

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
RANDOLPH HOSPITAL**

**MEDICAL STAFF
ORGANIZATION MANUAL**

Effective October 1, 2009

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ARTICLE 1

GENERAL

1.A: DEFINITIONS

The following definitions shall apply to terms used in this Manual:

- (1) "ALLIED HEALTH PROFESSIONAL" means a health care practitioner other than a physician, dentist, podiatrist, or oral surgeon who is authorized to provide patient care services in the Hospital.
- (2) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.
- (3) "CATEGORY I PRACTITIONER" means a Licensed Independent Practitioner, an Allied Health Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted.
- (4) "CATEGORY II PRACTITIONER" means an Advanced Dependent Practitioner, an Allied Health Professional who provides a medical level of care or performs surgical tasks (i.e., Advanced Practice Registered Nurse ("APRN"), Physician Assistant ("PA")) consistent with the clinical privileges granted, but who is required by law and/or the Hospital to exercise those clinical privileges under the direction of, or in collaboration with, a Supervising Physician, pursuant to a written supervision or collaborative agreement. Category II practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in the AHP Policy (e.g., moonlighting residents).
- (5) "CATEGORY III PRACTITIONER" means a Dependent Practitioner, an Allied Health Professional who is permitted by law or the Hospital to function only under the direction of, or in collaboration with, a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted. All aspects of the clinical practice of Category III practitioners at the Hospital shall be handled by the Hospital's Human Resources Department in accordance with applicable human resources policies and procedures, and the provisions of this Policy shall specifically not apply. Hereinafter, as used in this Manual, the term "Allied Health Professional" shall mean Category I and Category II practitioners only.
- (6) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to a practitioner to render specific patient care services, for which the Medical Staff leaders and Board have developed (i) eligibility and other

credentialing criteria, (ii) ongoing professional practice evaluation review criteria, and (iii) focused professional practice evaluation review criteria.

- (7) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff leaders and Board to require closely related skills and experience.
- (8) "CREDENTIALS POLICY" means the Hospital's Medical Staff Policy on Appointment, Reappointment and Clinical Privileges.
- (9) "DAYS" means calendar days.
- (10) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").
- (11) "EXECUTIVE SESSION" is a meeting of a Medical Staff committee or department which only the voting Medical Staff members may attend, along with senior Hospital management. Executive Sessions may be called by the presiding officer, and are intended to be utilized to discuss peer review issues, personnel issues, or any other issue requiring confidentiality.
- (12) "HOSPITAL" means Randolph Hospital.
- (13) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Executive Committee of the Medical Staff.
- (14) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.
- (15) "MEDICAL STAFF LEADER" means any Medical Staff officer, service line chair, and committee chair.
- (16) "MEMBER" means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.
- (17) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.
- (18) "ORAL OR MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has successfully completed an accredited post-graduate training program in oral and maxillofacial surgery.

- (19) "ORGANIZED HEALTH CARE ARRANGEMENT" means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.
- (20) "PATIENT CONTACT" includes any admission, assumption of care, consultation, procedure (inpatient or outpatient), or response to emergency call performed in the Hospital. It shall not include referrals for diagnostic or laboratory tests, or for non-diagnostic treatments or procedures.
- (21) "PERMISSION TO PRACTICE" means the authorization granted to Allied Health Professionals by the Board or President/CEO, as applicable, to exercise a scope of practice and/or clinical privileges.
- (22) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- (23) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
- (24) "PRESIDENT/CEO" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (25) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (26) "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.
- (27) "SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise or collaborate with a Category II practitioner and to accept full responsibility for the actions of the Category II practitioner while he or she is practicing in the Hospital.
- (28) "SUPERVISION" means the supervision of (or collaboration with) a Category II practitioner by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general – Supervising Physician is available by telephone; direct – Supervising Physician is physically on the Hospital campus; or personal – Supervising Physician is present in the room) shall be determined at the time each Category II practitioner is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist.

- (29) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment, and who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

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) Unless otherwise provided, when a function is to be carried out by a member of Hospital management, 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 to perform a necessary function, one or more of the Medical Staff Leaders shall perform the function personally or delegate the function to another appropriate individual.

1.D: GOVERNING LAWS

The Medical Staff Bylaws, Policies, Rules and Regulations, and related documents have been drafted in accordance with relevant Federal and North Carolina laws and shall be interpreted in accordance with those laws.

ARTICLE 2

CLINICAL SERVICE LINES

2.A: LIST OF SERVICE LINES

The following clinical service lines are established:

Medical

Surgical

Maternal/Child Care

2.B: SERVICE LINE MEMBERSHIP

Service line membership and cross-representation shall be based on provider privileges and shall be as follows:

- (1) Medical Service Line: Privileges of providers within this service line include internal medicine, adult family practice, dermatology, gerontology, allergy and immunology, rheumatology, emergency medicine, hematology, oncology, cardiology, neurology, radiology, pulmonology, radiation oncology, gastroenterology, infectious disease, nephrology, hospitalist. The Medical Service Line shall have a cross-representation member with *general surgery or surgical specialty privileges*.
- (2) Surgical Service Line: Privileges of providers within this service line include general surgery, oral and maxillofacial surgery, anesthesia, pathology, podiatry, and other surgical specialties. The Surgical Service Line shall have cross-representation members with the following privileges: emergency medicine, obstetrics and gynecology, medical, and diagnostic imaging.
- (3) Maternal/Child Care Service Line: Privileges of providers within this service line include obstetrics and gynecology, pediatrics, and pediatric family practice. The Maternal/Child Care Service Line shall have cross-representation members with the following privileges: anesthesia, *general surgery or surgical specialty*, emergency medicine, and diagnostic imaging.

2.C: FUNCTIONS AND RESPONSIBILITIES OF SERVICE LINES

The functions and responsibilities of service lines and service line chairs are set forth in Article 4 of the Medical Staff Bylaws.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A: MEDICAL STAFF COMMITTEES AND FUNCTIONS

- (1) This Article outlines the Medical Staff committees of the Hospital that carry out ongoing and focused professional practice evaluations, peer review, and other performance improvement functions that are delegated to the Medical Staff by the Board.
- (2) Procedures for the appointment of committee chairs and members of the committees are set forth in Article 5.B of the Medical Staff Bylaws.

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 written report after each meeting to the MEC and to other committees and individuals as may be indicated in this Manual.

3.C: PROFESSIONAL PRACTICE EVALUATION COMMITTEES

Medical Staff members' service on any of the Professional Practice Evaluation Committees shall be deemed to be the primary Medical Staff citizenship responsibility for these individuals. Medical Staff members who serve on these committees may be excused from other committee responsibilities. *Members that serve on these committees may not serve as medical staff officers, on the Medical Executive Committee or the Credentials Committee.*

3.C.1. Medical Staff Quality Council ("MSQC"):

- (a) Composition:

The MSQC shall consist of the most immediate past Chief of Staff who will serve as the chair of the Committee, the chair and *chair-elect* of the Surgical Case Review Committee, and the chair and *chair-elect* of the Medical Case Review Committee. Administrative support will be provided by the Director of Medical Staff and Accreditation Services.

(b) Duties:

The MSQC shall oversee the implementation and effectiveness of the Medical Staff Professional Practice Evaluation Plan in accordance with the duties and responsibilities set forth in that Plan.

3.C.2. Medical Case Review Committee:

(a) Composition:

The Medical Case Review Committee shall consist of an Active Staff member elected from each of the following specialties: radiology, internal medicine or medical specialist, family practice or pediatrics, hospitalist and emergency medicine. The chairperson shall be elected by the committee and shall serve a one-year term as chairperson. Members of the Medical Case Review Committee shall serve two-year terms and may be re-elected to serve additional two-year terms, but not consecutively.

(b) Duties:

The Medical Case Review Committee shall review clinical care and make recommendations in accordance with the duties and responsibilities set forth in the Medical Staff Professional Practice Evaluation Plan.

3.C.3. Surgical Case Review Committee:

(a) Composition:

The Surgical Case Review Committee shall consist of an Active Staff member elected from each of the following specialties: anesthesia, pathology, general surgery, other surgical specialties, and obstetrics and gynecology. The chairperson shall be elected by the committee and shall serve a one-year term as chairperson. Members of the Surgical Case Review Committee shall serve two-year terms and may be re-elected to serve additional two-year terms, but not consecutively.

(b) Duties:

The Surgical Case Review Committee shall review clinical care and make recommendations in accordance with the duties and responsibilities set forth in the Medical Staff Professional Practice Evaluation Plan.

3.D: OTHER MEDICAL STAFF COMMITTEES

3.D.1. Bylaws Committee:

(a) Composition:

The Bylaws Committee shall consist of at least four members of the Active Medical Staff.

(b) Duties:

The Bylaws Committee shall, at the request of Medical Staff members or Medical Staff committees, review issues and formulate recommendations for revising or amending the Bylaws, the related policies, and the Rules and Regulations of the Medical Staff.

3.D.2. Cancer Committee:

(a) Composition:

The Cancer Committee shall consist of at least one Medical Staff member from the specialties of diagnostic radiology, radiation oncology, pathology, general surgery, and medical oncology, the Cancer Liaison Physician (who may also fulfill the role of one of the required physician specialties), the Cancer Program Administrator, an Oncology Nurse, a Social Worker or case manager, the Certified Tumor Registrar, and a representative from Quality Management, all serving with vote. A physician member of the Active Staff shall serve as the chair of the Cancer Committee. In consultation with the Cancer Liaison Physician and/or the Cancer Committee chair, additional physicians or non-physician members may be asked to attend meetings as non-voting members, as appropriate. The composition of the Cancer Committee may change as required by the Commission on Cancer.

(b) Duties:

The Cancer Committee shall:

- (1) designate, on an annual basis, four coordinators to oversee activities related to the Tumor Conference, quality control of cancer registry data, quality improvement, and community outreach;
- (2) develop and evaluate annual goals and objectives for clinical activities, community outreach, quality improvement, and other programmatic activities related to cancer care;
- (3) promote a coordinated, multidisciplinary approach to patient management;

- (4) establish the Tumor Conference frequency, format and the required number and types of cases discussed as required by the Commission on Cancer;
- (5) ensure that Tumor Conferences held meet the accreditation standards established by the American College of Surgeons Commission on Cancer Accreditation;
- (6) establish and implement a plan to evaluate the quality of cancer registry data and activity;
- (7) analyze patient outcomes and disseminate the results of the analysis; and
- (8) shall meet as often as necessary, but at least quarterly.

3.D.3. Credentials Committee:

(a) Composition:

The Credentials Committee shall consist of at least two past Medical Staff leaders and at least five members of the Active Staff. Total composition of the Committee must include at least one representative from each of the specialties of surgery, family practice, obstetrics and gynecology, internal medicine, and radiology. A past Medical Staff leader (i.e., a past Chief of Staff, former department chairman, and/or former service line chair) shall serve as the Chair of the Committee. Representatives of the Medical Staff Office may attend meetings as support staff, without vote.

(b) Duties:

The Credentials Committee shall:

- (1) in accordance with the Credentials Policy, review the credentials of applicants for Medical Staff appointment, reappointment, 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) in accordance with the Allied Health Professionals Policy, review the credentials of applicants seeking to practice as Category I or Category II practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

- (3) review, as may be requested by the MEC, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Professionals and, as a result of such review, make a written report of its findings and recommendations;
- (4) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.B.1 ("Clinical Privileges for New Procedures") and Section 4.B.2 ("Clinical Privileges That Cross Specialty Lines") of the Credentials Policy; and
- (5) review the effectiveness of the credentialing and privileging process at least once a year and provide a report to the MEC and Board.

3.D.4. Medical Executive Committee:

The composition and duties of the MEC are set forth in Section 5.D of the Medical Staff Bylaws.

3.D.5. Pharmacy and Therapeutics Committee:

(a) Composition:

The Pharmacy and Therapeutics Committee shall consist of a member of the Active Medical Staff to serve as chair, and at least four additional Medical Staff members. Total composition of the Committee must include at least one representative from each of the specialties of family practice, pediatrics, internal medicine, and surgery. The Committee shall also include two representatives from pharmacy service, one representative from nursing service, and one representative from food services. All members of this Committee shall have a vote.

(b) Duties:

The Pharmacy and Therapeutics Committee is responsible for fulfilling staff functions relating to pharmacy and therapeutics policies and practices and the development and review of nutrition policies and practices, including the development of the medication formulary and guidelines/protocols on the use of special diets and total parenteral nutrition. The Pharmacy and Therapeutics Committee shall meet at least quarterly, or more frequently as needed.

3.E: OTHER MULTIDISCIPLINARY COMMITTEES

Medical Staff members are expected to participate in, and attend meetings of, other multidisciplinary committees of the Hospital that require the input of the Medical Staff as

assigned by the Board or Medical Staff leadership (e.g., Infection Control Committee, Quality Committee, and Utilization Review).

ARTICLE 4

AMENDMENTS

- (a) An amendment to this Manual may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists.
- (b) Notice of all proposed amendments shall be provided to each member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place. Any member of the Medical Staff may submit written comments on the amendments to the MEC.
- (c) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted, and made effective as of October 1, 2009, upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Adopted by the Medical Staff on July 16, 2009:

Chief of Staff

Approved by the Board on July 28, 2009:

Chair, Board of Directors

Revision Dates:
January 26, 2010