St. David's South Austin Medical Center

ORGANIZATION MANUAL

Approved: December 20, 2018 by Board of Trustees
Revised: June 2019, August 2019, March 2020, July 2020

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
Radiology
Anesthesiology
Emergency Medicine
Trauma

2.B. SECTIONS

Each department may be divided into Sections[2] or further subdivided into specialty Sections. These shall be designated within departmental rules and regulations.

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

The Medical Executive Committee may create, eliminate, subdivide or combine Departments or Sections, subject to approval by the Board of Trustees, based on the evolving scope of clinical services of the Hospital and the need of the Medical Staff organization to most effectively support the oversight of quality of patient care. Since the primary function of a Department or a Section is responsibility for the quality of patient care provided by the members of the Department or Section, the primary criteria for creating or subdividing a Department or Section, or in eliminating or combining a Department or Section shall be whether the Department or Section has a sufficient number of active Medical Staff members and sufficient patient volume to support the quality assessment and performance improvement activities required of a Department or Section.

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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

(1) CRITERIA TO QUALIFY AS A DEPARTMENT: To qualify as a Department, there shall be at least three active Medical Staff members in a clinically distinct area of medical practice with sufficient patient volume to support meaningful ongoing quality assessment and performance improvement activities.

(2) CRITERIA TO QUALIFY AS A SECTION: To qualify as a Section, there shall be at least five active Medical Staff members in a clinically distinct area of medical practice with sufficient patient volume to support the occasional need of these specialists to deliberate quality of care issues unique to their specialty.

(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 COMMITTEE

3.C.1. Composition:

The Advanced Practice Professionals 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 Committee shall also include at least the following as voting members, each of whom shall be appointed by the Chief of Staff: at least one nurse practitioner or one physician assistant from Anesthesia, Trauma, Emergency Department, Hospitalist, Bone Marrow Transplant, Critical Care, and Neonatology services, and three members of the Medical Staff who shall be selected so that the Committee has adequate clinical expertise to perform its functions.

A medical staff member shall be appointed as chairperson by the Chief of Staff.

Other Medical Staff Members or Hospital personnel, including the relevant department chairperson(s), other individual(s) in the Medical Staff department, Section 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 Advance Practice Professionals Committee in its discussions and deliberations regarding issues on its agenda.

3.C.2. Duties:

The Advanced Practice Professionals Committee shall:

(1) evaluate and make recommendations to the Medical Executive Committee (MEC) 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) assist the MEC, as needed, in reviewing the qualifications of 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.

3.C.3. Meetings and Reports:

The Advanced Practice Professionals Committee shall meet as often as necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall make a report of its recommendations after each meeting 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 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 Chief of Staff and a minimum of three (1) Active Staff Members from departments selected by the Chief of Staff. The ex officio members without vote, shall be: the Chief Executive Officer the Chief Medical Officer, and Medical Staff Services director and other 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 Section 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. CRITICAL CARE COMMITTEE

3.E.1. Composition:

(1) The Critical Care Committee shall be composed of specialists from Emergency Medicine, Anesthesia, Pulmonary and Critical Care Medicine, Pathology, Trauma Surgery, Cardiothoracic and Vascular Surgery, Medicine, Medical Hospitalist Services, Infectious Disease, and Radiology. The Chairperson (or Co-Chairs) and committee members shall be appointed by the Chief of Staff. The Chief of Staff and Chief Medical Officer shall serve as ex officio without vote.

(2) Hospital Members shall be appointed by the Chief Executive Officer and shall serve *ex officio without vote.* The following departments shall be represented: Respiratory Care, Laboratory, Pharmacy, STICU, ICU, and Quality.

3.E.2 Duties:

The purpose of the committee is to promote coordination and standardization of critical care in the hospital. Duties shall include:

(1) Utilize evidence-based medicine when providing recommendations regarding changes in clinical practice

[3] MS.02.01.01

(2) Prioritize and recommend opportunities for improvement in critical care

(3) Recommend programs or learning activities related to critical care

(4) Recommend criteria for competence in the critical care setting

(5) Provide regular reports to the Medical Executive Committee

(6) Annually review the Plan for Provision of Care and makes recommendation for change

3.E.3 Meetings

The Critical Care Committee shall meet no less than quarterly unless there is no business to conduct in which case the Chair may cancel the meeting.

3.F. MEDICAL CARE EVALUATION COMMITTEE

3.5.1 Composition

The Medical Care Evaluation Committee ("MCEC") shall be composed of the Chief Medical Officer, who shall also serve as Chairperson, Secretary of Medical Staff, Immediate Past Chairperson, Vice Chiefs of each medical staff department or their designees, Section Directors , and other members as appointed by the Chief of Staff with the right to vote.

The MCEC shall also have the option of calling upon any member of the Medical Staff or other individual with clinical privileges to serve on the committee on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment subject to the approval of the Chief of Staff acting on behalf of the Medical Executive Committee and the Board in this singular capacity.

Ad hoc members of the committee shall be bound by the confidentiality requirements of the committee and shall be provided indemnification while serving on the committee, subject to the provisions of these bylaws. Ad hoc members of the committee shall not have voting rights on the committee.

3.F.2 Duties

The MCEC 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; and

(3) ensure that when the finding of the quality assessment process (either aggregate data or single events) are relevant to a Practitioner's competence and make recommendations accordingly;

3.F.3 Meetings

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

3.G. PHARMACY AND THERAPEUTICS COMMITTEE

3.G.1 Composition

The Pharmacy and Therapeutics (P&T) Committee shall consist of no less than one active staff member and the pharmacy director and the director of nursing and/or his or her designee. The pharmacy director will be a voting member of the committee. Other members shall include those physicians and hospital employees mutually agreed upon by the Chairperson and Chief of Staff

3.G.2 Duties

(1) To serve in an evaluative, educational, and advisory capacity to the medical staff and hospital administration in all matters pertaining to the use of medications (including investigational medications) in the hospital.

(2) To establish programs and procedures that help ensure safe and effective drug therapy and cost-effective drug therapy.

(3) To oversee Medication Safety related to prevention, monitoring, and reporting of medication errors.

(4) To participate in quality –assurance activities related to distribution, administration, and use of medications and report results to appropriate committees.

(5) To develop and review periodically a formulary on drug list for use in the hospital.

(6) To report adverse drug events (medication errors and adverse drug reactions) with appropriate analysis.

(7) To perform such other duties as assigned by the Chief of Staff or the Chief Executive Officer

3.G.3 Meetings

The P&T committee shall meet on a quarterly basis and report the performance of the various functions to the MEC.

3.H NOMINATION COMMITTEE

3.H.1 Composition

The Nominating Committee shall consist of the Immediate Past Chief of Staff, the Chief of Staff, the Chief of Staff Elect, the Secretary of the Staff, Chief Medical Officer and the Hospital CEO.

3.H.2 Duties

The Nominating Committee shall perform the key function of Nominating, as described in the bylaws, under the oversight and direction of the MEC. The committee shall solicit and accept nominations for elected Medical Staff Officer Positions, consult with the nominees concerning their qualifications and willingness to serve, prepare ballots, and supervise the election of officers.

3.H.3 Meetings

The Nominating Committee shall meet not less than 90 days prior to the annual General Medical Staff meeting of each even –numbered year. The committee's recommendations shall be reported to the MEC and the Medical Staff as described in the bylaws.

3.I CREDENTIALS COMMITTEE:

Functions and duties of a credentials committee will be performed by the Medical Executive Committee.

3.J UTILIZATION REVIEW COMMITTEE

3.J.1 Composition

The Chairperson shall be a physician appointed by the Chief of Staff and subject to approval by the Medical Executive Committees. *The chairperson will be a member of the Medical Executive Committee and shall attend MEC meetings.* Physician committee members and hospital representatives shall be appointed as detailed in the Utilization Management Plan. Physicians are the only voting members on the committee.

3.J.2 Duties

The duties of the UR committee will be detailed in the Utilization Management Plan.

3.J.3 Meetings

The UR committee will meet at least quarterly and on an ad hoc basis as detailed in the Utilization Management Plan. Committee reports shall be made available to the Medical Executive Committee as detailed in the UM plan.

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.

Approved by the Medical Executive Committee: November 9, 2018

Adopted by the Medical Staff: As of December 19, 2018

Approved by the Board of Trustees: December 20, 2018

Revised: June 2019, August 2019, March 2020, July 2020

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 the initial and renewed grant of Medical Staff Membership and/or,Clinical

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1 MS.01.01.01, MS..03.01.01, MD=S.05.01.01
2 MS.03.01.03, 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.03.01.01
10 MS.05.01.01

Privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

(1) establishing specifically defined mechanisms for the process of granting membership 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 Membership 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:

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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, MS.03.01.01, MS.06.01.05
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

(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;

(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]

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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(-(5), 42 C.F.R. §482.25(b)(6)

(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

(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]

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29 MS.05.01.01, 42 C.F.R. §482.21, 42 C.R.R. §482.23©(4)-(5)
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
33 MS.05.01.01
34 MS.05.01.03
35 MS.03.01.01
36 MS.05.01.03
37 MS.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)

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

(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]

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41 MS.05.01.03
42 MS.05.01.03, 42 C.F.R. §482.22(a)(1)
43 MS.12.01.01, Ethics and Compliance Policy LL.010
44 MS.12.01.01
45 MS.12.01.01
46 MS.04..01.01
47 MS.01.01.01
48 LD.04.01.01

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

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

[49] MS.01.01.01, LD.01.05.01

[50] LD.01.03.01