



MOUNT CARMEL

Medical Staff

Organization Policy

MOUNT CARMEL HEALTH SYSTEM

A Medical Staff Document

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**ARTICLE I
MEDICAL STAFF OFFICERS AND MEMBERS AT LARGE**

1.1 Duties of Medical Staff Officers.

1.1.1 Medical Staff President. The Medical Staff President shall:

- (a) Serve as the chief administrative officer of the Medical Staff.
- (b) Act in coordination and cooperation with the Chief Executive Officer in all matters of mutual concern within the Hospital.
- (c) Aid in coordinating the activities and concerns of Hospital administration, nursing and other patient care services with those of the Medical Staff.
- (d) Call, preside at, and oversee preparation of the agenda for meetings of the Medical Staff.
- (e) Serve as chair of the MEC, with vote.
- (f) Serve as an *Ex-Officio* member of all other Medical Staff committees.
- (g) Enforce the Medical Staff Bylaws, Policies, and Rules and Regulations, the Hospital code of regulations, and applicable Hospital policies and procedures; implement sanctions where indicated; and oversee the Medical Staff's compliance with appropriate procedure as set forth in the Bylaws in all instances where corrective action has been requested against a Practitioner.
- (h) Unless otherwise provided, appoint and remove members and chairs to/from all standing and *ad hoc* Medical Staff committees, with the exception of the MEC.
 - (i) In the case of Mount Carmel East/West, this responsibility may be delegated by the President to the CDC chairs, as applicable.
- (i) Report the views, needs, policies, and grievances of the Medical Staff to the Board and the Chief Executive Officer.
- (j) Communicate Hospital policies to the Medical Staff, and report to the Board regarding the Medical Staff's delegated responsibility for the performance and maintenance of quality medical care.
- (k) Be the spokesperson for the Medical Staff in its professional and public relations.
- (l) Provide oversight for the educational activities of the Medical Staff.
- (m) Provide oversight for the Medical Staff components of the quality review, risk management and utilization management programs; assure that such programs are clinically and professionally sound, accomplish established objectives, and are compliant with regulatory and accrediting agency requirements; and, report to the Board regarding such programs and activities.
- (n) Attend meetings of the Board/designated Board subcommittees, without vote, unless otherwise provided by the Hospital.

- (o) Perform such other duties and exercise such authority commensurate with the office as set forth in the Medical Staff Bylaws, Policies, Rules and Regulations, the Hospital's code of regulations, and applicable Hospital policies; or, as otherwise may be reasonably requested, from time to time, by the MEC, the Board, or the Chief Executive Officer.
- (p) Keep and maintain, or cause to be kept and maintained, adequate and correct accounts of the Medical Staff funds, if any, and business transactions of the Medical Staff.

1.1.2 The Medical Staff President-elect shall:

- (a) Perform all the duties and assume all the responsibilities of the Medical Staff President in his/her absence.
- (b) Be a voting member of the MEC.
- (c) Succeed the Medical Staff President when the latter fails to serve for any reason.
- (d) Attend meetings of the Board/designated Board subcommittees, without vote, unless otherwise provided by the Hospital.

1.1.3 The immediate past Medical Staff President shall:

- (a) Be a voting member of the MEC
- (b) Perform all other duties as assigned by the Medical Staff President.

1.2 **Duties of Members at Large.**

Members at large shall represent the Medical Staff on the MEC and fulfill such other duties as assigned by the Medical Staff President.

**ARTICLE II
CLINICAL DEPARTMENTS AND SECTIONS**

2.1 Medical Staff Departments/Department Chairs.

Information related to Medical Staff Departments and Department Chairs is set forth in the Medical Staff Bylaws.

2.2 Medical Staff Sections.

Departments may be divided into Medical Staff Sections upon recommendation of the MEC and approval of the Board.

2.3 Section Chiefs.

2.3.1 **Qualifications.** Each Section shall have a Section Chief who must be an Active Medical Staff Member and a member of the applicable Section; remain in Good Standing throughout his/her term; and be willing and able to faithfully discharge the functions of his/her position. The Section Chief shall be board certified by an appropriate specialty board.

2.3.2 **Appointment.** Section Chiefs shall be appointed by the applicable Department Chair and ratified by the MEC and Board.

(a) In the case of Mount Carmel East/West, the appointment shall be ratified by the CDC and Board.

2.3.3 **Term.** Sections Chiefs will serve a two (2) year term commencing January 1 following his/her appointment and continuing until his/her successor is chosen, unless he/she sooner resigns or is removed from his/her position. A Section Chief may serve for an unlimited number of successive terms.

2.3.4 **Responsibilities and Authority.** Each Section Chief shall have such responsibilities and authority as provided by the applicable Department Chair.

2.3.5 Resignation or Removal from Position.

(a) **Resignation.** A Section Chief may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt or at any later time specified therein.

(b) **Removal.** A Section Chief may be removed from his/her position by the Department Chair based upon the same grounds as set forth in the Bylaws for removal of Department Chairs. Such removal shall be ratified by the MEC and Board.

(i) In the case of Mount Camel East/West, the removal shall be ratified by the CDC and Board.

2.3.6 **Unexpected Vacancy.** An unexpected vacancy in a Section Chief position will be filled in the same manner in which the original selection was made.

**ARTICLE III
MEDICAL STAFF COMMITTEES**

3.1 Medical Executive Committee.

The requirements relating to the composition, duties and meetings of the Medical Executive Committee are set forth in the Medical Staff Bylaws.

3.2 Clinical Care Committee (CCC)

Mount Carmel Health, Mount Carmel St. Ann's, and Mount Carmel New Albany Surgical Hospital shall each have a CCC.

3.2.1 Composition

- (a) The Clinical Care Committee (CCC) is a Hospital multi-disciplinary committee consisting of representatives from Medical Staff leadership (including representation from at least Emergency Medicine, Hospital Medicine, Intensive Care, and Surgery), the Chief Nursing Officer, the VPMA(s), the Chief Pharmacy Officer (or designee), the Emergency Department Nursing Director, the ICU Nursing Director, and the Surgery Nursing Director, and the System Director of Quality Improvement (or designee). The Medical Staff leadership representative will be chosen by the VPMA(s) in consultation with the Medical Staff President. Representatives from the Hospital's Services Lines will be invited, as guests, on a not less than quarterly basis.
- (b) *Ad-hoc* members may be added by the CCC on an as-needed and time-limited basis as determined by the needs of the CCC including, but not limited to representatives from the Radiology Department, Risk Management Department, etc. An *ad-hoc* member may have any qualifications deemed appropriate by the CCC.
- (c) To the extent Department Chairs are appointed to this Committee by virtue of their position, they will serve as committee members consistent with the term of their positions. All other appointed members will serve two (2) year terms with such terms being staggered in order to provide for continuity.

3.2.2 Functions and Responsibilities. The CCC will:

- (a) Report to and be subject to the authority of the System Clinical Care Council.
- (b) Communicate the purpose, direction, and progress of quality assessment and improvement activities as they relate to the Hospital's mission back to the Medical Staff, Medical Executive Committee, reporting committees, and administration including an annual report evaluating the overall success of quality improvement activities.
- (c) Review summaries of Hospital reports regarding sentinel events and root cause analyses and, if appropriate, work collaboratively with the MEC or Human Resources (as applicable) to review and/or recommend corrective action.
- (d) Monitor trends and significant/sentinel events identified by quality monitoring and reviews.

- (e) Provide and coordinate the direction, function, and resources of CCC sub-committees.
- (f) Provide and/or obtain recommendations annually for all quality monitoring and/or performance improvement activities from the Hospital and Medical Staff Departments, the Quality & Safety Department, the Medical Executive Committee, and other relevant sections.
- (g) Receive and review aggregate, trended reports of all quality indicators and monitoring.
- (h) Develop systems, strategies, and mechanisms to monitor and manage the use of Hospital resources.
- (i) Prepare, implement, and review the Hospital's Performance Improvement Plan (Plan) and policies and procedures to carry out necessary collection analysis and review of appropriate Hospital and patient data (including patient satisfaction), as well as oversee compliance with the Plan.
- (j) Assist in overseeing the development of consistent standards, protocols, and procedures for the execution of specified functions to achieve Hospital goals related to performance improvement, and identify the responsibilities of individuals providing services in each of the Hospital and Medical Staff Departments participating in the Plan.
- (k) Determine the need for focused performance improvement action plans within the Hospital as evidenced by trends in peer reviewed cases and significant events.
- (l) Assign responsibility for developing and implementing any focused performance improvement plans.
- (m) Monitor results of any performance improvement activity to ensure successful completion.

3.2.3 Meetings

- (a) Meetings of the CCC will be held not less than ten (10) times a year or as otherwise required at the call of the committee chair.

3.3 **Multidisciplinary Peer Review Committees (MPRC)**

Mount Carmel Health, Mount Carmel St. Ann's, and Mount Carmel New Albany Surgical Hospital shall each have a MPRC to engage in peer review activities.

Composition:

The MPRC consist of the following members:

- Medical Staff President-Elect (who shall serve as the committee chair) (with vote).
- Not less than five (5) other Practitioners representing a variety of specialties at the Hospital (with vote).
- The VPMA(s), *ex officio* (***without vote***)

Note: Preference is for the Department Chair to sit on Peer Review Committees that report up to MPRC and not on MPRC.

- In order to qualify for appointment to the committee, the Practitioner must be in Good Standing and with a Medical Staff appointment at the Hospital.
- MPRC members serve a two (2) year term unless a member sooner resigns or is removed from such position; provided, however, that to the extent a member is serving based upon a Medical Staff leadership position and the term for that position terminates, the term for that position shall control. Terms should be staggered to assure continuity.
- MPRC members may be reappointed to the committee for an unlimited number of successive terms.
- MPRC members are required to sign a confidentiality agreement upon appointment to the committee.
- The duties of the MPRC will include, but not be limited to the following:
 - Being responsible for evaluating and improving Practitioner and Allied Health Professional (AHP) performance for designated specialty areas and performance dimensions.
 - Conducting case reviews for the purpose of determining the appropriateness of care by Practitioners and AHPs.
 - Evaluating Practitioner/AHP-specific rate and rule indicators.
 - Assuring that when opportunities for improvement are identified, the appropriate individual(s) is notified of the issues and a reasonable improvement plan is developed and tracked for compliance, and that the MPRC is kept apprised of such compliance (or lack thereof).
 - Assisting with professional behavior issues in accordance with the Disruptive Behavior Policy.
 - Calling upon other Practitioners within the System as needed to assist with professional peer review matters.
- The MPRC will meet at least eight (8) times a year and as otherwise needed on the call of its chair.
- A quorum for purposes of making decisions and case determinations is fifty percent (50%) of the voting committee members. Decisions are made by verbal vote and a simple majority of votes carries the determination.
- Each MPRC member must attend a minimum of fifty percent (50%) of the MPRC meetings on an annual basis. Failure to do so is grounds for removal from the MPRC. Committee members are also expected to participate in applicable education programs provided by the Hospital or Medical Staff to increase their knowledge and skills in meeting the committee's responsibility
- The committee will maintain a record of its proceedings and action and will report to the Medical Executive Committee.

- The MPRC may create peer review subcommittees (PRC) to address specialty areas. If PRCs are established, the applicable Department Chair may be a member, but may not be the chair. A PRC may not have less than three (3) members. PRCs will perform those duties as delegated to them by the MPRC, meet at such time as is established by the MPRC, and be subject to the authority of the MPRC. PRCs will maintain minutes of all meetings. Such minutes are forwarded to the MPRC for its information.

3.4 Peer Review Committees (PRC)

Mount Carmel Health, Mount Carmel St. Ann's, and Mount Carmel New Albany Surgical Hospital shall each have a MPRC to engage in peer review activities.

Composition. PRC members shall be chosen by MPRC chair. PRC members will elect their chair by majority vote. AHPs may be appointed as members of an AHP PRC and, if so appointed, will be able to vote.

Qualifications. Practitioner members of each PRC must be eligible Appointees in Good Standing at the time of their appointment and must remain eligible Appointees in Good Standing during the term of their position. AHP members of an AHP PRC must have no restrictions on their ability to exercise their clinical privileges. The members of each PRC must be qualified by training, experience, and clinical ability in the clinical area covered by the PRC.

Duties of PRC

The duties of each PRC will include, but not be limited to the following:

Being responsible for evaluating and improving Practitioner and MLP performance for the PRC's designated specialty areas for the performance dimensions set forth in the Medical Staff Professional Practice Evaluation Policy.

Conducting case reviews for the purpose of determining the appropriateness of care by Practitioners and AHPs.

Evaluating Practitioner/AHP-specific rate and rule indicators as follows:

- Performing regular review of adverse outliers from aggregated results of rule indicators and of adverse patterns, trends, and outlier status for rate indicators relevant to all dimensions of Practitioner and AHP performance for the specific clinical conditions as defined by the PRC. The purpose of the review is to determine if additional analysis or a focused professional practice evaluation is needed.
- Identifying individual- or Hospital-process opportunities for improvement, and determining if additional analysis or a focused professional practice evaluation is needed.
- Assuring that when opportunities for improvement are identified, the appropriate individual(s) is notified of the issues and a reasonable improvement plan is developed, as follows:
- Communicating individual improvement opportunities and developing an improvement plan if necessary.
- Communicating system improvement opportunities to the appropriate Hospital committee.
- Tracking responses and improvement plans.
- Reviewing the improvement plan on a scheduled basis.

- Reporting to the MPRC regularly regarding actions taken to improve care and any cases where action was not taken when requested or actions are perceived to be inadequate.

3.5 **Surgical Administrative Committee (SAC)**

Mount Carmel Health, Mount Carmel St. Ann's, and Mount Carmel New Albany Surgical Hospital shall each have a Surgical Administrative Committee.

Committee Description:

The Surgical Administrative Committee (SAC) is a hospital-based committee that reports to the President/Chief Operating Officer (COO) and the Clinical Department Council (CDC) and/or Medical Executive Committee (MEC) at Mount Carmel East/Mount Carmel West/Mount Carmel St. Ann's (MCE/MCW/MCSA).

Compensation: This committee has non-compensated representatives that have voting capabilities.

Meeting Frequency: The committee shall meet at least monthly or as necessary to conduct business or meet responsibilities.

Minutes/Reporting: The committee shall maintain a record of its activities and the chair person must be available to report to any medical staff committee that requests updates/input from SAC.

Membership:

- **Appointment:** Members are appointed by the respective Department Chair, with approval by:
MCE/MCW CDC Chair with input from the President/COO
MCSA Medical Staff President in conjunction with the President/COO
- **Chair / Co-Chair:** The committee has a leadership structure that includes a chair that is voted on by its members and a co-chair (Director of Surgical Services). The chair will serve 2 year terms.
- **Members:** Term is for two years beginning July 1, with renewal of appointment at the discretion of:

MCE/W The appropriate Department Chair, CDC Chair and with input from the President/COO providing the member agrees to continue as a committee member.

MCSA The appropriate Department Chair, Medical Staff President and the President/COO providing the member agrees to continue as a committee member.

Voting members include:

- One representative as applicable from the EENT, OB/GYN, Orthopedics, General Surgery, Vascular, Neurosurgery, Urology and/or other surgical specialties or sub-specialties as appropriate. Each campus committee will determine the areas of representation.
- President/COO
- VPMA
- Anesthesia Medical Director
- Director of Surgical Services

Non-voting members include:

- Nurse Manager, Surgery
- Nurse Manager, Pre-Op, PAT, PACU
- Surgical Facilitator

SAC Responsibilities:

- Develop and recommend policies for the daily operation in Surgical Services
- Interpret and implement policies and procedures in Surgical Services
- Evaluate and make recommendations on requests for capital equipment and expenditures
- Approve, implement, and monitor plans to improve clinical, operating, or financial metrics
- Develop and implement a plan surrounding efficiency of the perioperative suites including, but not limited to, number of OR's running daily, allocated / block time procedures, PAT and efficient OR utilization
- Develop standardization of protocols that promote quality, efficiency, and safety
- Develop strategies to grow surgical volume

3.6 SYSTEM MEDICAL STAFF COMMITTEES

3.6.1 SYSTEM CLINICAL CARE COUNCIL

Composition

- (a) The System Clinical Care Council (SCCC) is a System multi-disciplinary committee consisting of representatives from System Hospitals. *[to be determined]*
- (b) *Ad hoc* members may be added by the SCCC on an as-needed and time-limited basis as determined by the needs of the CCC. An ad hoc member may have any qualifications deemed appropriate by the CCC.
- (c) To the extent individuals re appointed to this committee by virtue of their position, they will serve as committee members consistent with the term of their positions. All other appointed members will serve two (2) year terms, staggered in order to assure continuity.

Functions & Responsibilities. The SCCC will:

- (a) Assist the Board in overseeing and ensuring the quality of clinical care, patient safety, and patient advocacy provided throughout the Hospital.
- (b) Review and recommend a multi-year Strategic Quality Plan with long-term annual improvement goals.
- (c) Reviewing and recommending quality, patient safety and patient advocacy-related policies and standards.
- (d) Approve and monitor a dashboard of key performance indicators compared to System goals and industry benchmarks and report the findings summary to the Board.
- (e) Monitor summary reports of Hospital and Medical Staff quality, patient safety and patient advocacy activities.
- (f) Oversee compliance with quality, patient safety, and patient advocacy-related federal, state, and private accreditation standards and survey findings.
- (g) Make recommendations to the Board on all matters related to the quality of care, patient safety, patient advocacy, and organizational culture.
- (h) Report to the Board, at least quarterly, including an annual quality review. Regular reports will generally include:

- Quality indicators in dashboard format, including ongoing measures of clinical quality, patient safety and patient advocacy (quarterly)
- Progress on major performance improvements and patient safety goals (quarterly or twice a year)
- Root Cause Analysis (quarterly)
- Sentinel event summary (quarterly)
- Patient advocacy summary (ongoing) and patient satisfaction/perceptions (quarterly and annual in-depth report)
- Practitioner satisfaction/perceptions (every 2 years)
- Patient safety culture analysis (annual)
- Accreditation and survey findings and plans of correction (when received)

Meetings

Meetings of the SCCC will be held not less than quarterly or as otherwise needed at the call of the committee chair.

3.6.2 SYSTEM MEDICAL STAFF CREDENTIALS COMMITTEE

The System Credentials Committee is the body to which the Medical Staff credentialing functions are delegated as specified in the Medical Staff Bylaws and Credentials Policy.

Composition. The Credentials Committee shall be composed of Active physicians, each of whom is a member of the Medical Staff of at least one MCHS Hospital.

The Committee will be composed of multi-specialists in order to provide representation of the major departments and clinical specialties.

The composition of the Committee shall include the following:

Chair / Vice-Chairs: The committee has a leadership structure that includes one (1) chair and two (2) vice-chairs appointed in collaboration by the three (3) Medical Staff Presidents. The position of Chair will rotate between the three Medical Staffs.

The Chairs and Vice-Chairs will share the responsibility of reviewing their respective medical staff applications if they are the applicant's primary site prior to each meeting in an effort to place those applicants on the "Consent Agenda".

Members: Physician members will be recommended by the respective Medical Staff's Credentials Committee Chair or Vice-Chair and appointed by the Medical Staff Presidents.

The Chair of the Allied Health Professional Credentials Committee

One (1) administrative member from each hospital may attend as a guest with no vote.

Term / Contract / Compensation: Members of the Committee will be under a contract to serve a three year term and will receive compensation for each meeting attended. Upon expiration of the member's contract, the Medical Staff Presidents will determine to terminate the contract or extend for an additional 3 year term.

Voting: Each committee member has one vote.

Attendance: Members may attend meetings in person or by conference call, so long as all members of the Committee attending in person and via conference telephone call can hear and be heard by all other members attending.

Quorum: No less than fifty percent (50%) of the members of the Committee constitute a quorum. The affirmative vote of a majority of the members present at a meeting at which a quorum is present is required for Committee action.

Duties: The Credentials Committee shall:

- (a) Review the credentials of all Applicants and provide an opinion to the MECs regarding Medical Staff appointment and/or delineation of Privileges in accordance with the Medical Staff Bylaws and Policies.
- (b) Prepare a written report for the MECs on each Applicant for Medical Staff appointment and/or Privileges, including specific consideration of the opinion from the Department in which the Applicant requests Privileges and/or the AHP Credentials Committee.

The Chair and two Vice Chairs will present the report to their respective MECs.

- (c) Review, at least every two (2) years, all available information regarding the qualifications and competence of Practitioners and, as a result of such review, provide an opinion regarding the granting of Privileges, reappointment (Medical Staff category), regrant of Privileges, and Department assignment(s).
- (d) Review and make recommendation to the Credentialing Board regarding on new or revised Delineation of Privilege (DOP) forms and/or criteria used by the Departments; receive recommendations from System Department Chairs on these matters.
- (e) Investigate any matter referred to it by the MEC.

Meetings: The Credentials Committee shall meet at least ten (10) times per year and otherwise at the call of the committee chair.

3.6.3 SYSTEM ALLIED HEALTH PROFESSIONAL (AHP) CREDENTIALS COMMITTEE

The System AHP Credentials Committee shall be a System wide Medical Staff committee.

Composition. The System AHP Credentials Committee shall be composed of:

- The physician chair shall be a member of the System Medical Staff Credentials Committee
- a physician vice chair
- a minimum of four (4) AHPs from one or more of the MCHS hospitals representing a majority of the different AHP categories with equal representation from each
- CNO(s)

The committee will be provided with administrative support by an Advanced Practice Registered Nurse (APRN), Physician Assistant (PA) or Anesthesiology Assistant (AA) who

practices at a clinical medical level of care and the Manager of the Credentialing Verification Office (CVO).

Each member shall serve a three (3) year term with staggered expiration dates.

Duties. The System AHP Credentials Committee shall:

- (a) Review the credentials of all AHP (APRN/PA/AA) Applicants and provide an opinion to the Medical Staff Credentials Committees regarding delineation of Privileges in accordance with the Medical Staff Bylaws and Policies.
- (b) Prepare a written report for the Medical Staff Credentials Committees on each AHP Applicant for Privileges, including specific consideration of the opinion from the Department in which the Applicant requests Privileges.
- (c) Review, at least every two (2) years, all available information regarding the qualifications and competence of Practitioners and, as a result of such review, provide an opinion regarding the granting of Privileges, reappointment (Medical Staff category), regrant of Privileges, and Department assignment(s).
- (d) Investigate any matter referred to it by the Medical Staff Credentials Committee.

Meetings. The System AHP Credentials Committee shall meet at least ten (10) times per year and otherwise at the call of the committee chair.

3.6.4 Central Medical Staff Policy Committee. The Central Medical Staff Policy Committee shall be a System wide Medical Staff committee.

Composition. The Central Medical Staff Policy Committee shall be composed of the following individuals:

- (i) Executive Vice President and Chief Clinical Operations Officer who shall serve as committee chair
- (ii) President, Mount Carmel Health Medical Staff
- (iii) President, St. Ann's Medical Staff
- (iv) President, New Albany Medical Staff
- (v) Chair, Credentials Committee, Mount Carmel Health
- (vi) Chair, Credentials Committee, Mount Carmel St. Ann's
- (vii) Chair, Credentials Committee, Mount Carmel New Albany
- (viii) President-Elect, St. Ann's Medical Staff
- (ix) President-Elect, New Albany Medical Staff
- (x) President-Elect, Mount Carmel Health Medical Staff
- (xi) CDC Chairs (one of whom shall serve as President-Elect), Mount Carmel East and Mount Carmel West

- (xii) Vice President Medical Affairs, Mount Carmel West
 - (xiii) Vice President Medical Affairs, Mount Carmel East
 - (xiv) Vice President Medical Affairs, Mount Carmel St. Ann's
 - (xv) Vice President Medical Affairs, Mount Carmel New Albany
 - (xvi) System Director, Medical Staff Services, without vote
 - (xvii) Manager, Medical Staff Services, without vote
 - (xviii) Manager, Credentialing Verification Office, without vote
- (e) **Duties.** The Central Medical Staff Policy Committee, consisting of equal representation from each of the Medical Staff's leadership, was developed in 2008 to discuss standardizing various provisions of the Medical Staff governing documents at Mount Carmel Health (East/West), Mount Carmel St. Ann's Hospital, and Mount Carmel New Albany Surgical Hospital. The committee has recognized the importance of making such an assessment consistent with the System's other related activities such as the establishment of a Central Verification Office (CVO) and standardization of Clinical Privilege sets. With the implementation of these measures, the standardization of Medical Staff documents helped lessen any inconsistencies in areas such as scope of practice, and ability to apply for appointment/reappointment and/or Privileges/regrant of Privileges throughout the System. Accordingly, the duties of the Central Medical Staff Policy Committee shall include review and revision of the Medical Staff Bylaws, Policies, and Rules & Regulations, as needed.
- (f) **Meetings.** The Central Medical Staff Policy Committee shall meet as needed at the call of the committee chair to conduct its business and fulfill assigned responsibilities.

3.6.5 **Graduate Medical Education Committee.**

- (g) **Composition.** The Graduate Medical Education Committee shall be composed of the following individuals:
- (i) Vice President of Graduate Medical Education/Designated Institutional Official, who serves as committee chair
 - (ii) Program Directors
 - (iii) Chief Medical Officer
 - (iv) Campus Vice President/Chief Medical Officer
 - (v) System Director of Research
 - (vi) Two (2) resident representatives (rotates every year with one (1) resident from a surgical program and one (1) from a medicine program).
 - (vii) GME Operations Manager (standing guest attendee without vote)

- (viii) Campus COO (standing guest attendee without vote).
- (ix) Additional guests (without vote) may be invited as needed for discussion.
- (h) **Duties.** The Graduate Medical Education Committee shall:
 - (i) Oversee graduate medical education for the System
 - (ii) Ensure appropriate training for all residents within their specialty
 - (iii) Oversee quality and safety of the patients being cared for under the auspices of the graduate medical education program.
- (i) **Meetings.** The committee shall meet monthly and as otherwise needed at the call of the committee chair to conduct its business and fulfill assigned responsibilities.

3.6.6 **Continuing Medical Education Committee**

DESCRIPTION: The Continuing Medical Education Committee shall be classified as a system administrative committee established to perform regular ongoing functions relative to the continuing medical education of the Medical Staffs of Mount Carmel Health System.

GOVERNANCE: The Continuing Medical Education Committee shall report its recommendations and actions to the Medical Executive Committees following each meeting, as well as to the Vice President of Medical Education.

APPOINTMENT: The Presidents of each Medical Staff shall appoint up to two physician members from each hospital to the Continuing Medical Education Committee. Physicians who have dual privileges may be considered either MCE or MCW members. Appointees should be chosen from a variety of specialties. To maintain continuity, committee member appointments should be staggered. In addition, the CME Committee will elect a Chairperson (separate from the two hospital physician appointments).

TERM: All committee members shall serve a two-year term, unless they shall sooner resign or be removed from the committee. A member may serve additional two-year terms, if all interested parties are in agreement. A vacancy in the committee shall be filled for the unexpired portion of the term in the same manner in which original appointment is made

ATTENDANCE: Each member must attend 50% of all meetings held. Failure to meet the attendance requirements may be grounds for removal from the committee. If one of the members from any hospital is unable to attend a CME Committee meeting, he or she should notify the other member to ensure that their hospital has a representative present. Any member, who wishes to resign from the committee, must submit notification to the CME Committee and the President of his/her primary Medical Staff in writing.

QUORUM: Voting members present (but not less than three) at any committee meeting shall constitute a quorum.

MANNER OF ACTION AND VOTING: The Chairperson (or designee) will preside over meetings. The action of a majority of the voting members present at a meeting shall be the action of the group. Action may also be taken by the committee utilizing the following process 1) CME Office sends a written description of items that are to be acted upon to each voting member, 2) voting members vote in writing on those issues and return votes to the Office of CME. Each

member of the committee has only one vote on any issue brought before the group. The Chairperson shall also be entitled to vote.

In the event that an application for CME credit must be acted upon in the absence of the CME Committee, the Chairperson and CME Manager shall be able to designate the activity for CME credit, based upon its compliance with the OSMA's Accreditation Standards. Such action will be reported to the CME Committee at its next meeting.

COMPOSITION: The Continuing Medical Education Committee shall include:

VOTING MEMBERS:

- 1) Up to two Medical Staff members, per hospital, appointed by the Presidents of each Medical Staff. Appointments should represent a cross-section of diagnostic and clinical specialties.
- 2) The Chair
- 3) CME Manager
- 4) Vice President of Medical Education

NON-VOTING MEMBERS:

- 1) CME Program Administrator(s)
- 2) Director of Library Services or designee
- 3) Outcomes Measurement Resources (OMR) representative

DUTIES: The Continuing Medical Education Committee shall:

- 1) develop and provide to the Medical Executive Committees a Mission Statement, which describes the goals of the overall CME Program, scope of the CME effort and types of activities and services provided. The committee shall ensure that the goals are achieved to assure quality education and to meet continuing medical education requirements for the Medical Staffs of Mount Carmel Health System and the Ohio State Medical Association's requirements for accreditation. The Mission Statement shall be approved annually by the CME Committee and when revisions are made the Mission Statement shall be reviewed by the Medical Executive Committees and the combined Credentialing Board of Mount Carmel Health System.
- 2) assure that requirements for OSMA accreditation are met and participate in the on-site review.
- 3) develop CME activities based upon the findings of performance improvement activities (and other appropriate needs assessment documentation). The CME Office will assist physician planners in the prioritization, planning, organization and presentation of continuing medical education activities that address the needs of practicing physicians of the Medical Staffs of Mount Carmel Health System. These activities shall be designed to foster improvements in competence, performance and/or patient outcomes and relationships that physicians use to provide services for patients, the public or the profession. The committee may draw upon other Medical Staff Departments or individual members as needed.
- 4) encourage involvement of all members of the Medical Staffs, throughout the educational process, by enlisting their help in the determination of needs, development of objectives, implementation, teaching, learning, and evaluation.
- 5) establish a procedure for evaluating the effectiveness of the activities and determining if the objectives are being accomplished and report findings to the Medical Executive Committees.
- 6) publicize the continuing medical education effort to the Medical Staffs, alumni, and other interested physicians in the target audience(s).
- 7) review and recommend the aggregate budget for the continuing medical education program and each activity contained therein.
- 8) counsel the Senior Vice President or Chief Medical Officer regarding the utilization of operating and Foundation resources designated for continuing medical education.
- 9) maintain a record of all committee activities, and report monthly to the Medical Executive Committees.

MEETINGS: CME meetings will be held bi-monthly with provision that CME Committee Chair and CME Manager may cancel a meeting when agenda items do not warrant holding a meeting. Meetings will rotate between all hospital sites.

3.6.7 Utilization Management Committee

The Utilization committee is a subcommittee of the hospitals Medical Executive Committee. The committee, through regular review of utilization information, determines whether under-utilization and, when appropriate, over-utilization of services adversely effect the quality of patient care and recommend appropriate actions to be taken. Information reviewed by the Committee is protected as described in the hospital by-laws.

Duties:

The responsibilities of the Utilization Committee include but are not limited to:

- a) Optimizing medical management of cases to reduce admissions without medical necessity and to minimize hospital stays by reducing non-acute days
- b) Analyzing data and information compiled on utilization management indicators
- c) Recommending corrective action to solve identified problems and monitoring problem resolution
- d) Recommending strategies and process changes to enhance the quality and efficiency of patient care while controlling cost
- e) Providing physician advisor support for the Case Management staff

Membership:

The committee membership will consist at the minimum of:

- 1) At least two (2) members of the medical staff that are representative of the population served. This can be the Physician Advisor and Vice President of Medical Affairs or designees
- 2) Chief Nursing Officer or Chief Operating Officer
- 3) Director of Case Management
- 4) Nurse Case Manager

The following are excluded from discussion of particular cases:

- f) An individual who is directly responsible for the care of the patient whose care is being reviewed
- g) An individual with a financial interest in patients' medical care

Meetings:

Each site committee will meet quarterly and as necessary, but no less than 4 times per year

3.7 Mount Carmel Health East/West Medical Staff Committees.

3.7.1 Clinical Department Councils. (Mount Carmel East/West)

Composition. Mount Carmel East and Mount Carmel West shall each have a Clinical Department Council (“CDC”) composed of the following individuals:

- (i) The chair of each of the current clinical Departments of the Hospital, including the chair of the combined Departments, or his/her designee.
- (ii) The elected chair of the CDC.
- (iii) Two (2) additional members at large may be selected for a two (2) year term from the Departments of Medicine or Surgery, if additional representation is needed. Each member at large shall be a member of the Active Medical Staff, shall have demonstrated ability in at least one (1) of the clinical areas covered by the Department, shall be recognized for excellence in personal and professional competence, professional leadership, ethical standing and capacity for responsibility and shall be willing and able to faithfully discharge the functions of the position. The preferential slate of CDC member at large nominees shall be presented to the MEC, which may confirm or reject the preferred nominees. The MEC shall notify the CDC of its vote and provide its reasons to the CDC if preferred nominees are rejected.
- (iv) Chair of the Medical Staff Quality and Peer Review Committee, or his/her designee, without vote
- (v) Hospital CEO, without vote
- (vi) Hospital COO, without vote
- (vii) Hospital Chief Nursing Officer, without vote
- (viii) Vice President Medical Affairs, without vote
- (ix) System COO, without vote
- (x) Chief Medical Information Officer, without vote
- (xi) Vice President Quality & Safety, without vote
- (xii) System Director, Medical Staff Services, without vote
- (xiii) Manager, Medical Staff Services, without vote

Duties. The duties of the CDC shall be to:

- (xiv) Receive and review the reports and recommendations from the clinical Departments under its jurisdiction, the functions of the decentralized Medical Staff committees and transmit its own reports and

recommendations along with the Department's actions, as required by the Bylaws and Medical Staff Policies, to the relevant central committees or MEC.

- (xv) Receive, for informational purposes, follow-up, or action as it deems necessary, the findings and recommendations of the Medical Staff Quality and Peer Review Committee and to provide appropriate input to it.
 - (xvi) Receive reports and recommendations from the decentralized committees established at its respective Hospital, take final action thereon and report such actions to the MEC for its approval (which as part of its authority and responsibility under the Bylaws and this Policy may retroactively rescind any CDC action which, in its views, does not comport with an overall plan of integration and unification).
 - (xvii) Coordinate the activities of, and policies adopted by, the Departments and decentralized committees operating at its respective Hospital.
 - (xviii) Make recommendations to the MEC regarding corrective action as requested by the MEC.
 - (xix) Take reasonable steps to insure professionally ethical conduct and competent performance on the part of the Practitioners at its respective Hospital, including initiating investigations and pursuing corrective action, when warranted, and to see that the Ethical and Religious Directives for Catholic Health Facilities are followed.
 - (xx) Make recommendations to the MEC on medico-administrative and Hospital management matters pertinent to its respective Hospital.
 - (xxi) Perform such other duties as may reasonably be assigned to it by the President of the Medical Staff, the MEC or the Board.
- (j) **Meetings.** The CDC shall meet monthly or as otherwise needed at the call of the committee chair to conduct its business and fulfill assigned responsibilities.

3.7.2 Subcommittee for the Review and Accreditation of GI Endoscopy. (Mount Carmel East/West)

The Subcommittee for the Review and Accreditation of GI Endoscopy is a central committee that reports to the Medical Staff Quality Committee.

Composition. The Subcommittee for the Review and Accreditation of GI Endoscopy shall include, in addition to its chair:

- (i) At least two (2) gastroenterologists (one (1) from Mount Carmel West and one (1) from Mount Carmel East)
- (ii) Two (2) colorectal surgeons (one (1) from Mount Carmel West and one (1) from Mount Carmel East)
- (iii) One (1) general surgeon who is credentialed in the performance of gastrointestinal endoscopy Privileges.

- (iv) One (1) representative of the Outcomes Measurement staff, without vote.

Duties. The Subcommittee for the Review and Accreditation of GI Endoscopy shall:

- (v) Establish the necessary credentials and requirements for the initial grant of gastrointestinal endoscopy Privileges, expansion of existing gastrointestinal endoscopy Privileges, and regrant of gastrointestinal endoscopy Privileges.
- (vi) Monitor ongoing procedural performance and outcomes.

Meetings. The committee shall meet quarterly or as otherwise needed at the call of the committee chair to conduct its business fulfill assigned responsibilities.

3.7.3 Critical Care Quality Committee. (Mount Carmel West only)

The Critical Care Quality Committee is a decentralized committee that functions only at Mount Carmel West and reports to the Medical Staff Quality Committee.

Composition. The Critical Care Quality Committee is a multidisciplinary group that consists of critical care Physicians, GME representatives, surgeons, administrators, Medical Staff leaders, nurses and a pharmacist from the ICU. The Critical Care Quality Committee is co-chaired by the medical directors of MCICU and SICU.

Duties. The Critical Care Quality Committee shall work to improve the quality of care delivered in the Hospital's intensive care units.

Meetings. The Critical Care Quality Committee shall meet monthly and as otherwise needed at the call of the committee chair to conduct its business and fulfill assigned responsibilities.

3.7.4 Surgical Administrative Committee. (Mount Carmel East Only)

The Surgical Administrative Committee is a decentralized committee that reports to the Clinical Department Council.

Composition. The Surgical Administrative Committee shall include, in addition to its chair:

One (1) representative each from the Departments of Anesthesiology, EENT, OB/GYN, Orthopedics and Surgery.

Chief resident in Orthopedics or Surgery, without vote.

A representative of the surgical nursing staff, without vote.

Duties. The Surgical Administrative Committee shall:

Develop and recommend policies for the day-to-day operation of the surgical suite.

Implement such policies and procedures as are approved by its CDC.

Interpret policies associated with the operational aspects of the surgical suite.

Evaluate and make recommendations on requests for capital equipment and expenditures.

Maintain a record of its activities and report periodically thereon to its CDC.

Meetings. The committee shall meet monthly or as otherwise needed at the call of the committee chair to conduct its business and fulfill assigned responsibilities.

3.7.5 Trauma Systems Performance Committee. (Mount Carmel West only)

Composition. The Trauma Systems Performance Committee shall be composed of the following individuals:

- (vii) Trauma Medical Director (who also acts as committee chair)
- (viii) Trauma Attending Physicians
- (ix) Emergency Department Medical Director
- (x) Emergency Physician(s)
- (xi) Orthopedic Surgeon(s)
- (xii) Neurosurgeon(s)
- (xiii) Anesthesiologist(s)
- (xiv) Radiologist (*ad hoc*)
- (xv) Trauma Nurse Coordinator, without vote
- (xvi) Director of ED/Trauma Services, without vote
- (xvii) Emergency Department Unit Director, without vote
- (xviii) Surgical Intensive Care Unit Director, without vote
- (xix) Trauma Registrar, without vote
- (xx) Operating Room Unit Director, without vote

Duties. The Trauma Systems Performance Committee shall:

- (xxi) Assist and advise the Hospitals in attaining and maintaining American College of Surgeons Level II certification.
- (xxii) Develop, organize and implement system processes and protocols that streamline and improve the care of trauma patients.

- (xxiii) Establish clinical guidelines for patient care.
- (xxiv) Develop, maintain and modify a flexible monitoring process that identifies current or potential problems in all areas of care of the injured patient.
- (xxv) Establish and maintain a peer review process that evaluates cases or problems identified by the monitoring process.
- (xxvi) Document its functions.
- (xxvii) Implement corrective actions and reassess the results of these actions.
- (xxviii) Evaluate the effectiveness of its role and functions by reviewing outcomes.

Meetings. The committee shall meet monthly and as otherwise necessary at the call of the committee chair to conduct its business and fulfill assigned responsibilities.

3.7.6 Trauma Peer Review Committee. (Mount Carmel West only)

The Trauma Peer Review Committee is a decentralized committee of the Trauma Committee. The Trauma Peer Review Committee reports to the Medical Staff Quality Committee.

Composition. The Trauma Peer Review Committee is a multidisciplinary committee composed of the Physician voting members of the Trauma Committee.

Duties. The Trauma Peer Review Committee shall conduct peer review of trauma medical issues independently from Department based peer review, including all mortalities. Performance improvement issues related to medical care are specifically addressed and forwarded to appropriate committees and personnel in the Medical Staff structure as needed.

Meetings. The committee shall meet monthly and as otherwise needed at the call of the committee chair to conduct its business and fulfill assigned responsibilities.

3.7.7 Peer Support and Wellness Committee. (Mount Carmel East/West)

Composition. The Peer Support and Wellness Committee (“Peer Support Committee”) is a standing committee of the Medical Staff composed of not less than three (3) Active Medical Staff Members.

The committee may be expanded to include other members as necessary to accomplish its appointed task.

The committee may request consultation when it sees fit. Consultants may be external to the Medical Staff or internal.

Committee members will serve a minimum two (2) year term.

Duties. The changing environment of healthcare delivery creates a framework for constant stress. The increasing demands for care and shrinking resources in a twenty-four (24) hour health care delivery system creates significant strain on the health and well-being of the Members of the Medical Staff. The Peer Support Committee shall:

Fulfill the responsibilities set forth in the Practitioner Wellness Policy, as such Policy may be amended from time to time.

Be a resource for understanding the forces negatively impacting the health and well-being of Practitioners and creating solutions through education, counseling, and system changes.

Assist with intervention should an issue of health or wellness of an individual Practitioner be of concern.

Meetings. The Peer Support Committee shall meet as needed at the call of the committee chair to conduct its business and fulfill assigned responsibilities.

3.8 Mount Carmel St. Ann's Medical Staff Committees.

3.8.1 Service Assessment Committee. (St. Ann's)

Composition. The Service Assessment Committee will be a standing committee of the Medical Staff and shall be composed of the following individuals:

(xxix) Immediate Past Medical Staff President, who shall serve as committee

(xxx) Medical director of the Emergency Department

(xxxi) Vice President of Medical Affairs

(xxxii) President-elect of the Medical Staff

(xxxiii) President & Chief Operating Officer

(xxxiv) Vice President of Patient Care Services & Chief Nursing Officer

(xxxv) Three (3) active Medical Staff Members

Duties. The Service Assessment Committee was formed in 1999 in response to changing needs of the Medical Staff with regard to call rosters for the Emergency Department, changes in requirements for those Practitioners participating in call rosters, and to assist the Medical Executive Committee in assessing needed services at the Hospital. The committee shall:

(xxxvi) Serve to advise the Medical Executive Committee which will in turn advise the Hospital Board of Trustees.

(xxxvii) Formulate, review, and recommend to the MEC any policies necessary to comply with EMTALA legislation and resultant policies and regulations.

Meetings. The Service Assessment Committee will meet as often as necessary to appropriately advise the Medical Executive Committee about the issues with which it is charged.

3.8.2 Peer Support and Wellness Committee. (St. Ann’s)

Composition. The Peer Support and Wellness Committee (“Peer Support Committee”) is a standing committee of the Medical Staff composed of the following individuals:

The last three (3) past Presidents of the Medical Staff. The committee will be chaired by the immediate past Medical Staff President.

As many additional members as necessary to support the needs of the Medical Staff.

The committee may request consultation when it sees fit. Consultants may be external to the Medical Staff or internal.

Committee members will serve a minimum two (2) year term.

Duties. The changing environment of healthcare delivery creates a framework for constant stress. The increasing demands for care and shrinking resources in a twenty-four (24) hour health care delivery system creates significant strain on the health and well-being of the Members of the Medical Staff. The Peer Support Committee shall:

Fulfill the responsibilities set forth in the Practitioner Wellness Policy, as such Policy may be amended from time to time.

Be a resource for understanding the forces negatively impacting the health and well-being of Practitioners and creating solutions through education, counseling, and system changes.

Assist with intervention should an issue of health or wellness of an individual Practitioner be of concern.

Meetings. The Peer Support Committee shall meet as needed at the call of the committee chair to conduct its business and fulfill assigned responsibilities.

3.9 New Albany Surgical Hospital Medical Staff Committees.

3.9.1 Peer Support and Wellness Committee. (New Albany)

Composition. The Peer Support and Wellness Committee (“Peer Support Committee”) is a standing committee of the Medical Staff composed of not less than three (3) Active Medical Staff Members.

The committee may be expanded to include other members as necessary to accomplish its appointed task.

The committee may request consultation when it sees fit. Consultants may be external to the Medical Staff or internal.

Committee members will serve a minimum two (2) year term.

Duties. The changing environment of healthcare delivery creates a framework for constant stress. The increasing demands for care and shrinking resources in a twenty-four (24) hour health care delivery system creates significant strain on the health and well-being of the Members of the Medical Staff. The Peer Support Committee shall:

Fulfill the responsibilities set forth in the Practitioner Wellness Policy, as such Policy may be amended from time to time.

Be a resource for understanding the forces negatively impacting the health and well-being of Practitioners and creating solutions through education, counseling, and system changes.

Assist with intervention should an issue of health or wellness of an individual Practitioner be of concern.

Meetings. The Peer Support Committee shall meet as needed at the call of the committee chair to conduct its business and fulfill assigned responsibilities.

3.11 Conversion from Medical Staff to Hospital Committee.

As necessary and appropriate, a Medical Staff committee may become a Hospital Committee with designated Medical Staff representation as recommended by the MEC and approved by the Board.

3.12 Ad Hoc Committees.

In the course of governing the Medical Staff, it has been recognized that on occasion a small group of Medical Staff Members, working separate from the Medical Executive Committee, may research, gain consensus, and generate workable solutions for problems encountered in the day-to-day operation of the Medical Staff. *Ad hoc* committees may be formed at the recommendation of Medical Executive Committee. Specific goals and timeframes for the committee will be defined as it is chartered. *Ad hoc* committees will be charged with submitting a written report to the Medical Executive Committee on the committee's findings and recommendations. With the submission of a final report, the *ad hoc* committee will be dissolved.

3.13 Committee Members and Chairs.

Selection, Removal and Vacancy. Selection and removal of standing and *ad hoc* Medical Staff committee members and chairs is addressed in §1.1.1 (h) of this Policy, the Medical Staff Bylaws, and the applicable committee descriptions. Unless otherwise provided, a vacancy in a committee member or chair position shall be filled in the same manner in which the original selection was made.

Term and Voting. Unless otherwise provided, all committee members shall serve for the term specified at the time of his/her selection, unless he/she sooner resigns or is removed, and may vote on committee matters.

3.1.4 Joint Conference Committee.

The Joint Conference Committee is an *ad hoc* Board committee and shall be composed of such individuals, have such duties, and meet at such times as set forth in the Hospital's code of regulations, or as otherwise determined by the Board. In the event of any change in the purpose, composition, meeting, or reporting requirements related to the Joint Conference Committee

pursuant to the Hospital's code of regulations, the code of regulations shall govern and this provision will be likewise amended.

3.1.5 Joint Meetings.

Hospital and Affiliate Hospital Medical Staff committees may meet separately or together as deemed necessary and appropriate by the Hospital and Affiliate Hospitals based upon specific needs and circumstances.

3.1.6 Indemnification.

To the fullest extent permitted by the laws of the State of Ohio, the Hospital shall indemnify and hold harmless all Medical Staff officers, committee chairpersons and Members who perform, in good faith and without malice, functions as agents of the Hospital, from any monetary settlements made or judgments rendered against such persons; provided, however, that such indemnification shall not extend to any claims or legal proceedings made or brought against such persons which arise out of such person's acts outside the scope of the agency or which are committed in bad faith or with malice.

**ARTICLE IV
MEDICAL STAFF, DEPARTMENT AND
COMMITTEE MEETINGS**

4.1 **General Medical Staff Meetings.**

4.1.1 **Regular Meetings.** The Medical Staff shall hold at least one (1) meeting each year to be held at the time and place, and subject to such notice requirements as determined by the MEC. The purpose of such meeting(s) shall be to provide information regarding general Medical Staff business and analysis of the clinical work of the Hospital following the agenda set forth in §4.1.7 below, and to vote on all applicable Medical Staff matters.

4.1.2 **Special Meetings.**

(a) The Medical Staff President or the MEC may call a special meeting of the Medical Staff at any time if a decision is required by the Medical Staff. The Medical Staff President shall call a special meeting upon receipt of a request for such meeting signed by not less than twenty percent (20%) of the Members of the Active Medical Staff stating the purpose of such meeting.

(b) Notice stating the date, time and place of any special meeting shall be distributed, in such manner as determined appropriate by the MEC, to each Member of the Active Medical Staff not less than one (1) day before the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

4.1.3 **Quorum.** Unless otherwise provided by the Bylaws or Medical Staff Policies, ten percent (10%) of the Active Medical Staff Members present (either in person, by absentee ballot, or by the use of communications equipment) at any regular or special Medical Staff meeting, but not less than two (2) Members shall constitute a quorum.

4.1.4 **Manner of Action.** Unless otherwise provided in the Medical Staff Bylaws or Policies, the action of a majority of the Active Medical Staff Members in Good Standing present (either in person, by absentee ballot, or by the use of communications equipment) and entitled to vote at a Medical Staff meeting at which a quorum is present shall be the action of the Medical Staff. The voting process shall remain open for seven (7) calendar days following the meeting date.

4.1.5 **Action without a Meeting.** Unless otherwise provided in the Medical Staff Bylaws or Policies, any action which may be authorized/taken at a meeting of the Medical Staff, may be authorized/taken without a meeting if the action is approved by not less than a majority of the Active Medical Staff Members in Good Standing, who would be entitled to vote at a meeting called for such purpose, by ballot received prior to the deadline set forth in the notice advising of the purpose for which action is to be taken.

4.1.6 **Attendance Requirements.** Attendance and involvement at general Medical Staff meetings is encouraged but not required. Attendance and involvement shall be a consideration in the Member's overall involvement in Medical Staff activities for purposes of reappointment/regrant of Privileges. Attendance at all meetings of the Medical Staff shall be recorded.

4.1.7 **Agenda.**

(a) The agenda at any regular Medical Staff meeting may include:

- (i) Call to order
 - (ii) Approval of the minutes of any previous Medical Staff meetings
 - (iii) Unfinished business
 - (iv) Report of the Chief Operating Officer of the Hospital.
 - (v) Report of the Chief Executive Officer of the Health System.
 - (vi) New business
 - (vii) Review and analysis of the clinical work of the Hospital including presentation of interesting or pertinent findings stemming from utilization review and/or patient care evaluation studies
 - (viii) Reports of standing and special Medical Staff committees that have met since the last regular Medical Staff meeting
 - (ix) Discussion and recommendations for improvement of professional services at the Hospital
 - (x) Education
 - (xi) Adjournment
- (b) The agenda at special meetings of the Medical Staff shall include:
- (i) The reading of the notice calling the meeting
 - (ii) Transaction of business for which the meeting was called
 - (iii) Adjournment

4.1.8 **Minutes.** Written minutes of Medical Staff meetings shall be prepared, approved by the Medical Staff, and permanently filed on a confidential basis at the Hospital.

4.2 **Department, Section, and Committee Meetings.**

4.2.1 **Regular Meetings.** Departments shall meet, as needed, at the call of the Department Chair or as otherwise required by applicable Department rules and regulations. Sections shall meet, as needed, at the call of the Section Chief. All committees shall meet as specified in the Bylaws and this Policy and may establish their own schedules in accordance with this Policy.

4.2.2 **Special Meetings.** Special meetings of Medical Staff Departments, Sections, and committees may be called by the Medical Staff President, the Department or committee chair, or Section Chief upon receipt of a request for such meeting signed by not less than twenty percent (20%) of the Department, Section, or committee members in Good Standing and eligible to vote stating the purpose of such meeting, or at the request of the Board.

4.2.3 **Notice.** Notice stating the place, date, and time of any committee or Department/Section meeting shall be distributed, in such manner as determined

appropriate by the Department, Section, or committee chair, to each member not less than seven (7) days before the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting. In lieu of the required seven (7) day notice, a committee or Department/Section may issue a schedule at the beginning of each Medical Staff Year providing for regular committee, Department, and Section meetings.

- 4.2.4 **Quorum.** Unless otherwise provided by the Bylaws or Medical Staff Policies:
- (a) **MEC, Credentials Committee, and Clinical Department Council.** Not less than fifty (50%) of the committee/council members shall constitute a quorum at a meeting of the MEC, Credentials Committee, or Clinical Department Council.
 - (b) **Department, Section, and other Medical Staff Committees.** Not less than two (2) members, shall constitute a quorum at any Department, Section, or committee meeting other than the MEC, Credentials Committee, or Clinical Department Council.
- 4.2.5 **Manner of Action.** Unless otherwise provided by the Medical Staff Bylaws or Policies, the action of a majority of the Department, Section, or committee members in Good Standing, present (either in person, by absentee ballot, or by the use of communications equipment) and entitled to vote at a meeting at which a quorum is present shall be the action of the committee, Department, or Section. In the event that less than fifty percent (50%) of the Department, Section, or Medical Staff committee members are in attendance at the meeting, the voting process shall remain open for seven (7) calendar days following the meeting date.
- 4.2.6 **Attendance.** Fifty percent (50%) attendance at all Department, Section, and committee meetings is mandatory and shall be recorded. Attendance and involvement at such meetings is encouraged (and may be required at the Department level by an individual Department Chair) and shall be a consideration in a Medical Staff Member's overall involvement in Medical Staff activities for purposes of reappointment/regrant of Privileges. Failure to attend 50% of committee meetings is grounds for removal from the committee. Members who do not meet attendance requirements may not hold elected office; vote for elected officers or on general medical staff matters. Such practitioners may vote on Departmental issues when present at the meeting but no mail ballots shall be allowed. MEC, CDC, and Credentials Committee members shall attend at least fifty percent (50%) of the MEC, CDC, or Credentials Committee meetings as well.
- 4.2.7 **Right of Ex-Officio Committee/Department Members.** Persons serving as *Ex-Officio* members of a committee or Department/Section shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum nor may they vote unless the particular committee or Department/Section provides otherwise.
- 4.2.8 **Minutes.** Minutes of each regular and special meeting of a committee or Department/Section shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be approved by the Department/Section or committee members and forwarded to the CDC and/or MEC, as applicable. Each committee and Department/Section shall maintain a permanent file of the minutes of each meeting.

4.3 **Voting Options/Conduct of Meetings.**

- 4.3.1 **Voting Options.** Unless otherwise provided by the Bylaws or Medical Staff Policies, voting may occur in any of the following ways as determined by, as applicable, the Medical Staff President, Department Chair, Section Chief, or committee chair: vote by hand/voice ballot at a meeting at which a quorum is present; vote by written ballot at a meeting at which a quorum is present; vote without a meeting by written or electronic ballot provided such votes are received prior to the deadline date set forth in the notice advising of the purpose for which a vote is to be taken; absentee written/electronic ballots provided the ballots are received prior to the deadline set forth in the notice advising of the purpose for which a vote is to be taken.
- 4.3.2 **Conduct of Meetings.** Common sense, as determined by the presiding officer shall be applied in the conduct of meetings. To the extent there is a disagreement as to procedure, the latest edition of Robert's Rules of Order may be consulted for guidance.
- 4.3.3 **Electronic Communication.** Unless otherwise provided in the Medical Staff Bylaws or Policies, individuals may participate and act at any meeting in person, by absentee ballot or by conference call or other communication equipment through which all persons participating in the meeting can communicate with each other. Participation by such means shall constitute attendance/presence at the meeting.

**ARTICLE V
MISCELLANEOUS**

5.1 **Definitions.**

The definitions set forth in the Medical Staff Bylaws shall apply to this Organization Policy unless otherwise specified herein.

5.2 **Adoption and Amendment.**

This Organization Policy may be adopted and amended in accordance with the applicable procedures set forth in the Medical Staff Bylaws.

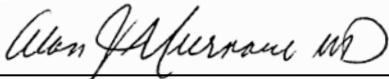
**ARTICLE VI
CERTIFICATION OF ADOPTION & APPROVAL**

ADOPTED by the Medical Executive Committee on April 15, 2014.



Richard Oberlander, D.O.
Chair, Medical Executive Committee
Mount Carmel Health (MCE/MCW)

ADOPTED by the Medical Executive Committee on April 21, 2014.



Alan J. Murnane, M.D.
Chair, Medical Executive Committee
Mount Carmel St. Ann's

ADOPTED by the Medical Executive Committee on April 17, 2014.



Michael B. Cannone, D.O.
Chair, Medical Executive Committee
Mount Carmel New Albany

APPROVED by the Credentialing Sub-Committee of the MCHS Board of Trustees on April 28, 2014.



Charles D. Kerr, D.O., Chair
Credentialing Sub-Committee of the MCHS Board of Trustees

Added Surgical Administrative Committee (SAC)	1/2012
Added Continuing Medical Education Committee (CME)	1/2013
Added Utilization Management Committee (UM)	4/2013
Added Multi-Disciplinary Peer Review Committee (MPRC)	1/27/2014
Peer Review Committee (PRC), System Clinical Care Committee, Clinical Care Committees	
Allied Health Professional (AHP) Credentials Committee	
Added System Medical Staff Credentials Committee	4/28/2014