

**MEDICAL STAFF BYLAWS, POLICIES, AND  
RULES AND REGULATIONS  
OF  
OUR LADY OF LOURDES  
MEMORIAL HOSPITAL**

**MEDICAL STAFF  
ORGANIZATION MANUAL**

*Revised effective April 15, 2016*

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## ARTICLE 1

### GENERAL

#### 1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the 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

Functions assigned to an identified individual or committee may be delegated to one or more designees.

## ARTICLE 2

### CLINICAL DEPARTMENTS AND SECTIONS

#### 2.A. DEPARTMENTS AND SECTIONS

The Medical Staff will be organized into the following departments and sections:

Department of Anesthesia

Department of Diagnostic Imaging

Department of Emergency Medicine

Department of Laboratory/Pathology

Department of Medicine (includes Intensivists):

- Internal Medicine
- Inpatient Medicine (Hospitalists)
- Cardiology
- Dermatology
- Endocrinology
- Gastroenterology
- Neurology
- Hematology/Oncology
- Palliative Medicine
- Pulmonology
- Rehabilitation/Physiatry
- Rheumatology

Department of Family Medicine

Department of Obstetrics & Gynecology

Department of Pediatrics

Department of Psychiatry

Department of Radiation Oncology

Department of Surgery:

- General Surgery
- Neurosurgery
- Ophthalmology
- Oral Surgery/General Dentistry
- Orthopedics
- Otorhinolaryngology
- Plastic Surgery
- Podiatry
- Urology
- Vascular Surgery

## 2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND SECTIONS

The functions and responsibilities of departments, sections, department chairpersons, and section chiefs 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 that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.
- (2) Procedures for the appointment of committee chairpersons and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

#### 3.B. MEETINGS, REPORTS, AND RECOMMENDATIONS

- (1) Unless otherwise indicated, each committee described in this Manual will meet as necessary to accomplish its functions and will maintain a permanent record of its findings, proceedings, and actions. Each committee will make a timely written report after each meeting to the Executive Committee, the Vice President for Medical Affairs, and other committees and individuals as may be indicated in this Manual.
- (2) Unless specifically provided otherwise, only Medical Staff members may vote at committee meetings.
- (3) As a general practice, when an individual serves as a member of the Professional Care Review Committee, the Credentials Committee and/or the Executive Committee, on any particular issue that might come before such committee, the individual will vote at one committee meeting.

#### 3.C. BYLAWS COMMITTEE

##### 3.C.1. Composition:

The Bylaws Committee will consist of at least three members of the Medical Staff. Hospital legal counsel and a representative from Medical Staff Services will also serve on the committee.

##### 3.C.2. Duties:

The Bylaws Committee will:

- (a) review the Medical Staff Bylaws, Rules and Regulations, and related policies, protocols and manuals every two years; and

- (b) receive and consider all recommendations for changes to the Medical Staff Bylaws, Rules and Regulations, and related policies, protocols and manuals.

### 3.D. CONTINUING MEDICAL EDUCATION COMMITTEE

#### 3.D.1. Composition:

- (a) The Continuing Medical Education Committee will consist of the following:
  - (1) at least five members of the Medical Staff;
  - (2) the Vice President for Medical Affairs/Chief Medical Officer;
  - (3) the Chairperson of the Graduate Medical Education Committee;
  - (4) Graduate Medical Education Director;
  - (4) the Program Director from each Residency program;
  - (5) a resident from each Residency program;
  - (6) the Medical Librarian;
  - (7) the Director of Learning Services; and
  - (8) at least one representative from the Hospital departments of Emergency, Nursing, Quality Services, Medical Staff Services, and Pharmacy.
- (b) One of the Medical Staff members will be appointed to serve as chairperson of the Continuing Medical Education Committee.

#### 3.D.2. Duties:

The Continuing Medical Education Committee will:

- (a) ensure that all requirements of the Medical Society of the State of New York are met for accreditation of the Hospital's continuing medical education programs;
- (b) oversee scheduling, topics, and speaker honoraria for all continuing medical education programs offered at the Hospital;
- (c) ensure that all criteria are met for all programs designated for continuing medical education credits;



- (d) ensure that continuing medical education programs meet the mission goals of the Hospital, based on input from Medical Staff leaders as represented on the Executive Committee;
- (e) through high quality, up-to-date continuing medical education programs provided on a regular basis, promote the health status of the community by encouraging the Medical Staff to deliver quality medical care and maintain its expertise by keeping current with information in the broad scope of medicine, as well as the core programs at the Hospital;
- (f) survey the Medical Staff on a periodic basis to determine interest in the continuing medical education programs offered at the Hospital; and
- (g) establish a subcommittee to review all continuing medical education activity within the Hospital, especially those activities that involve formal continuing medical education credits.

### 3.E. CREDENTIALS COMMITTEE

#### 3.E.1. Composition:

- (a) The President of the Medical Staff, in consultation with the Vice President for Medical Affairs, will appoint at least five members of the Active, Senior Active or Honorary Staff to serve on the Credentials Committee. Members will be selected based on their interest or experience in credentialing matters.
- (b) The committee will also include a representative from Quality Services and Medical Staff Services.
- (c) The President-Elect of the Medical Staff will serve as the chairperson of the Credentials Committee.
- (d) Physician members of the Credentials Committee will be appointed for an initial three-year term and will be replaced on a rotating basis to ensure continuity. Members may be reappointed for subsequent terms.
- (e) Department chairpersons will not be appointed to serve on the Credentials Committee.
- (f) All new physician members of this committee, either prior to beginning to serve on the committee or while serving on the committee, must obtain specific education and training regarding the credentialing process.
- (g) Service on this committee will be considered as the primary Medical Staff obligation of each member of the committee and other Medical Staff duties will not interfere.

### 3.E.2. Duties:

The Credentials Committee will:

- (a) review the credentials of all applicants for 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;
- (b) review, as may be requested by the Executive Committee, all information available regarding the current clinical competence and behavior of individuals currently appointed to the Medical Staff or the Allied Health Staff and, as a result of such review, make a written report of its findings and recommendations;
- (c) recommend the numbers and types of cases to be reviewed as part of the initial focused professional practice evaluation;
- (d) review and approve specialty-specific criteria for ongoing professional practice evaluation, and specialty-specific triggers for that are identified by each department; and
- (e) recommend appropriate threshold eligibility criteria for clinical privileges, including clinical privileges for new procedures and clinical privileges that cross specialty lines.

### 3.F. EXECUTIVE COMMITTEE

The composition and duties of the Executive Committee are set forth in Section 5.B of the Medical Staff Bylaws.

### 3.G. GRADUATE MEDICAL EDUCATION COMMITTEE

#### 3.G.1. Composition:

The Graduate Medical Education Committee will consist of the following:

- (a) Director of Graduate Medical Education, who will serve as chairperson;
- (b) Vice President for Medical Affairs/Chief Medical Officer, who will serve as chairperson in the event there is a vacancy in the office of Director of Graduate Medical Education;
- (c) Residency Program Directors;
- (d) Residency Assistant Program Directors;

- (e) Physician Faculty, to be appointed by the chairperson;
- (f) Site Coordinator for Continuity Clinic;
- (g) Residency Program Coordinators;
- (h) Representative from Quality Services, on an ad hoc basis;
- (i) Chief Residents;
- (j) Representative from Medical Staff Services;
- (k) Representative from Peri-Operative Services, on an ad hoc basis; and
- (l) Director of Learning Services;
- (m) Medical Librarian

### 3.G.2. Duties:

The Graduate Medical Education Committee will have oversight of the Podiatry Residency Program and will:

- (a) review results of recruitment;
- (b) review issues affecting graduates' practice in the Hospital and in outpatient settings;
- (c) review the performance of the training program through various measures, such as residents' success in passing board examinations, practice opportunities, quality improvement, and Joint Commission compliance;
- (d) provide an annual report on the credentials of program trainees to the Credentials Committee, the Executive Committee, and the Board;
- (e) make recommendations regarding the annual program budget;
- (f) review resident complement and program characteristics on an annual basis;
- (g) review community participation and benefit;
- (h) review and approve program policies;
- (i) ensure compliance with state & national training program requirements;

- (j) review reports of accrediting bodies and ensure compliance with the recommendations; and
- (k) review issues monitored and tracked through the Hospital's performance improvement activities.

### 3.G.3. Meetings:

The Graduate Medical Education Committee will meet a minimum of three times a year.

## 3.H. PHARMACY, THERAPEUTICS AND NUTRITION COMMITTEE

### 3.H.1. Composition:

The Pharmacy, Therapeutics and Nutrition Committee will consist of the following:

- (a) at least three members of the Medical Staff; and
- (b) at least one representative from Pharmacy, Nursing and Administration.

### 3.H.2. Duties:

The Pharmacy, Therapeutics and Nutrition Committee will:

- (a) develop and review drug utilization policies and practices within the Hospital in order to monitor clinical results and the potential for hazards;
- (b) assist in the formulation of policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, and safety procedures relating to drugs in the Hospital;
- (c) recommend drugs to be stocked in the nursing unit and in other departments;
- (d) develop and review at least biannually a formulary or drug list for use in the Hospital; and
- (e) evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

### 3.H.3. Meetings:

The Pharmacy, Therapeutics and Nutrition Committee will meet at least bimonthly.

### 3.I. PROFESSIONAL PRACTICE COMMITTEE

The composition and duties of the Professional Practice Committee are set forth in the Medical Staff Peer Review Policy. The Professional Practice Committee is the collegial peer review committee for Lourdes Hospital.

### 3.J. TRANSFUSION AND TRANSPLANTATION COMMITTEE

#### 3.J.1. Composition:

- (a) The Transfusion and Transplantation Committee will consist of the following:
  - (1) Medical Staff representatives from all major medical departments that routinely order blood and all subspecialty departments with high blood usage; and
  - (2) at least one representative from Nursing, Hospital Quality Services, Laboratory, Blood Bank staff and Administration.
- (b) The chairperson of the committee will be a pathologist selected by the President of the Medical Staff and the Medical Director of the Hospital's Laboratory Department.

#### 3.J.2. Duties:

The Transfusion and Transplantation Committee will:

- (a) establish policies for blood transfusion therapy;
- (b) develop and monitor criteria for transfusion practice concerned with administration or non-administration when indicated or not indicated;
- (c) assess blood and blood component use for ways to improve patient care;
- (d) review and analyze statistical reports of the transfusion service;
- (e) audit and assess transfusion reactions, post-transfusion reactions and other adverse events affecting inpatients and outpatients;
- (f) monitor previously identified problem areas to evaluate improvement;
- (g) promote continuing education in transfusion practices for the Hospital staff;
- (h) assist blood suppliers in blood procurement efforts;

- (i) assess the adequacy and safety of the blood supply;
- (j) monitor whether written policies and procedures are reviewed annually and conform to AABB Standards and Joint Commission quality improvement requirements;
- (k) report to the Executive Committee and recommend corrective actions when indicated;
- (l) monitor whether the processes related to the use of blood and blood components are defined and that data are systematically collected and reviewed at regular intervals;
- (m) monitor whether data are collected for both improvement priorities and continuing measurement; and
- (n) compare performance data about processes and outcomes to other hospitals, including through the use of reference databases.

### 3.J.3. Meetings:

The Transfusion and Transplantation Committee will meet at least quarterly.

## 3.K. UTILIZATION MANAGEMENT COMMITTEE

### 3.K.1. Composition:

The Utilization Management Committee will consist of the following:

- (a) Medical Staff representatives from various clinical departments;
- (b) at least one representative from Medical Records, Nursing, Case Management and Physician Advisors; and
- (c) the Vice President for Medical Affairs.

### 3.K.2. Duties:

The Utilization Management Committee will:

- (a) develop and maintain a system to evaluate the quality of medical care which is objective, efficient, documented, clinically sound and flexible;
- (b) provide for an ongoing audit through which patterns of care can be evaluated;

- (c) identify educational and organizational needs and recommend to the Credentials Committee action which appropriately responds to those needs in accordance with the Credentials Policy;
- (d) monitor whether previous recommendations have been appropriately reviewed and acted upon;
- (e) review the adequacy of medical records and make recommendations to the Executive Committee concerning the pertinence and timely completion of medical records; and
- (f) formulate a written utilization review plan, which will contain the following elements:
  - (1) organization and composition of the committee which will be responsible for the utilization review function;
  - (2) frequency of meetings;
  - (3) types of records to be kept;
  - (4) the method to be used in selecting cases on a sample or other basis;
  - (5) the definition of what constitutes the period of extended duration; and
  - (6) the relationship of the utilization review plan to claims administration by a third party.

### 3.K.3. Meetings:

The Utilization Management Committee will meet bimonthly.

## ARTICLE 4

### AMENDMENTS

The process for amending this Medical Staff Organization Manual is set forth in Section 9.B of the Medical Staff Bylaws.



ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective 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 MEC: August 14, 2012

Approved by the Board: November 16, 2012

*Adopted by the MEC: August 14, 2012*  
*Approved by the Board: November 16, 2012*

**Amendments to the Medical Staff Organization Manual**

1. Amendment to Section 3.E.1., Composition of Credentials Committee, to reinstate the former provision that the President-Elect of the Medical Staff serves as Chairman of Credentials Committee.  
Approved by Medical Executive Committee, August 13, 2013  
Approved by Board of Directors, August 16, 2013
2. Amendment to Article 2, Section 2.A Clinical Departments and Sections updated/revised.  
Approved by the Medical Executive Committee, April 12, 2016  
Approved by the Board of Directors, April 15, 2016
3. Amendment to Article 3, Section 3.D.1., Composition of Continuing Medical Education Committee, to correct job titles of those that attend and include Family Medicine Residency and Podiatric Residency as appropriate.  
Approved by the Medical Executive Committee, April 12, 2016  
Approved by the Board of Directors, April 15, 2016
4. Amendment to Article 3, Section 3.G.1., Composition of Graduate Medical Education Committee, to correct job titles of those that attend and include Family Medicine Residency and Podiatric Residency as appropriate.  
Approved by the Medical Executive Committee, April 12, 2016  
Approved by the Board of Directors, April 15, 2016
5. Amendment to Article 3, Section 3.G.2. & 3.G.3., Duties & Meetings of the Graduate Medical Education Committee, to restate that the committee makes recommendation regarding annual program budget & committee will meet a minimum of three times a year.  
Approved by the Medical Executive Committee, April 12, 2016  
Approved by the Board of Directors, April 15, 2016
6. Amendment to Article 3, Section 3.I., Professional Practice Committee (PPC), to state that the PPC is the collegial peer review committee for Lourdes Hospital.  
Approved by the Medical Executive Committee, April 12, 2016  
Approved by the Board of Directors, April 15, 2016