St. David's North Austin Medical Center

ORGANIZATION MANUAL

Approved: December 19, 2016

ORGANIZATION MANUAL
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ARTICLE 1
GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in the Medical Staff Bylaws, Credentials Policy, and Organization Manual are set forth in the Medical Staff Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital Administration, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff Member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2
CLINICAL DEPARTMENTS AND SECTIONS

2.A. DEPARTMENTS

The Medical Staff shall be organized into the following departments[1]:

- Medicine/Family Medicine
- Surgery
- Obstetrics and Gynecology
- Pediatrics
- Pathology
- Medical Imaging
- Anesthesiology
- Emergency Medicine

2.B. SECTIONS

Each department may be divided into the following sections:[2]

Medicine/Family Medicine

- Allergy & Immunology
- Cardiology
- Dermatology
- Family Medicine
- Gastroenterology
- Internal Medicine
- Neurology
- Physical Medicine & Rehabilitation
- Preventive Medicine
- Psychiatry & Neurology

Surgery

- Anesthesiology
- Colorectal Surgery
- General Surgery
- Ophthalmology
- Otolaryngology
- Neurological Surgery
- Pathology
- Plastic Surgery
- Urology
- Vascular Surgery

Emergency Medicine

- Pediatric Emergency Medicine

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1 MS.01.01.01, MS.06.01.07, LD.04.01.05

2 MS.01.01.01, MS.06.01.07, LD.04.01.05

2.C. SERVICE LINES

Service lines may exist to provide fully integrated services which are necessary to manage the health of a defined classification of patients. The classification may be based upon a medical condition, a procedure or clinical service or a patient population. Service lines need not be specifically identified in this Organization Manual or other any other Bylaws document or Hospital or Medical Staff policy.

2.D. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS AND SECTIONS

(1) Clinical departments and sections shall be created and may be consolidated or dissolved by the Medical Executive Committee upon approval by the Board as set forth below.

(2) The following factors shall be considered in determining whether a clinical department or section should be created:

- (a) there exists a number of Members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department or section (this number must be sufficiently large to enable the department to accomplish its functions as set forth in the Bylaws);
- (b) the level of clinical activity that will be affected by the new department or section is substantial enough to warrant imposing the responsibility to accomplish departmental or section functions on a routine basis;
- (c) a majority of the voting Members who would be assigned to the proposed department or section vote in favor of the creation of a new department or section;
- (d) it has been determined by the Medical Staff leadership and the Chief Executive Officer that there is a clinical and administrative need for a new department or section; and
- (e) the voting Medical Staff Members who are in favor of, and would be assigned to, the proposed department or section have offered a reasonable proposal for how the new department or section will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) In the event that a new department or section is created, the Medical Executive Committee will recommend those Practitioners who shall be assigned to the department or section.

(4) The following factors shall be considered in determining whether the dissolution of a clinical department or section is warranted:

- (a) there is no longer an adequate number of Members of the Medical Staff in the clinical department or section to enable it to accomplish the functions set forth in the Bylaws and related policies;
- (b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members of the department or section;
- (c) the department or section fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;
- (d) no qualified individual is willing to serve as department chief or section chief; or

(e) a majority of the voting members of the department or section vote for its dissolution.

(5) In the event that a department or section is dissolved, the Medical Executive Committee will recommend the new department or section assignment for those Practitioners whose department or section was dissolved.

2.E. CREATION AND DISSOLUTION OF SERVICE LINES

Service lines may be created, consolidated, and dissolved jointly by the Medical Executive Committee and the Board of Trustees. Service line creation is appropriate when it is determined that quality care can be provided more efficiently and effectively to a defined classification of patients through a service line. Consolidation is appropriate when it is determined that the service line would function more effectively or efficiently in combination with other service lines. Dissolution is appropriate when there is an insubstantial number of patients or an insignificant amount of clinical activity within the service line or when it is determined that patients could be better served through a different organizational structure (such as departments or sections).

ARTICLE 3
MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other medical peer review functions that are delegated to the Medical Staff by the Board.

(2) The Medical Executive Committee and the general procedures for the appointment of committee chairs and members of the committees are set forth in Article 6 of the Medical Staff Bylaws.

(3) This Article details the standing members of each Medical Staff committee other than the Medical Executive Committee. In addition to the standing members, other Medical Staff Members or Hospital personnel may be invited to attend a particular Medical Staff committee meeting (as guests, without vote) in order to assist such committee in its discussions and deliberations regarding one or more issues on its agenda. All such individuals are an integral part of the medical and peer review process and are bound by the same confidentiality requirements as the standing members of such committees.

(4) A standing committee shall also have the option of calling upon any Member of the Medical Staff or other Practitioner to serve on the committee on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment subject to approval of the Chief of Staff. Ad hoc members of a committee shall be bound by the confidentiality requirements of the committee. Ad hoc members of the committee shall not have voting rights on the committee.

(5) Individual Members of the Medical Staff and other practitioners with Clinical Privileges care for patients within an organizational context. Within this context, members of the Medical Staff and other Practitioners with Clinical Privileges participate in the important Medical Staff activities summarized in Appendix A through departments, sections, service lines, if any, and committees.

(6) See Credentials Policy, Section 1.D. regarding indemnification.

3.B. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely report after each meeting to the Medical Executive Committee and to other committees and individuals as may be indicated in this Manual.

3.C. ADVANCED PRACTICE PROFESSIONALS REVIEW COMMITTEE

3.C.1. Composition:

The Advanced Practice Professionals Review Committee shall consist of the following individuals who shall serve *ex officio*, with vote: the Chief Medical Officer, the Chief Nursing Officer, the Chief of Staff and the Medical Staff Services Director. The Advanced Practice Professionals Review Committee shall also include at least the following as voting members, each of whom shall be appointed by the Chief of Staff: one nurse practitioner and one physician assistant with

Clinical Privileges. Other Medical Staff Members or Hospital personnel (including the relevant department chairperson(s), other individual(s) in the Medical Staff department, division or service line with relevant clinical expertise, and head(s) and/or nurse manager(s) of the Hospital departments in which the Advanced Practice Professional would work, may be invited to attend meetings in order to assist the Advanced Practice Professional Review Committee in its discussions and deliberations regarding issues on its agenda.

3.C.2. Duties:

The Advanced Practice Professionals Review Committee shall:

(1) evaluate and make recommendations to the Medical Executive Committee and Board of Trustees regarding the need for the services that could be provided by the types of Advanced Practice Professionals that are not currently permitted to practice in the Hospital;

(2) develop and recommend policies for each type of Advanced Practice Professional permitted by the Board of Trustees to practice in the Hospital, which shall specify training, education and experience requirements for applicants, the scope of practice or Clinical Privileges to be granted, any conditions that apply to the Advanced Practice Professionals functioning within the Hospital, any ongoing supervision requirements, and malpractice insurance requirements;

(3) review the qualifications of all Advanced Practice Professionals who apply for Clinical Privileges in the Hospital, interview such applicants as may be necessary, and make a written report of its findings and recommendations;

(4) review on an ongoing basis the quality of care provided by Advanced Practice Professionals at the Hospital, including developing plans for focused professional practice evaluation ("FPPE") and ongoing professional practice evaluation ("OPPE") related to the professional practice of Advanced Practice Professionals and review data and make recommendations regarding continuation, limitation or revocation of Clinical Privileges of each Advanced Practice Professional based on such data; and

(5) review, as questions arise, all information available regarding the clinical competence and/or professional conduct of Advanced Practice Professionals currently permitted to practice in the Hospital and, as a result of such review, make a written report of its findings and recommendations.

3.C.3. Meetings and Reports:

The Advanced Practice Professionals Review Committee shall report its recommendations after each meeting to the Credentials Committee, as appropriate, in addition to the Medical Executive Committee. The chairperson of the committee shall be available to meet with the Medical Executive Committee, Board of Trustees, its committees or the Chief Executive Officer on all recommendations that the Advanced Practice Professionals Review Committee may make.

3.D. BYLAWS COMMITTEE

3.D.1. Composition:

The Bylaws Committee shall be composed of the Immediate Past Chief of Staff who shall chair the committee, the Vice Chief of Staff and a minimum of three (3) Active Staff Members from each department selected by the Chief of Staff. In addition, to the Chief Executive Officer and the Chief Medical Officer, the *ex officio* members without vote shall also include Medical Staff Services personnel appointed by the Chief Executive Officer.

3.D.2. Duties:

The Bylaws Committee shall be responsible for performing the review and revisions of the Bylaws under the oversight and direction of the Medical Executive Committee. The Bylaws Committee shall review these Bylaws, this Manual, the Credentials Policy, the Rules and Regulations and associated Medical Staff policies and recommend any needed additions, revisions, modifications, amendments or deletions. The Bylaws Committee shall also review all department and division rules and regulations.

3.D.3. Meetings and Reports:

The Bylaws Committee shall meet at least annually and shall report its recommendations and activities to the Medical Executive Committee.[3]

3.E. CREDENTIALS COMMITTEE

3.E.1. Composition:

The Credentials Committee shall consist of the Vice Chief of Staff, who shall chair the committee, the Chairpersons of each of the Medical Staff Departments, and the Section Chiefs. In addition to the Chief Executive Officer and the Chief Medical Officer, the *ex officio* members without vote shall also include the Chairperson of the Advanced Practice Professionals Review Committee and a designated representative from the Medical Staff Services department.

3.E.2. Duties:

The Credentials Committee shall:

(1) in accordance with the Credentials Policy, review the credentials of all Applicants for initial and renewed Medical Staff Membership and Clinical Privileges, conduct a thorough review of the Applications, interview such Applicants as may be necessary, and make written reports of its findings and recommendations;

(2) review, as may be requested by the Medical Executive Committee or other appropriate committee, all information available regarding the current clinical competence of Practitioners and, as a result of such review, make a written report of its findings and recommendations;

(3) recommend the numbers and types of cases to be reviewed as part of the initial focused professional practice evaluation;

(4) review and approve specialty-specific criteria for ongoing professional practice evaluation and specialty-specific triggers that are identified by each department;

[3] MS.02.01.01

(5) recommend to the Medical Executive Committee appropriate threshold eligibility criteria for Clinical Privileges, including Clinical Privileges for new procedures and Clinical Privileges that cross specialty lines; and

(6) collaborate with the Advanced Practice Professionals Review Committee regarding questions about scope of licensure, the relationships between Advanced Practice Professionals and Supervising/Collaborating Practitioners, and, as applicable, the level of delegation, direction or supervision required for Advanced Practice Professionals.

3.E.3. Meetings:

The Credentials Committee shall meet at least monthly and shall report its recommendations and activities to the Medical Executive Committee.[4]

3.F. PROFESSIONAL REVIEW COMMITTEE

3.F.1. Composition:

(1) The Professional Review Committee shall be comprised of the following voting members:
   (a) Chief of Staff, who shall serve as Chair;
   (b) Chair, Peer Review Committee ("PRC"); and
   (c) Immediate Past Chief of Staff.

(2) The following individuals shall serve as *ex officio* members, without vote, to facilitate the Professional Review Committee's activities:
   (a) Chief Medical Officer (or designee); and
   (b) PRC Support Staff representatives.

(3) Other Medical Staff Members or Hospital personnel may be invited to attend a particular Professional Review Committee meeting (as guests, without vote) in order to assist the Professional Review Committee in its discussions and deliberations regarding issues on its agenda. These individuals shall be present only for the relevant agenda items and shall be excused for all others. Such individuals are an integral part of the medical peer review process and are bound by the same confidentiality requirements as the standing members of the Professional Review Committee.

3.F.2. Duties:

The Professional Review Committee shall perform the following functions:

(1) review and address concerns about Practitioners' professional conduct as outlined in the Medical Staff policy on professionalism found in the Medical Staff Rules and Regulations;

(2) review and address concerns about Practitioners' health status and the ability to provide safe and competent care as outlined in the policy on Practitioner health;

(3) review and address issues regarding Practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy (Peer Review);

[4] MS.02.01.01

(4) meet, as necessary, to consider and address any situation that may require immediate action;

(6) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any department or unit within the Hospital; and

(7) perform any additional functions requested by the Medical Executive Committee, or the Board.

3.**F.3. Meetings:**

The Professional Review Committee shall report to the PRC in addition to, the MEC, and others as described in the Policies noted above.

3.G. PEER REVIEW COMMITTEE ("PRC")

3.G.1. Composition:

(1) The Peer Review Committee ("PRC") shall consist of at least seven (7) voting members who shall be active Medical Staff members in good standing. The voting members shall include:

- (a) One (1) Active Medical Staff representative from the each department (Anesthesiology, Medicine, Surgery, Obstetrics and Gynecology and Emergency Medicine and Pediatrics);
- (b) Additional Medical Staff Members who are:
  - (i) broadly representative of the clinical specialties on the Medical Staff,
  - (ii) experienced and/or interested in credentialing, privileging, PPE/peer review, or other Medical Staff affairs,
  - (iii) supportive of evidence-based medicine protocols, and
  - (iv) appointed by the Medical Executive Committee as deemed apprpropriate.

(2) The following individuals shall serve as *ex officio* members, without vote, to facilitate the PRC's activities:

- (a) Chief Executive Officer; and
- (b) Chief Medical Officer (or designee); and
- (b) Director of Quality Management; and
- (c) Risk Manager

3.G.2. Duties:

The PRC shall perform the following functions:

(1) assess the quality of patient care provided in accordance with the performance improvement plan, including FPPE and OPPE, and recommend and implement develop performance improvement interventions when needed under the oversight and direction of the Medical Executive Committee;

(2) plan, implement, coordinate and promote ongoing Medical Staff participation in the Hospital's performance improvement peer review program;

(3) ~~shall~~ ensure that when the findings of the quality assessment process (either aggregate data or single events) are relevant to a Practitioner's performance, the committee shall conduct a review of the Practitioner's competence and make recommendations accordingly;

3.J.3. Meetings:

The PRC shall meet at least monthly, unless there is no business to come before the committee in which case the Chair may cancel the meeting.

ARTICLE 4
ADOPTION AND AMENDMENTS

(1) This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other conflicting policies and rules and regulations of the Medical Staff or Hospital pertaining to the subject matter thereof.

(2) The amendment process for this Manual is set forth in the Bylaws.

Adopted by the Medical Staff: _____

[DATE]

Approved by the Board of Trustees: _____

[DATE]

APPENDIX A

SUMMARY OF MEDICAL STAFF ACTIVITIES

Appendix A.1 - Governance:

The Medical Staff is not a separate legal entity, but is an integral part of the Hospital, which shall:

(1) establish a framework for self-governance of Medical Staff activities and accountability to the Board of Trustees[1]; and

(2) establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.[2]

Appendix A.2 - Planning:

The Medical Staff leaders shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

(1) planning patient care services;[3]

(2) planning and prioritizing performance improvement activities;[4]

(3) budgeting;[5]

(4) providing for uniform performance of patient care processes;[6]

(5) recruitment, retention, development and continuing education of all staff;[7]

(6) consideration and implementation of clinical practice guidelines as appropriate to the patient population;[8]

(7) establishing and maintaining responsibility for written policy and procedures governing medical care provided in the emergency service or department;

(8) establishing, if emergency services are not provided at the Hospital, policies and procedures for appraisal of emergencies, initial treatment and referral of patients when needed;[9] and

(9) securing autopsies in all cases of unusual deaths and of medical, legal and educational interest.[10]

Appendix A.3 - Credentialing and Privileging:

The Medical Staff is responsible to the Board of Trustees for the credentialing process, which includes a series of activities designed to collect relevant data that will serve as a basis for decisions regarding appointments and reappointments to the Medical Staff, as well as delineation of Clinical Privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

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1 MS.01.01.01, MS.01.03.03

2 MS.03.01.03, LD.1.10, LD.03.04.01

3 LD.02.01.01

4 LD.03.03.01, LD.03.05.01, LD.04.04.01, PI.03.01.01

5 LD.04.01.03

6 LD.02.01.01, MS.01.01.01, LD.01.05.01

7 LD.02.01.01, LD.03.06.01

8 LD.04.04.07

9 MS.05.01.01

10 MS.05.01.01

(1) establishing specifically defined mechanisms for the process of appointment and reappointment to the Medical Staff, and for the granting of delineated Clinical Privileges to qualified applicants;[11]
(2) establishing professional criteria for Membership and for Clinical Privileges;[12]
(3) conducting an evaluation of the qualifications and competence of individuals applying for Medical Staff Membership or Clinical Privileges;[13]
(4) submitting recommendations to the Board of Trustees regarding the qualifications of an applicant for appointment, reappointment or Clinical Privileges;[14]
(5) establishing a mechanism for fair hearing and appellate review;[15] and
(6) establishing a mechanism to ensure that the scope of practice of individuals with Clinical Privileges is limited to the Clinical Privileges granted.[16]

Appendix A.4 - Quality Assessment/Performance Improvement/Patient Safety/OPPE/FPPE:

The Medical Staff is accountable to the Board of Trustees for the quality of care provided to patients.[17] All Medical Staff Members and all others with delineated Clinical Privileges will be subject to periodic review and appraisal as part of the Hospital's quality assessment, peer review and performance improvement activities.[18] All organized services related to patient care will be evaluated.[19] The Medical Staff shall perform the roles in quality assessment, peer review and performance improvement that are listed below as well as additional rules that may be set forth in Medical Staff policies.[20] The Medical Staff will be responsible for communicating the findings, conclusions, recommendations, and actions taken to improve organization performance to appropriate Medical Staff Leaders and the Board of Trustees.[21]

The Medical Staff shall participate with the Board of Trustees and Administration in the performance of executive responsibilities related to the Hospital quality assessment, peer review and performance improvement program which address the following:

(1) an ongoing program for quality improvement and patient safety, including the reduction of medical errors;
(2) Hospital-wide quality assessment and performance improvement efforts that address priorities for improved quality of care and patient safety and the evaluation of those actions;
(3) the results of Hospital-wide quality assessment and performance improvement being utilized for ongoing professional practice evaluation ("OPPE") and focused professional practice evaluation ("FPPE"), and other medical peer review activities;

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11 MS.01.01.01.
12 MS.02.01.01, MS.06.01.03, MS.06.01.07, MS.08.01.03
13 MS.06.01.07
14 MS.01.01.01, MS.06.01.03, MS.06.01.07
15 MS.10.01.01
16 MS.08.01.03
17 42 C.F.R. §482.12(a)(5)
18 MS.01.01.01, MS.05.01.01, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.22(a)(1)
19 42 C.F.R. §482.21(a)(1)
20 42 C.F.R. §482.21
21 MS.05.01.03

(4) the establishment of clear expectations for safety; and
(5) the number of improvement projects that will be conducted annually.

Appendix A.5.1 - Leadership Role in Performance Improvement:

The Medical Staff shall perform a leadership role in the Hospital's quality assessment, peer review, performance improvement, and patient safety activities when the performance of a process is dependent primarily on the activities of one or more individuals with Clinical Privileges.[22]

Such activities shall include, but not be limited to, a review of the following:

(1) use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;[23]
(2) root cause analysis, investigation and response to any unanticipated adverse events;[24]
(3) medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;[25]
(4) performance based on the results of core measures and other publicly reported performance information;[26]
(5) use of information about adverse privileging decisions for any Practitioner privileged through the Medical Staff process;[27]
(6) use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;[28]
(7) use of blood and blood components, including the review of any significant transfusion reactions;[29]
(8) use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses;[30]
(9) appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge and resource/utilization review;[31]
(10) significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff;[32] and

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22 MS.05.01.01
23 LD.04.04.05, MS.05.01.01
24 LD.04.04.05, MS.05.01.01
25 MS.05.1.01, 43 C.F.R. §482.21(a)(3)
26 Hospital Quality Alliance and public reporting initiatives
27 MS.05.01.01
28 MS.05.01.01, 42 C.F.R. §482.21, 42 C.F.R. §482.23(c)(4), 42 C.F.R. §482.25(b)(6)
29 MS.05.01.01, 42 C.F.R. §482.21
30 MS.05.01.01, 42 C.F.R. §482.21
31 MS.05.01.01, 42 C.F.R. §482.21, 42 C.F.R. §482.30
32 MS.05.01.01

(11) use of developed criteria for autopsies.[33]

Appendix A.5.2 - Participant Role in Performance Improvement:

The Medical Staff shall participate in the measurement, assessment and improvement of other patient care processes.[34] Such activities shall include, but are not limited to, the following:

(1) analyzing and improving patient satisfaction;[35]
(2) education of patients and families;[36]
(3) coordination of care with other Practitioners and Hospital personnel, as relevant to the care of an individual patient;[37]
(4) accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates;[38]
(5) the quality of history and physical exams;[39] and
(6) surveillance of nosocomial infections.[40]

Appendix A.5.3 - OPPE, FPPE and Peer Review:

Findings relevant to a Practitioner are used in OPPE to verify continued competence for the Clinical Privileges granted and FPPE for both the initial appraisal of the Practitioner's competence and when indicated for cause.[41] When the findings of quality assessment or performance improvement activities are relevant to a Practitioner's performance and the Practitioner has Clinical Privileges, the Medical Staff is responsible for determining the use of the findings in FPPE, OPPE or peer review. In accordance with the Credentials Policy, Clinical Privileges are renewed or revised appropriately as determined by the Medical Staff or Board based on OPPE or FPPE findings.[42]

Appendix A.6 - Continuing and Graduate Medical Education:

The Hospital and Medical Staff shall sponsor educational activities that are consistent with the Hospital's mission, the patient population served, and the patient care services provided, within the limitations of applicable federal laws and Hospital policy.[43] The Medical Staff shall develop education programs for Medical Staff Members and others with Clinical Privileges related at least in part to:

(1) the type and nature of care offered by the Hospital;[44] and

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33 MS.05.01.01
34 MS.05.01.03
35 MS.03.01.01
36 MS.05.01.03
37 MD.05.01.03
38 MS.05.01.03, RC.01.03.01, 42 C.F.R. §482.21
39 MS.03.01.01
40 IC.01.03.01, 42 C.F.R. §482.21(a)(2), 42 C.F.R. §482.42(b)(1-2)
41 MS.05.01.03
42 MS.05.01.03, 42 C.F.R. §482.22(a)(1)
43 MS.12.01.02, Ethics and Compliance Policy LL.010
44 MS.12.01.01

(2) the findings of performance improvement activities.[45]

The Medical Staff shall also support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies to provide for supervision of participants in an affiliated professional graduate education program by Members of the Medical Staff in carrying out their patient care responsibilities.[46]

Appendix A.7 - Bylaws Review and Revision:

The Medical Staff shall provide a mechanism for adopting and amending the Medical Staff Bylaws, Rules and Regulations, and policies and for reviewing and revising the Medical Staff Bylaws, Rules and Regulations, and policies as necessary to:

(1) remain consistent with the Bylaws of the Board of Trustees;[47]

(2) remain in compliance with all applicable federal and state laws and regulations, and applicable accreditation standards;[48]

(3) remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities;[49] and

(4) remain consistent with Hospital policies.[50]

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45 MS.12.01.01

46 MS.04.04.01

47 MS.01.01.01

48 LD.04.01.01

49 MS.01.01.01, LD.01.05.01

50 LD.01.03.01