff membership.

3. Board and Executive Committee Communication:

The Chairman of the Credentials Committee, the Chairman's representative and/or such member of the Committee as are deemed necessary, shall be available to meet with the Executive Committee or Board, or their applicable committees, on all Bylaws to increase direct communication between the Executive Committee and the Credentials Committee on all matters with the scope of the Credentials Committee's duties and to afford the Board the opportunity to communicate directly with the Credentials Committee.

4. Meetings, Reports and Recommendations:

The Credentials Committee shall meet as often as is necessary to accomplish its duties. A permanent record of its proceedings and actions shall be kept. It shall report its recommendations to the Executive Committee and Board of Directors.

PART D. Bylaws Committee.

1. Composition:

The Bylaws Committee shall consist of not less than three (3) persons appointed from the active Medical Staff. One of the officers of the Medical Staff shall be one of the three (3) members of the Medical appointed to the Committee. The Chairman shall be appointed by the Chief of Staff. Members shall be appointed for terms of one year. A representative or representatives of the

Hospital administration may be invited to attend meetings of the Committee to assist the Committee in discharge of its responsibilities.

2. Duties:

The Bylaws Committee shall review the Bylaws rules and regulations of the Medical Staff and recommend amendments thereto to the Executive Committee on no less than an annual basis. The Committee shall receive and consider all recommendations for changes in theses Bylaws by the Board, the Executive Committee, the services, the Chief of Staff, the Chief Executive Officer, Committees of the Medical Staff and any individual appointed to the Medical Staff. They shall examine and propose amendments to correct conflicts and inconsistencies and shall suggest revisions to reflect the Hospital's current practices with respect to Medical Staff functions and organization.

3. Meetings, Reports, and Recommendations:

The Bylaws Committee shall meet as often as necessary to fulfill its duties, shall maintain a permanent record of its activities, and shall report its recommendations to the Executive Committee and the Chief Executive Officer.

PART E. Nominating Committee.

1. Composition:
The Nominating Committee shall consist of the three most recent past Chiefs of Staff. The immediate past Chief of Staff shall serve as its chairman.

2. Duties:
It shall be the duty of the Committee to present, at the May meeting of the Medical Staff, one or more nominees for the offices of Chief of Staff, Vice Chief of Staff, and secretary-treasurer of the Medical Staff.

3. Meetings, Reports and Recommendations:
The Nominating Committee shall meet as often as necessary to accomplish its purpose. It shall report its recommendations to the Medical Staff membership.

III. ORGANIZATION OF CLINICAL SERVICES

PART A: CLINICAL SERVICES

1. General

The exercise of clinical privileges within any service is subject to the Rules and Regulations of that service and to the authority of the service Chief.

2. List of Services.

The Medical Staff shall be divided into the following services, but such services may be changed, when necessary, upon agreement by the Executive Committee and the President/Chief Executive Officer, with approval of the Board.

A. Medicine
    1. Cardiology
    2. Dermatology
    3. Neurology
    4. Psychiatry
B. Surgery
    1. Orthopedics
    2. Anesthesiology
    3. Pathology
    4. Urology
    5. Podiatry
    6. Gynecology
    7. ENT
    8. Ophthalmology
    9. Oral Surgery
    10. Dentistry
C. Obstetrics
D. Family Medicine
E. Emergency Medicine
F. Radiology
G. Pediatrics

Surgery includes all members of Medical Staff who practice surgery or one of its subspecialties

3. Functions of Services.

A. Each service shall be responsible for conducting a review of records of patients and other pertinent service sources of medical information relating to quality and appropriateness of patient care. Such review shall be ongoing and shall be for the purpose of monitoring and evaluating the quality and appropriateness of the care and treatment of patients by individuals with clinical privileges in that service and to monitor adherence to these Bylaws and Hospital policies and procedures. The service shall maintain a record that includes the conclusions, recommendations and actions pertaining to such monitoring and evaluation. Periodic assessments of this information shall be performed to identify opportunities to improve care and identify important problems in patient care.

B. Each service shall establish objective qualifications and criteria for granting and reviewing clinical privileges of practitioners within the service, generally and where appropriate for specific procedures. In those circumstances where clinical problems are managed by more than one service, separately or in a multi-

disciplinary approach, each service shall coordinate and cooperate with other services so that credentialing criteria for the various services is uniform and consistent. All credentialing criteria shall be approved by the Executive Committee and the Board.

1. Each service shall evaluate the credentials of all applicants for membership and make recommendations to the Credentials Committee regarding such membership and clinical privileges to be granted.

C. Each service shall cooperate with the quality assurance committee and shall review, monitor, evaluate and analyze on a peer group basis the major clinical work and activities of the members of the service.

D. Each service shall establish and maintain policies in keeping with objectives of the Board and in keeping with these Bylaws, Rules and Regulations.

E. Each service shall review problems of medical care and disciplinary problems that arise within the service. Each service shall, as much as feasible, and as much as in keeping with these Bylaws, rules and regulations, handle minor problems and discipline, behavior and conduct of its members by informal persuasion. Whenever a major problem arises and one which points to possible disciplinary action, and whenever informal persuasion is ineffective, a written report and recommendation shall be made by the chief and forwarded to the Executive Committee as provided in Article X, Part A, Section 1.

F. Each service shall conduct and participate in and make recommendations regarding the need for continuing professional education programs.

G. Each service shall establish qualifications and responsibilities as to emergency calls for each member of the service. The service shall be responsible for providing continuous emergency call coverage. Annually, each service shall submit to the Executive Committee for review and approval and emergency call plan. The plan shall include volunteer and mandatory rosters and the qualifications required to serve on each.

H. The Chief of the Medicine Service shall:

1. Act as the director of the Critical Care Unit;

2. oversee the effective operation of said Unit;

3. report findings and recommendations to the Executive Committee.

4. <u>Service Chief</u>

A. All services shall have a service chief selected by their service and approved by the Board. Any service officer may be removed from office at any time upon a majority vote of all of the active members of the service.

B. Each chief shall be a member of the active staff qualified by training, experience, and demonstrated ability for the position.

C. Each chief shall be appointed for a one (1) year term subject to approval of the Board, and may be re- appointed for additional terms.

5. Functions of Service Chief

Each chief shall:

A. Be accountable for all professional and administrative activities within his/her service.

B. Make specific recommendations and suggestions regarding his/her own service in order to assure quality patient care, cooperation and harmony between the Medical Staff, Hospital administration and the Board.

C. Be responsible for assuring the implementation of a planned and systematic process for continual monitoring and evaluating quality and appropriateness of patient care and treatment by members of his service and the clinical performance of all members in this service and report regularly thereon to the Executive Committee.

D. Be responsible for enforcement of the Hospital Bylaws, policies and procedures and of the Medical Staff Bylaws, rules and regulations within his service.

E. Be responsible for the implementation within his service of actions taken by the executive committee of the Medical Staff.

F. Transmit to the Executive Committee his services' recommendations concerning criteria for clinical privileges.

G. Transmit to the Executive Committee his services' recommendations concerning the staff classifications, the appointments and the reappointments, and the delineation of clinical privileges for all practitioners in his service.

H. Be responsible for the teaching, education, and research program in his service.

I. Participate in administration of his service through cooperation with the nursing service and the Hospital administration in matters effecting patient care.

J. Assist in the preparation of such annual reports pertaining to his service as may be required by the Executive Committee, the President/Chief Executive Officer or the Board.

K. Report to the chief of the Executive Committee for his consideration any situation involving questions of clinical competency, patient care and treatment, case management, professional ethics, infraction of Hospital or Medical Staff Bylaws, or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

L. Perform all duties and responsibilities of a service chief set forth elsewhere in these Bylaws.

M. In addition to the above, the Service Chief may be asked to:

1. Assess and recommend to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital.

2. Integrate the department into the primary functions of the Hospital.

3. Coordinate and integrate interdepartmental and intradepartmental services

4. Recommend a sufficient number of qualified and competent Practitioners to provide care, treatment, and service.

5. Confirm that the Hospital maintains a process to determine the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

6. Maintain quality improvement programs, as appropriate.

7. Confirm that the Hospital provides for the orientation and continuing education of all persons in the department.

8. Recommend space and other resources needed by the department.

6. Assignment to Service

A. The Executive Committee, after consideration of recommendations made by clinical services, shall recommend initial service assignments for all Medical Staff members and for all other approved practitioners holding clinical privileges.

B. Practitioners will be assigned to one primary service, but may hold privileges in other services in addition to those in their primary service area.

C. General practitioners may hold clinical privileges in one or more services according to their education, training, experience, and demonstrated competence. General practitioners shall be subject to all of the rules of the services to which they are assigned and to the jurisdiction of the respective service chief.

D. At times the Medicine Service and Family Medicine Service may find it convenient to regularly meet together to address those functions under Article XIII, Part A., Section 3. Such meeting will be referred to as Primary Care. Each Service will maintain individual Service Chiefs.

IV. FUNCTION AND COMMITTEES OF THE MEDICAL STAFF

PART A. STAFF FUNCTIONS

1. General Function

The Medical Staff, subject to Board approval, shall provide effective mechanisms to monitor and evaluate the quality and appropriateness of all patient care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms shall provide a means by which important problems and patient care can be identified and resolved and opportunities to improve care can be addressed.

2. Specific Functions

By assignment to the services or to the Medical Staff committees, the following functions shall be performed by the Medical Staff:

A. To monitor and evaluate the quality and appropriateness of all patient care, and to participate fully in the Hospital's quality assurance program.

B. To conduct and review monitoring activities, including surgical case review and autopsy reports.

C. To develop and maintain surveillance over blood usage and blood transfusions and conduct reviews with respect there to.

D. To require that patient records are complete, timely and clinically pertinent.

E. To develop and maintain surveillance over drug usage and pharmacy and therapeutic policies and practices and conduct ongoing reviews with respect there to.

F. To prevent, investigate and monitor control of Hospital acquired infections and conduct reviews with respect thereto.

G. To plan for response to fire and other disasters and Hospital safety, for Hospital growth and development, and for provision of Medical services required to meet community needs.

H. To conduct and review the conduct of utilization review activities.

I. To conduct and review all credentialing activities, corrective action activities, and fair hearing proceedings.

J. To provide continuing professional education responsive to evaluation findings and new developments.

K. To direct the staff organizational activities including Staff Bylaws, rules and regulations, review and revision, staff officer committee nominations, liaison with the board and Hospital administration and review and maintenance of Hospital accreditation.

L. To coordinate the care provided by practitioners and other professionals with the

care provided by the nursing service and other Hospital patient care administrative services.

M. To develop and implement staff programs, activities and functions necessary to maintain Hospital accreditation.

N. To review Medical records in cooperation with the nursing department management and administrative services, and other appropriate Hospital Staff.

O. To conduct and perform such other duties and responsibilities as are assigned by the Board.

All such functions shall be reviewed and evaluated on an annual basis and shall be conducted and performed in such a manner as to meet all licensure and accreditation requirements including, without limitation, the accreditation requirements of the joint commission on accreditation of Hospitals.

PART B. PROVISIONS COMMON TO ALL COMMITTEES

1. Removal

The Executive Committee, by a two-thirds (2/3rds) vote may remove any Chairman or Member of any Committee (other than an ex-officio member) for conduct detrimental to the interests of the Hospital, or for failure to fulfill the duties of that individual's office in a timely, appropriate or satisfactory manner, provided that notice of the meeting at which such action takes place shall be given in writing to such Chairman or Member at least ten (10) days prior to the date of such meeting. The Chairman or Member shall be afforded the opportunity to speak in his own behalf before the Executive Committee prior to the taking of any vote on his removal. A Member of the Hospital's Administrative Staff who is serving on a Committee may be directed not to attend at any time by the President/Chief Executive Officer.

2. Composition and Appointment.

A. Chairman:

Unless otherwise provided for in these Bylaws, appointment of all committee chairmen shall be made by the Chief of the Medical Staff. All chairmen shall be selected from persons appointed to the active staff.

Such appointments shall be made by the Chief of Staff at the end of the Medical Staff year for succeeding Medical Staff year. Each appointment shall be made for an initial term of one year. After serving an initial term, a chairman may serve additional terms if reappointed by the Chief of Staff.

Unless otherwise provided, the Chairman of each Committee shall vote only when there is a tie or deadlock.

B. Members:

A Medical Staff committee established to perform one or more of the staff functions required by these Bylaws shall be composed of members of the Medical Staff and unless otherwise provided, may include non-voting representation from Active Ambulatory Staff, Hospital administration, nursing service, Medical records service, pharmaceutical services, social service and such other Hospital services as are appropriate to the function to be discharged. Non-physician staff members may be invited to attend Committee meetings by the Committee Chairperson. Non-Medical Staff members who are invited to attend on a regular basis shall be designated by the President/Chief Executive Officer, but shall attend at the pleasure of the Committee. Persons not attending on a regular basis may be designated or invited by the Committee, Medical Staff members of each committee, except as otherwise provided in these Bylaws, shall be appointed for one year terms. These appointments shall be made at the regular staff meeting in the month of May by the Chief of Staff. There is no limitation in the number of terms that a member may serve on any Committee. The involvement of a non-Medical Hospital administration staff member in any committee shall automatically terminate upon termination of such individual's employment with the Hospital.

The President/Chief Executive Officer and Chief of Staff, or their respective designees, if not made members of the Committee by these Bylaws, shall serve as ex officio members on all committees. As ex officio members, they shall serve, but shall not vote.

C. Removal:

The chairman or any member of any committee, other than an ex officio member, may be removed, at any time, by a majority vote of the Executive Committee. A member of the Hospital administrative staff who is serving on a Committee may be directed not to attend at any time by the President/Chief Executive Officer.

D. Vacancies:

Unless otherwise specifically provided, vacancies on any staff committee shall be filled in the same manner in which original appointment to such committee is made.

E. Meetings:

A staff committee established to perform one or more of the staff functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties as specified in these Bylaws or in its statement of purpose.

3. Creation of Standing Committees

In addition to the specific standing committees described in this Article, the Executive Committee, by resolution, may suggest that a standing committee, as may be necessary or appropriate to perform one or more of the Medical Staff functions, be established. In order to establish a standing committee, these Bylaws must be amended. The resolution of the Executive Committee shall be delivered to the appropriate committees to initiate the process of Bylaw amendment.

The Executive Committee may, by resolution and without amendment to these Bylaws, add to the duties or charges of a currently existing committee without amending these Bylaws.

However, the Executive Committee may not dissolve or rearrange committee structures without going through the Bylaw amendment process.

Any function required to be performed by these Bylaws which are not assigned to a standing or special committee shall be performed by the Executive Committee of the Medical Staff.

If a new standing committee is to be established, the Executive Committee, at the time the Committee is suggested to the Executive Committee, shall outline in a written report and with particularity, the following:

A. The composition, duties, purpose and authority of the committee;

B. The frequency of meetings and record keeping requirements; and

C. The individual or other committee or authority to which the committee is to report.

This written report shall be submitted to the Medical Staff and shall be maintained as a permanent record. If accepted by the Medical Staff, it shall be enacted as an amendment to these Bylaws following the normal amendment process.

Provision shall be made in these Bylaws or by resolution of the Executive Committee, either through assignments to the services, to staff committees, to staff officers, or officials, or to interdisciplinary Hospital committees, for the effective performance of the staff functions as specified in these Bylaws and of such other staff functions as the Executive Committee shall reasonably require.

The Executive Committee shall review, on an annual basis, all committees and their effectiveness and especially their effectiveness in monitoring and evaluating quality and appropriateness of patient care. Following such review, the Executive Committee shall suggest changes regarding the committees as the Executive Committee may deem appropriate. Such recommendations can include a suggestion that the Committee be terminated. Such recommendations shall be made to Medical Staff and, before becoming effective, must be approved by the Board.

4. Creation of Ad Hoc Committees.

Unless otherwise specified in these Bylaws, ad hoc committees shall be appointed by the Executive Committee or by the Chief of Staff of the Medical Staff as required. Such committees shall confine their activities to the purpose for which they were appointed and shall report to the Executive Committee or to the committee to which they are directed to report by the Executive Committee. At the time such committees are established, the Executive Committee or Chief of Staff, as appropriate, shall outline, in the minutes of the meeting where the ad hoc committee was established, generally the following:

A. The composition, duties, purpose and authority (including the authority to compel personal appearance) of the committee;

B. Frequency of meetings and record keeping requirements; and

C. The individual or other committee to whom the committee is to report.

5. Creation of Sub-committees.

Sub-committees may be appointed by the standing committees as required. Such sub-committees shall confine their activities to the purpose for which they were established and shall report to the Committee of which they are a part. At the time such sub-committees are established, the Committee establishing the sub-committee shall outline the purpose, nature, and authority of the sub-committee.

6. Conflicts of Interest

In any instance where a member of a committee has a conflict of interest in any matter involving another member of the Medical Staff which comes before the committee, or in any instance where a member of the committee brought the complaint against that member, that member shall not participate in the discussion or voting on the matter and shall declare his conflict and absent himself from the meeting during the time of discussion and voting. He may be asked and may answer any questions concerning the matter before leaving.

PART C. DESIGNATION OF CERTAIN COMMITTEES

1. Generally

There shall be a Medical Executive Committee and the other standing committees outlined in this Part C, Article XIV, and such other standing or committees of the Medical Staff responsible to the Executive Committee as may from time to time be necessary and desirable to perform the Medical Staff functions.

2. Executive Committee.

A. Composition:

The Executive Committee shall consist of the officers of the Medical Staff including the Chief of Staff, Vice Chief of Staff, Secretary-Treasurer, the immediate past Chief of Staff, and the Chiefs of Services of Medicine (representing cardiology, and dermatology), Surgery (representing urology, orthopedics, podiatry, ENT, ophthalmology, oral surgery, dentistry, gynecology), OB/GYN, Pediatrics, Emergency, Family Practice, and a Non-Primary Care Hospital Based Physician (anesthesia, radiology, or pathology). The President/Chief Executive Officer of the Hospital shall be an ex officio member of the Executive Committee without vote.

1. Officers of the Medical Staff shall be nominated by the Nominating Committee, and be approved by the Executive Committee and the Medical Staff.

2. At no time may an Officer of the Medical Staff, at the same time, be Chief of any Service.

3. The terms of committee members shall be for one year.

4. The Chief of Staff shall be the chairman of the Executive Committee.

5. All members of the Executive Committee shall consist of fully licensed physician members of the Medical Staff actually practicing in the Hospital.

B. Duties.

The duties of the Executive Committee shall be:

1. To make recommendations directly to the Board regarding the structure of the Medical Staff, including the creation of committees;

2. to make recommendations directly to the Board regarding the mechanism used to review credentials and to delineate individual clinical privileges;

3. to make recommendations directly to the Board regarding appointments, reappointments and grants, renewals of, terminations, or other changes in clinical privileges, staff status, staff membership, and service assignments for individual practitioners;

4. to evaluate and monitor the overall quality, efficiency and appropriateness of the Medical care rendered to patients and the clinical performance of all practitioners holding clinical privileges, including the organization of the quality assurance activities of the Medical Staff and the mechanism used to conduct, evaluate and revise such activities;

5. to make recommendations directly to the Board regarding all corrective action initiated and pursued under these Bylaws, including procedures for fair hearings, and the mechanisms pertaining to such corrective action, and hearing procedures;

6. to represent and to act, without requirement of subsequent approval, on behalf of the Medical Staff, in all matters between meetings of the Medical Staff, subject only to any limitations imposed by these Bylaws;

7. coordinate the activities and general policies of the various services and committees, and in particular, to recommend to the Board mechanism to assure the same level of quality patient care throughout the Hospital;

8. to receive and act upon service and committee reports and recommendations and to make recommendations, as appropriate, concerning them to the President/Chief Executive Officer and the Board;

9. to implement policies of the Medical Staff which are not the responsibility of the services;

10. to provide liaison among the Medical Staff, the President/Chief Executive Officer, and the Board;

11. to recommend action to the President/Chief Executive Officer on matters of a medico-administrative and Hospital management nature;

12. to identify community health needs and setting of Hospital goals and implementing programs to meet those needs.

C. Board Communication:

The chairman of the Executive Committee, his representative and such members of his committee as he deems necessary shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make, it being the purpose of these Bylaws to increase direct communication between the Board and the Executive Committee on all matters within the scope of the Executive Committee's duties.

D. Interim Action:

Between meetings of the Executive Committee, an ad hoc committee composed of such members of the Executive Committee as are then available shall be empowered to act in situations of urgent and/or confidential concern where not prohibited by these Bylaws. All such actions shall, to the extent practical, be reviewed, modified, or ratified with the full Executive Committee at its next regular meeting.

E. Meetings, Reports and Recommendations:

The Executive Committee shall meet monthly or more often if necessary to transact pending business. The chairman of the Executive Committee will maintain reports of all meetings, which reports shall include by reference the minutes of the various committees and services of the staff. Copies of all minutes and reports of the Executive Committee shall be made available when requested to the Medical Staff and the President/Chief Executive Officer routinely as prepared, and important actions of the Executive Committee shall be reported to the Medical Staff as determined from time to time by the Executive Committee. Recommendations of the Executive Committee shall be transmitted to the President/Chief Executive Officer and through him to the Board as the Committee deems appropriate.

3. Standing Committees

A. The Medical Staff shall have the following standing committees:

1. Performance Improvement Committee;
2. Credentials Committee;
3. Bylaws Committee;
4. Nominating Committee;

B. Composition, Purpose, Duties and Meeting.

The composition, purpose, duties, and meetings of these Committees shall be reflected in the Organizational Plan. The Bylaws Committee shall develop and provide such Organizational Plan to the Medical Staff and shall be responsible to the Executive Committee for oversight of the Organizational Plan. (The Organizational Plan shall be attached to these Bylaws for reference purposes only. The Organizational Plan is not a part of the Bylaws.)

APPROVED by the Medical Staff this 20th day February, 2020.

ADOPTED by the Board on the 10th day of March, 2020.