NEWPORT HOSPITAL
Newport, Rhode Island 02840-2299

MEDICAL STAFF ORGANIZATION MANUAL

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MEDICAL STAFF ORGANIZATION MANUAL

NEWPORT HOSPITAL

Newport, Rhode Island

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PART ONE: RESPONSIBILITIES AND AUTHORITY OF MEDICAL STAFF OFFICERS

1.1 Responsibilities and Authority of the President of the Medical Staff

The President of the Medical Staff has these responsibilities and authority:

a. Serve as Chair of the Medical Executive Committee and as an ex officio member of all other standing Medical Staff committees, with or without vote as provided in the statement of the committee's composition.

   As the Medical Executive Committee Chair, prepare minutes documenting the meetings and provide communications to the Board and Medical Staff members.

b. Convey the views and recommendations of the Medical Staff and the Medical Executive Committee (MEC) on matters of hospital policy, planning, operations, governance, and relationships with external agencies to the Hospital President and the Board of Trustees (or an appropriate representative(s) of the Board).

   Convey the views and decisions of the Board of Trustees and the Hospital President to the Medical Executive Committee and the Medical Staff.

c. Attend Board of Trustees meetings.

d. Preside at, and be responsible for the agenda of, all general and special meetings of the Medical Staff and of the Medical Executive Committee.

e. Appoint the Chairs and Medical Staff members of the Medical Staff Committees, except as otherwise provided in the Medical Staff Bylaws or this Manual.

f. Serve as Chair of the Professional Review Committee and oversee its activities.

Through leadership of the Medical Executive Committee, the President of the Medical Staff has a primary role to ensure that the Medical Executive Committee fulfills the following responsibilities and authority:

g. Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the Medical Staff in their relations with each other, the Board of Trustees, Hospital management, other professional and support staff, and the community the Hospital serves.

h. Promote and enforce compliance with the provisions of the Bylaws and related manuals, rules, policies and procedures of the Medical Staff and the Hospital and with regulatory and accrediting agencies' requirements.

i. Direct the Medical Staff administrative policy-making process and assist the responsible Hospital staff with coordinating the revision, implementation, and compliance with these policies.

j. Supervise the clinical organization of the Medical Staff, coordinate the delivery of services among the Medical Staff clinical services, and assist with coordinating the clinical activities with other professional services in the Hospital.

k. Advise the Board of Trustees and the Hospital President on matters impacting patient care and clinical services, including the need for new or modified programs and services, recruitment and training of professional and support staff personnel, and staffing patterns.

l. Periodically evaluate the effectiveness of the Medical Staff organization and activities.

b. Account for the collection and accounting for any funds that may be collected in the form of Medical Staff dues or assessments and prepare periodic Honorarium reports for the Medical Executive Committee. Provide an annual report of the Honorarium to the Medical Staff.

1.2 Responsibilities and Authority of the President-Elect of the Medical Staff

As the second ranking elected Medical Staff officer, the President-Elect of the Medical Staff has these responsibilities and authority:

a. Assume all of the duties and responsibilities and exercise all of the authority of the President of the Medical Staff when the latter is temporarily or permanently unable to accomplish the same.

b. Attend meetings of the Board of Trustees in the President's absence.

c. Serve as a member of the Medical Executive Committee, with vote.

d. Serve as Chair of the Credentials Committee.

e. Serve as Chair of the Bylaws Committee.

f. Serve as a member of the Professional Review Committee.

g. Perform such additional duties and exercise such authority as may be assigned or granted by the President of the Medical Staff, by the Medical Executive Committee, by the Board of Trustees, or in the Medical Staff Bylaws and related manuals and other Medical Staff or Hospital policies.

1.3 Responsibilities and Authority of the Secretary-Treasurer

The Secretary-Treasurer has these responsibilities and authority:

a. Serve as a member of the Medical Executive Committee, with vote.

c. Serve as Chairman of the Clinical Quality and Safety Council.

d. Advise the Board of Trustees, Hospital President, Medical Executive Committee, and other relevant Staff and Hospital individuals and groups on the functioning of the Quality Program.

e. Serve as a member of the Newport Hospital Quality Oversight Committee.

f. Be responsible for summarizing and reporting on the meetings of the Medical Staff.

g. Perform such additional duties and exercise such authority as may be assigned or granted by the President of the Medical Staff, by the Medical Executive Committee, or in the Medical Staff Bylaws and related manuals or other Medical Staff or Hospital policies.

1.4 Responsibilities and Authority of the Immediate Past President of the Medical Staff

The Immediate Past President of the Medical Staff has these responsibilities and authority:

a. Serve as a member of the Medical Executive Committee, with vote.

b. Serve as a member of the Professional Review Committee.

c. Perform such additional duties and exercise such authority as may be assigned or granted by the President of the Medical Staff, by the Medical Executive Committee, or in the Medical Staff Bylaws and related manuals or other Medical Staff or Hospital policies.

PART TWO: FUNCTIONS AND COMMITTEES OF THE MEDICAL STAFF

2.1 General

As noted in the Bylaws Manual, the functions of the Medical Staff shall be accomplished through assignment to the Medical Staff as a whole, to Departments, Sections or other clinical units, to Medical Staff committees, to Medical Staff officers or other individual Medical Staff members, or to interdisciplinary Hospital committees with participation of Medical Staff members. The formal processes, structures, and reporting relationships specific to the Medical Staff committees are delineated in this section. Those functions delegated to Departments and Sections are delineated separately.

2.2 Medical Executive Committee

The Medical Executive Committee represents the fundamental governance body of the Medical Staff. Its composition, duties, authorities, and meeting parameters are delineated in the Bylaws Manual. The President of the Medical Staff provides reports of Medical Executive Committee business directly to the Board of Trustees and to the Medical Staff after each meeting.

2.3 Nominating Committee

The Nominating Committee composition, responsibilities, and function are delineated in the Bylaws Manual. In fulfilling its duties, the Nominating Committee is directly responsible to the Medical Staff.

2.4 Professional Review Committee

a. Purpose and Objectives

The Professional Review Committee primarily addresses issues related to the Medical Staff Code of Conduct but could also be requested to address other significant medical staff issues such as administrative or clinical quality concerns. Committee function is outlined in the Medical Staff Code of Conduct policy.

b. Reporting Relationships

The Professional Review Committee is responsible to the Medical Staff under the guise of the Medical Executive Committee.

c. Meetings

The Committee convenes after the Medical Executive Committee meetings, as agenda business dictates, to expeditiously address any issues raised.

d. Composition

The Professional Review Committee membership includes:

(1) The President of the Medical Staff Chair who serves as Chair;

(2) The President-Elect of the Medical Staff;

(3) Secretary Treasurer of the Medical Staff;

(4) The Immediate Past President of the Medical Staff, without vote (ex officio); and

(5) The Vice President of Medical Affairs and Chief Medical Officer.

Ad hoc members invited to Committee meetings may include the Department Chair of specific practitioner(s) being reviewed and other individuals determined to be pertinent to the Committee's deliberations.

2.5 Bylaws Committee

a. Purpose and Objectives

The Bylaws Committee fulfills Medical Staff responsibilities for reviewing Lifespan Core Bylaw changes and making recommendations to the Medical Executive Committee about these changes. Additionally, the local Bylaws Committee is responsible for revising the affiliate specific Non-Core Medical Staff Bylaws and related manuals.

b. Reporting Relationships

The Bylaws Committee reports directly to the Medical Executive Committee.

c. Meetings

The Bylaws Committee meets monthly, as agenda business dictates.

d. Composition

The Bylaws Committee membership includes:

(1) The President-Elect of the Medical Staff, who serves as Chair;

(2) At least four (4) members from the Active, Senior Active, or Doctoral Staffs;

(3) President of the Medical Staff, without vote (ex officio);

(4) Medical Staff Services Coordinator, or designee, without vote, as staff; and

(5) Vice President of Medical Affairs and Chief Medical Officer, without vote, as staff.

2.6 Credentials Committee

a. Purpose and Objectives

Coordinate the credentialing process for all credentialed providers by

(1) Receiving and analyzing applications and recommendations for appointment and reappointment, provisional period conclusion or extension, clinical privileges and modifications thereof, and recommending action thereon.

(2) Evaluating criteria for clinical privileges including those for the performance of new procedures or devices.

(3) Developing or coordinating, periodically reviewing, and making recommendations on the procedures and forms used in connection with each component of the credentialing process.

(4) Recommending standards for the content, organization, and maintenance of the individual credentials files.

b. Reporting Relationships

The Credentials Committee reports directly to the Medical Executive Committee.

c. Meetings

The Credentials Committee meets monthly.

d. Composition

The Credentials Committee membership includes:

(1) The President Elect of the Medical Staff Chair who serves as Chair;

(2) At least five (5) members from the Active, Senior Active, or Doctoral Staffs, including a Navy representative;

(1) President of the Medical Staff, without vote (ex officio);

(2) Lifespan Credentialing Manager, without vote, as staff; and

(3) Vice President of Medical Affairs and Chief Medical Officer, without vote, as staff.

2.7 Clinical Quality and Safety Council

a. Purpose and Objectives

The Clinical Quality and Safety Council oversees the functioning of the Hospital-wide Quality and Safety Program Plan, which includes Risk Management Program and the Utilization Review and Management Plan.

To address these purposes, the Clinical Quality and Safety Council focuses on the following objectives:

(1) Annually recommend Medical Staff wide priorities and approval of departmental priorities for review and monitoring;

(2) Review relevant departmental reports to monitor Quality and Safety activities and identify trends and issues requiring focused attention;

(3) Review the Utilization Management Plan and analyze the related data to improve processes;

(4) Assess criteria for departmental and program monitoring;

(5) Recommend CME topics and programs to address opportunities for improvement, as appropriate;

(6) Evaluate the effectiveness of the Quality and Safety Program and recommend appropriate process changes;

(7) Review the recommendations of Medical Staff departments and committees and advise the Medical Executive Committee regarding actions proposed.

b. Reporting Relationships

The Clinical Quality and Safety Council reports directly to the Medical Executive Committee and provides the minutes of its meetings, including quarterly department/committee meeting summaries.

As a component of the Hospital quality management structure, the Clinical Quality and Safety Council minutes are forwarded and presented to the Newport Hospital Quality Oversight Committee.

c. Meetings

The Clinical Quality and Safety Council meets monthly.

d. Composition

The Clinical Quality and Safety Council membership includes:

(1) The Secretary-Treasurer of the Medical Staff, who serves as Chair;

(2) At least four (4) Medical Staff Members at-large with expertise and interest in quality improvement, utilization management and risk management;

(3) Chair of the Infection Control Committee;

(4) Director of Pharmacy Services;

(5) Director, Lifespan Performance Evaluation and Improvement Department;

(6) Vice President of Nursing and Chief Nursing Officer;

(7) President of the Medical Staff, (ex officio);

(8) Risk Manager, without vote;

(9) Operational Excellence department members, without vote, as staff;

(10) Quality Data Coordinator, without vote, as staff; and

(11) Vice President of Medical Affairs and Chief Medical Officer, without vote, as staff.

2.8 Cancer Program Oversight Committee - Cancer Program Committee is a multidisciplinary Lifespan Corporate entity under Rhode Island Hospital dedicated to policy direction and clinical leadership for all aspects of the Lifespan Cancer Program.

2.9 Critical Care/Code Team Committee

a. Purpose and Objectives

The Critical Care/Code Committee is a multidisciplinary committee dedicated to issues related to the provision of critical care and telemetry services at the Hospital in addition to maximizing the survival opportunity for each patient experiencing a cardiopulmonary arrest through the smooth functioning of the Code Team.

Committee objectives include the following:

(1) Identify opportunities for service improvement and determine potential alternatives;

(2) Review quality data and determine improvement options;

(3) Recommend new program development;

(4) Review requests for new equipment through the value analysis process;

(5) Consider cost effective care alternatives;

(6) Create, review, and revise policies and procedures; and

(7) Interface with the Lifespan Inter ICU Council.

(8) Review and evaluate the performance and quality care rendered by Code Blue Teams;

(9) Promote care consistent with standards promulgated by national organizations such as the American Heart Association, the American Academy of Pediatrics, and others;

(10) Track changes in national standards and educate staff involved in cardiopulmonary arrest situations;

(11) Supervise equipment utilized in cardiopulmonary arrest scenarios, such as crash carts;

b. Reporting Relationships

The Critical Care/Code Committee reports to the Clinical Quality and Safety Council.

c. Meetings

The Critical Care/Code Committee meets at least quarterly or as agenda business dictates.

d. Composition

The Critical Care/Code Committee membership includes:

(1) Medical Staff Member who serves as ICU Medical Director and Committee Chair;

(2) Medical Representatives from

a. Intensivist Medicine;

b. Pulmonology;

c. Cardiology;

d. Anesthesiology;

e. Hospital Medicine

f. Pediatrics;

g. Emergency medicine.

(3) Nursing Representatives from

a. Emergency Medicine;

b. Maternal Child Health;

c. Medical and Surgical Units

d. IV team;

e. Clinical Nurse Specialists.

(4) Vice President of Nursing/Chief Nursing Officer, without vote.

(5) Vice President of Medical Affairs/Chief Medical Officer, without vote.

(6) Respiratory Therapy.

(7) Director of Cardiopulmonary Unit.

2.10 Emergency Preparedness Committee

a. Purpose and Objectives

The Emergency Preparedness Committee is a multidisciplinary committee that creates and affects the Hospital Emergency Operations Plan in all of its facets. The Plan is determined in part by the performance of annual Hazard Vulnerability Analyses. The Committee assures compliance with accreditation standards and state and federal regulations and interfaces regularly with local, health system, and statewide emergency preparedness entities.

b. Reporting Relationships

The Emergency Preparedness Committee reports to the Clinical Quality and Safety Council.

The Medical Executive Committee receives Emergency Preparedness reports at each meeting from the Vice President of Nursing and Chief Nursing Officer. In addition, a summary of the Safety Management Report presented twice a year to the Newport Hospital Quality Oversight Committee is presented in the forwarded Council minutes.

Individual Medical Staff members are apprised of the Emergency Preparedness Plan through Annual Safety Training. All Medical Staff Members are expected to be active participants in the Emergency Preparedness Plan.

c. Meetings

The Emergency Preparedness Committee meets monthly as agenda business dictates.

d. Composition

The Medical Staff assigns a Medical Liaison member to the Committee. Other Medical Staff Members are invited to attend as requested.

2.11 Infection Control Committee

The Infection Control Committee is a multidisciplinary committee led by the Medical Staff that is responsible for the surveillance, prevention, and control of infections in the Hospital. The Committee's purpose, objectives, authority, reporting relationships, meeting frequency, and membership composition are defined in the Administrative Manual Policy #1895.

2.12 Maternal Child Health Joint Practice Committee

a. Purpose and Objectives

The Maternal Child Health Joint Practice Committee is a multidisciplinary committee dedicated to issues related to the provision of obstetrical, neonatal, and inpatient pediatric services at the Hospital. The Committee format promotes collaboration and communication among the involved disciplines.

Committee objectives include the following:

(1) Identify opportunities for service improvement and determine potential alternatives;

(2) Review quality data and determine improvement options;

(3) Recommend new program development;

(4) Review requests for new equipment through the value analysis process;

(5) Consider cost effective care alternatives; and

(6) Create, review, and revise policies and procedures.

b. Reporting Relationships

The Maternal Child Health Joint Practice Committee reports through the Clinical Quality and Safety Council.

c. Meetings

The Maternal Child Health Joint Practice Committee meets every other month, and as agenda business dictates.

d. Composition

The Maternal Child Health Joint Practice Committee membership includes:

(1) Chair, Department of OB/GYN, who serves as Chair;

(2) Chair, Department of Pediatrics, or designee;

(3) Chair, Department of Anesthesiology, or designee;

(4) Certified Nurse Midwife;

(5) Director, Maternal Child Services;

(6) Assistant Clinical Manager, Maternal Child Services;

(7) Nursing Staff representatives;

(8) Surgical Services Department leadership representative; and

(9) Vice President of Nursing and Chief Nursing Officer, without vote.

2.13 Pharmacy and Therapeutics Committee

a. Purpose and Objectives

The Pharmacy and Therapeutics Committee is an all affiliate corporate Pharmacy committee with active participation from Newport Hospital which fulfills Medical Staff responsibilities related to pharmacy and therapeutics policies and practices.

The purpose of the Pharmacy and Therapeutics Committee is to ensure that the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials is controlled and monitored through approved policies and procedures in order to ensure optimal clinical outcomes, to minimize the risks associated with drug therapy and to achieve the cost-effective utilization of drugs and diagnostic testing materials.

The Pharmacy and Therapeutics Committee objectives include

(1) The development and approval of policies and procedures relating to the evaluation, selection, distribution, handling, use, and administration of drugs and diagnostic testing materials;

(2) The development and maintenance of an approved drug formulary, over which the Committee has full authority. This includes approval authority for adding or deleting medications to/from the formulary

(3) The evaluation of protocols concerned with the use of investigational or experimental drugs;

(4) The definition and review of all significant adverse drug reactions;

(5) The development of policies and procedures designed to reduce the high cost of drug therapy without compromising the quality of patient care;

b. Reporting Relationships

The Pharmacy and Therapeutics Committee report out to the Medical Executive Committee.

c. Meetings

The Pharmacy and Therapeutics Committee meets monthly, or as agenda business dictates. Distant electronic voting is used to approve/disapprove the addition of meds to the formulary.

d. Composition

The Pharmacy and Therapeutics Committee membership from Newport Hospital includes:

(1) An Active Medical Staff Member, who serves as lead;

(2) At least 2 Medical Staff members representing Newport Hospital.

(3) Director of the Newport Pharmacy;

(4) Nursing Services members representative of the scope of Hospital services rendered;

(5) Vice President of Medical Affairs/Chief Medical Officer.

2.14 Radiation Safety Committee

The Radiation Safety Committee is a multidisciplinary committee led by a Medical Staff member in the Diagnostic Imaging Department and is responsible for assuring the safe management of equipment and materials that are radioactive or produce radiation. The Committee's purpose, objectives, authority, reporting relationships, meeting frequency, and membership composition are defined in the Administrative Manual Policy #3524. This committee meets biannually and the minutes of these meetings are reported to the Clinical Quality and Safety Council.

2.15 Surgical Services Joint Practice Committee

a. Purpose and Objectives

The Surgical Services Joint Practice Committee is a multidisciplinary committee dedicated to issues related to the provision of surgical and endoscopic services at the Hospital. The Committee format promotes collaboration and communication among the involved disciplines.

Committee objectives include the following:

(1) Identify opportunities for service improvement and determine potential alternatives;

(2) Review quality data and determine improvement options;

(3) Recommend new program development;

(4) Review requests for new equipment through the value analysis process;

(5) Consider cost effective care alternatives;

(6) Review surgical schedule utilization and requests for additional surgical time; and

(7) Create, review, and revise policies and procedures.

b. Reporting Relationships

The Surgical Services Joint Practice Committee reports through the Clinical Quality and Safety Council.

c. Meetings

The Surgical Services Joint Practice Committee meets monthly, or as agenda business dictates.

d. Composition

The Surgical Services Joint Practice Committee membership includes:

(1) Chair, Department of Surgery, who serves as Chair;

(2) Chair, Department of Orthopedics, or designee;

(3) Chair, Department of OB/GYN, or designee;

(4) Chair, Department of Anesthesiology, or designee;

(5) Director, Surgical Services Department;

(6) Surgical Services Supervisors;

(7) Surgical Services Staff representatives;

(8) Vice President of Nursing and Chief Nursing Officer, without vote ; and

(9) Vice President of Medical Affairs and Chief Medical Officer, without vote.

2.16 Medical Records

a. The Medical Staff shall collaborate with the Health Information Services Department to define medical record practices to facilitate continuity of care and communications between all those providing patient care services in the Hospital. The medical record shall properly describe the reason that the patient is in the Hospital, the condition and progress of the patient, the therapy and tests provided including the reasons for and the results thereof, and the identification of responsibility for all actions taken.

b. Medical record entry and completion requirements related to Medical Staff functions are delineated in the Medical Staff Rules and Regulations.

c. Medical Staff Member performance with respect to the quality of medical record entries and compliance with medical record completion parameters will be evaluated and monitored through pertinent Medical Staff quality indicators and considered during the Members' privilege cycle and at the time of reappointment to the Medical Staff.

2.17 Practitioner Health Support

a. The Newport Hospital Medical staff is supported by an active member of the medical staff who serves as liaison with the Rhode Island Medical Society and sits on the RIMS Physician Health Committee.

b. The Liaison serves as a resource for referral including self-referral or referral from others in regard to the health and behavior of individual credentialed providers.

2.18 Policy Review Process

a. Responsibility for the primary policy review process will rest with the policy originator in accordance with Hospital policy. Those policies that contain items with clinical issues pertinent for Medical Staff review and input will be circulated to appropriate areas by the onsite Medical staff coordinator.

b. Reviews will be limited to clinical issues pertinent for medical staff input. Other issues involved in basic policy review will be referred to the appropriate area, e.g., nursing, Administration, or other appropriately responsible entity.

c. The Medical Executive Committee provides medical staff input and clinical review of pertinent hospital policies in the following contexts:

   (1) Reviews of patient care policies that do not have an inherent mechanism for Medical Staff input or review.

   (2) Reviews of patient care policies on the appeal of those involved in the initial policy review in which there is

      i. Disagreement between the originator of the policy and the reviewing individual/group, or

      ii. Perceived conflict of interest due to a personal stake in the process under review.

   (3) Reviews of clinical guidelines and patient care and administrative policies with applicability or impact that transcends individual Department or Committee scope of responsibility.

PART THREE: RESPONSIBILITIES AND AUTHORITY OF DEPARTMENT CHAIRS AND SECTION CHIEFS

3.1 Responsibilities and Authority of Department Chairs

Assuring accomplishment of the functions of a Department as outlined in the Medical Staff Bylaws and assuming responsibility for all professional and administrative activities within the Department, a Department Chair is responsible for the following:

a. Preparing the agenda for, presiding over, and summarizing the content of all department meetings;

b. Overseeing all clinically related activities of the Department;

c. Recommending a sufficient number of qualified and competent persons to provide care, treatment, and services;

d. Recommending to the Credentials and Medical Executive Committees the criteria for clinical privileges that are relevant to the patient care provided by the department;

e. Determining the qualifications and competence of Department members who are not licensed independent practitioners and who provide patient care, treatment, and services;

f. Preparing and transmitting recommendations concerning appointment, reappointment, delineation of clinical privileges, and corrective action with respect to practitioners who are appointed to or exercise privileges within the Department;

g. Developing and implementing policies and procedures that guide and support the provision of care, treatment, and services;

h. Supervising all administratively related activities of the Department unless otherwise provided by the Hospital;

i. Integrating the Department into the primary functions of the Hospital;

j. Coordinating and integrating interdepartmental and intradepartmental services;

k. Recommending space and other resources needed by the Department;

l. Recommending off-site sources for needed patient care, treatment, and services not provided by the Department or the Hospital;

m. Enforcing Hospital and Medical Staff Bylaws and related manuals, rules, policies, and procedures within the Department, including the initiation of investigation and intervention related to practitioner clinical performance;

n. Continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges, including the formal peer review process;

o. Continuously assessing and improving the quality of care, treatment, and services;

p. Developing and evaluating departmental quality indicators, as appropriate;

q. Performing such other duties and exercising such authority commensurate with the position as set forth in the Medical Staff Bylaws and related manuals, in other Hospital or Medical Staff rules and policies, and, if applicable, in a contract with the Hospital, and, as may from time to time be reasonably requested by the President of the Medical Staff, the Medical Executive Committee, the Hospital President, or the Board of Trustees.

3.2 Responsibilities and Authority of Section Chiefs

Assuring accomplishment of the functions of a Section as provided in the Medical Staff Bylaws and assuming responsibility for all professional and administrative activities within the Section, a Section Chief has these specific responsibilities and authority:

a. Preparing the agenda for, presiding over, and summarizing the content of all Section meetings;

b. Maintaining continuing review of the patient care and professional performance of practitioners with delineated clinical privileges in the Section and report to the Department Chair on patterns or situations affecting patient care, treatment, and services;

c. Conducting investigations and submitting reports and recommendations regarding appointment, reappointment, delineation of clinical privileges and corrective action with respect to practitioners who are appointed to or are applying to exercise clinical privileges in the Section;

d. Assisting the Department Chair in planning with respect to the Section's personnel, equipment, facilities, and services;

e. Managing the Section through cooperation and coordination with the Department Chair and the President of the Medical Staff and with the nursing and other patient care services and Hospital management on all matters affecting patient care, treatment, and services;

f. Enforcing the Hospital and Medical Staff Bylaws and related manuals, rules, policies, procedures, and regulations within the Section, including initiating investigation of and intervention related to practitioner clinical performance;

g. Implementing and supervising systems, in cooperation with the Department Chair and other appropriate officials and committees of the Medical Staff and Hospital, to carry out the quality assessment and improvement, risk management and utilization management functions assigned to the Section;

h. Reviewing data/information forwarded from the various Medical Staff committees charged with quality review, risk management or utilization management activities; responding to requests from and recommendations by said committees; and making recommendations or taking action as appropriate;

i. Assisting the Department Chair with the implementation of orders from the Medical Executive Committee, the Board of Trustees, and other relevant Staff and Hospital authorities;

j. Performing such other duties and exercising such authority commensurate with the position as set forth in the Medical Staff Bylaws and related manuals, in other Hospital or Medical Staff rules and policies, and, if applicable, in a contract with the Hospital, and, as may from time to time be reasonably requested by the President of the Medical Staff, the Medical Executive Committee, the Hospital President, or the Board of Trustees.

PART FOUR: MEDICAL STAFF DEPARTMENTS AND SECTIONS

4.1 Medical Staff Departments and Sections

The current Medical Staff Departments are:

a) Anesthesiology

b) Diagnostic Imaging

c) Emergency Services

d) Family Medicine
e) Medicine
f) Obstetrics & Gynecology
g) Orthopedics
h) Pathology
i) Pediatrics
j) Psychiatry
k) Surgery

PART FIVE: MEETING PROCEDURES

5.1 Notice of Meetings

Written and/or electronic notice of any regular general Medical Staff meeting, or of any regular Committee, Department or Section meeting must be delivered electronically to each person entitled to be present not less than three (3) business days nor more than ten (10) business days before the date of such meeting.

Notice of any special meeting of the Medical Staff, Committee, Department, or Section must be given electronically or orally at least seventy-two (72) hours prior to the meeting. No business shall be transacted at any special meeting except that stated in the meeting notice.

Personal attendance or telephonic attendance at a meeting constitutes a waiver of notice of such meeting, except when a person attends a meeting for the express purpose of objecting to the transaction of any business because the meeting was not duly called or convened. The objection must be stated at the beginning of the meeting and addressed at that time.

5.2 Quorum

Those present of the qualified voting members in good standing, but not less than two such members, constitutes a quorum for the transaction of any business at all types of Medical Staff related meetings, including annual, regular, and special general Medical Staff meetings and regular and special Department, Section, and Committee meetings.

5.3 Order of Business at Regular Medical Staff Meetings

The President of the Medical Staff determines the order of business at a regular Medical Staff meeting. The agenda includes at least:

a) Acceptance of the minutes of the last regular and all special meetings held since the last regular meeting.
b) Administrative reports from the President of the Medical Staff and the Hospital President.
c) The election of officers and at-large representatives to Medical Executive Committee, when required by the Medical Staff Bylaws.
d) Reports by responsible individuals to fulfill required Medical Staff functions.
e) New business.

5.4 Manner of Action

Business will preferably be conducted by consensus of the voting members present. When a formal vote is required, the actions of a simple majority of the voting members present at a meeting at which a quorum is present constitute the actions of the group, except where otherwise specified.

Action may be taken without a meeting by the Medical Staff, a Department, Section or Committee by presentation of the question(s) to each eligible voting member in person, by mail, or by electronic means and the individual's vote returned to the President of the Medical Staff in the case of a Medical Staff vote or to Chair of the group in the case of a Department, Section, or Committee. Such vote shall be binding so long as the question is voted on by at least the number of voting members of the group that would constitute a quorum.

5.5 Minutes

Minutes of all meetings shall be prepared and include a record of attendance and the vote taken on each matter. Copies of said minutes must be signed by the presiding individual, and forwarded to the Medical Executive Committee or the Clinical Quality and Safety Council. Minutes shall be made available, upon request to and at the discretion of the President of the Medical Staff, to any Medical Staff member who functions in an official capacity within the Hospital to have a legitimate interest in them.

Minutes of the Medical Executive Committee and general Medical Staff meetings will be retained indefinitely. Minutes of the Departments, Sections, and Committees will be maintained for a minimum of five years.

5.6 Procedural Rules

The actual conduct of meetings of the Medical Staff, Departments, Sections, and Committees will be determined by the presiding individual.

The latest edition of Robert's Rules of Order Revised may be used for reference at all meetings and elections, but shall not be required or binding. Specific provisions of these Bylaws and related manuals, and Medical Staff or committee custom, shall prevail at all meetings, and the presiding individual shall have the authority to rule definitively on all matters of procedure.

PART SIX: ADOPTION

6.1 Medical Staff

This Medical Staff Organization Manual was adopted and recommended to the Board of Trustees by the Medical Executive Committee on May 23, 2016.

_____

Jeffrey Gaines, MD

President of the Medical Staff

6.2 Board of Trustees

This Medical Staff Organization Manual was approved and adopted by resolution of the Board of Trustees on _____2016, after considering the Medical Executive Committee's recommendations.

_____

Chairman Board of Trustees

_____

Crista F. Durand

President, Newport Hospital