Boulder Community Health

Medical Staff

ORGANIZATION AND FUNCTIONS MANUAL

TABLE OF CONTENTS

SECTION 1. ENABLING PROCEDURES

1.1. This Organization and Functions Manual has been created pursuant to and under the authority of the Medical Staff Bylaws of Boulder Community Health. The purpose of the Manual is to describe the current organization of the Medical Staff and to define the mechanisms that the Medical Staff will utilize to accomplish the following functions as outlined in the current Medical Staff Bylaws. Manual is one of five that have been designed to support the Medical Staff Bylaws.

1.1.1. Credentials Policy and Procedure Manual
1.1.2. Organization and Functions Manual
1.1.3. Rules and Regulations
1.1.4. Investigations, Corrective Action, Hearing and Appeal Plan AHP Credentialing Manual

1.2. This manual and its contents are subject to the approval of the Medical Executive Committee using the procedures found in the Medical Staff Bylaws.

SECTION 2. APPROVAL AND MODIFICATION

2.1. This manual and its contents are subject to the approval of the Medical Executive Committee and of the Hospital Governing Board. Once approved, the manual will become effective subject to future amendments as may from time to time be required and approved by the Medical Executive Committee of the Medical Staff. All such amendments will be reviewed by the Hospital Governing Board for their concurrence.

SECTION 3. CURRENT ORGANIZATION

3.1. The Medical Staff of Boulder Community Health will be organized as a departmentalized medical staff, reporting to the Medical Executive Committee. The departments are composed of sections, when applicable, and consist of all practitioners, regardless of their medical staff category, who are assigned to the department/section, unless otherwise noted. The current existing department and sections are as follows (1.2019):

3.1.1. Ambulatory Medicine Department – consists of Employed Community Based Family and Internal Medicine practitioners and Employed Advanced Practice Professionals (APP) working in a BCH primary care clinic and other practitioners as may be determined by the Medical Executive Committee (MEC)

3.1.2. Hospital Medicine Department

1. Cardiology Section
2. Behavioral Health Section
3. Hospitalist Section
4. Neurology Section
5. Pulmonary/Critical Care Section
6. Primary Care & Medical Specialty Section – consists of Active practitioners, Community Based practitioners, Advanced Practice Professionals, and Community Based Advanced Practice Professionals who are not included in any of the above Hospital Medicine Sections and who are not employed by BCH.
7. Radiation Oncology Section

3.1.3. Surgical & Trauma Services Department

1. Anesthesia/Perioperative Section

2. Pathology Section
3. Surgery Section
4. Orthopedic Section

3.1.4. Imaging Department
1. IR Section

3.1.5. Emergency Medicine Department

3.1.6. Women & Family Services Department
1. Pediatric Section (to include Active Family Practitioners with pediatric privileges)
2. OB/GYN Section

3.2. In addition, the following are standing committees:

3.2.1. Advanced Practice Professionals Committee
3.2.2. Breast Program Committee
3.2.3. Cancer Committee
3.2.4. Credentials Committee
3.2.5. Physician Advisory Council
3.2.6. Joint Conference Committee
3.2.7. Medical Executive Committee
3.2.8. New Technology Committee
3.2.9. Quality & Patient Safety Council
3.2.10. Pharmacy and Therapeutics
3.2.11. Practitioner Health & Well Being Committee
3.2.12. Professional Practice Review Committee
3.2.13. Stroke Services Committee
3.2.14. Multidisciplinary Trauma Services Committee
3.2.15. Trauma Peer Review/Performance Improvement Committee

3.3 Unless otherwise set forth in the bylaws, this Manual, or any other manual of the Medical Staff, a quorum for purposes of taking any formal action by a department, section or committee, shall consist of the individuals present in person or by phone for the meeting. Departments, sections and committees may meet electronically or by phone as provided in in Sections 7.4.3 and 7.4.4 of the Medical Staff Bylaws. (1.2019)

SECTION 4. DEPARTMENTS

4.1. Members of the Medical Staff and Advanced Practice Professionals will be assigned to one of the six departments depending on their primary specialty and their primary area of medical practice. In the event a practitioner wishes to attend department meetings other than the one to which assigned, this is entirely permitted. The individual attending a department other than his/her official department will not be permitted to vote on issues within the department.

4.2. Department Chairs will call meetings when needed to conduct departmental business, to discuss a particular issue, or at the request of the MEC. Minutes of these meetings will be recorded. (1.2019)

4.3. There will be no mandatory attendance requirement at department meetings, except for Department Chairs and Section Chiefs, pursuant to their position descriptions. (1.2019)

4.4. Departments may perform the following activities:

4.4.1. Monitor, evaluate and improve care, treatment and services provided in and develop clinical policy for patient care units and special care areas, such as intensive or coronary care units; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, home care and other ambulatory care services;

4.4.2. Participate in performance improvement activities and reviews/monitoring efforts of the quality and appropriateness of patient care, to include invasive procedures, blood usage, drug usage, autopsies, sentinel events, patient satisfaction, utilization review activities and medical record reviews;

4.4.3. Participate in the development and implementation of patient and family education;

4.4.4. Participate in peer review activities as requested by the Medical Staff; (1.2019)

4.4.5. Make recommendations regarding professional criteria for clinical privileges and criteria for off-site sources needed for patient care;

4.4.6. Provide orientation and continuing education opportunities responsive to quality review findings, new state-of-the-art developments and other perceived needs;

4.4.7. Develop performance improvement initiatives and maintain surveillance in the use of medications;

4.4.8. Investigate and control nosocomial infections and monitor the Hospital's infection control program;

4.4.9. Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;

4.4.10. Direct staff organizational activities, including Bylaws review and revision, staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;

4.4.11. Coordinate the care, treatment and services provided by practitioners with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services;

4.4.12. Communicate all pertinent findings, conclusions, recommendations and action taken to improve performance to all department members and the MEC; and

4.4.13. Such other responsibilities as may be assigned by the President of the Medical Staff or the MEC (1.2019)

SECTION 5. SECTIONS

5.1. At the discretion of the MEC, practitioners in specific specialties may organize themselves into "sections" for purposes of education, discussion, policy direction, or for purposes of generating recommendations to the department chair concerning departmental issues. (See Bylaws Section 5.1.2)

5.2. Any section, if organized, will not be required to hold any number of regularly scheduled meetings.

5.3. There will be no mandatory attendance requirement at section meetings.

5.4. Sections may perform any of the following activities:

5.4.1. Continuing medical education

5.4.2. Discussion of policy
5.4.3. Discussion of equipment needs
5.4.4. Development of recommendation for Department Chair or Medical Executive Committee
5.4.5. Participation in the development of criteria for clinical privileges, when requested by the department chair
5.4.6. Discuss of a specific issue at the special request of a Department Chair or Medical Executive Committee
5.4.7. Consideration of a specific credential request, when requested by the Department Chair
5.4.8. Except in extraordinary circumstances, no minutes or reports will be required reflecting the activities of sections of the individual departments. Only in those instances when sections are making formal recommendations to a department will a report be required from the section chief documenting the division-specific position.
5.4.9. Section meetings will ordinarily not be "staffed" by representatives of the Medical Staff Department. Attendance will not ordinarily be taken, nor will any "rigid" agenda be followed.

SECTION 6. PATIENT CARE/ADMINISTRATIVE COMMITTEES

6.1. The Medical Staff of Boulder Community Health will operate through the following committee structure. All members of the committee are entitled to vote, unless they are specifically designated as "without vote" members. Each medical staff committee shall report to the Medical Executive Committee.

6.1.1. Advanced Practice Professionals' Committee (APPC)

1. Composition. This APPC Committee shall consist of advanced practice professional members of the medical staff in the active or employed community categories ("APPs"). For purposes of this Section, APPs shall mean physician assistants, and advanced practice nurses, including without limitation, nurse practitioners, nurse midwives, and any other category of advance practice nursing that is approved by the Board to obtain clinical privileges. The APP Steering Committee (Steering Committee) is responsible for setting the agenda and direction of APPC meetings. Steering Committee members will be selected by the Steering Committee. Steering Committee members shall serve staggered three-year terms. The Committee may form subcommittees as determined by the Steering Committee and approved by the MEC. All sub-committees shall report their activities at least quarterly to the Steering Committee. The initial Chair of the APPC and Steering Committee shall be appointed by MEC and thereafter elected by the Steering Committee. The Chair shall serve a one (1) year term and may be re-elected for subsequent terms.
2. Duties. The Committee may perform any or all of the following functions:
    - 6.1.1.2.1. Continuing APP education
    - 6.1.1.2.2. Discussion of policy
    - 6.1.1.2.3. Discussion of equipment needs
    - 6.1.1.2.4. Development of recommendations for Department Chair or Medical Executive Committee
    - 6.1.1.2.5. Participation in the development of criteria for clinical privileges, when requested by the Department Chair, Section Chief or the MEC

6.1.1.2.6. Discussion of a specific issue at the special request of a Department Chair, Section Chief or the MEC

6.1.1.2.7. Conducting or participating in peer review of APP members of the Medical Staff, as requested by the Medical Staff;

6.1.1.2.8. Consideration of a specific credential request, when requested by the Department Chair, Section Chief, Credentials Committee or MEC;

6.1.1.2.9. Other duties as may be assigned by the Medical Staff or any officer or committee. (1.2019)

6.1.2. Cancer Committee (BOD 11/11, 3/12, 7/14, 3/17)

1. Composition. The cancer committee is established to provide leadership in the Cancer Program. According to the cancer program standards in Optimal Resources for Cancer Care 2020, updated April 2022, leadership is the prime element in an effective cancer program. The Program's success depends on an effective multidisciplinary cancer committee, who is responsible for goal setting, planning, initiating, implementing, evaluating, and improving all cancer-related activities in the program. The Cancer Committee encompasses numerous physician and non-physician professionals. The committee responsible for program leadership is multidisciplinary and represents the full scope of cancer care and services. The Cancer Committee is a standing committee.

   The cancer committee includes one board certified physician representative from surgery (includes general surgeon and/or surgical specialist(s) involved in cancer care), medical oncology, radiation oncology, diagnostic radiology, pathology, and a cancer liaison physician. When possible, it is expected that specialty physicians representing the cancer sites seen most often at the institution will be included. Non-physician membership must include a cancer program administrator, oncology nurse, social worker, and Certified Tumor Registrar (CTR). Recommended members include a performance or quality improvement professional, palliative care team member, genetics professional, clinical research coordinator, Registered Dietitian Nutritionist or nutrition services representative, rehabilitation services professional, spiritual care representative, psychiatric or mental health professional trained in the psychosocial aspects of oncology, and a representative from the American Cancer Society. Other physician and non-physician representatives should be included based on the cancer experience of the institution.

   The cancer committee chair is a physician who may also fulfill the role of one of the required physician specialties. The cancer liaison physician must be a member of the cancer committee and fulfill the role of one of the required physician specialties.

2. Duties. The duties of the cancer committee include the establishment, evaluation and monitoring of the following standards. Documentation in the cancer committee minutes is required for certain standards as defined by the Commission on Cancer:

   6.1.2.2.1. Administrative Commitment: Cancer committee authority is established and documented by the facility and includes all required elements.

   6.1.2.2.2. Membership: Designates one member from the committee to coordinate each of the six areas of cancer committee activities: cancer

conference, quality control of cancer registry date, quality improvement, clinical research, psychosocial services, and community outreach.

Cancer Liaison Physician (CLP): a physician of any specialty who is an active member of the medical staff. The CLP is the physician quality leader of the cancer committee and also serves as the alternate for the Cancer Committee Chair. The CLP is responsible for identifying, analyzing National Cancer Data Base (NCDB) data specific to the cancer program. NCDB report findings are reported to the cancer committee at least two times each calendar year and completes educational requirements each year.

6.1.2.2.3. Cancer Committee Meetings: meetings are at least once each calendar quarter.

6.1.2.2.4. Cancer Committee Attendance: Member attendance is required for at least 75% of cancer committee meetings held; members can send an alternate representative on their behalf.

6.1.2.2.5. Cancer Conference: Establishes the cancer conference frequency, format, and multidisciplinary attendance requirements on an annual basis. Monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, clinical trial options, prospective case presentation and any corrective action taken for an area that falls below the annual goal and mentions any QI activities that may have resulted from the evaluation as defined by the cancer conference policy. The assigned coordinator reports to the cancer committee on an annual basis.

6.1.2.2.6. Facility Accreditation: Ensures the facility is accredited or licensed by a recognized federal, state, or local authority appropriate to the facility type

6.1.2.2.7. Evaluation and Treatment Services: Ensures that quality assurance practices are in place for the required services available on site. Quality assurance is demonstrated by accreditation and/or policies and procedures.

6.1.2.2.8. Physician Credentials: Each calendar year the cancer program fulfills all of the compliance criteria for all physicians involved in the evaluation and management of cancer patients.

6.1.2.2.9. Oncology Nursing Credentials: Ensures all nurses providing direct oncology care hold a cancer-specific certification or demonstrate ongoing education by earing 36 cancer related continuing nursing education contact hours each accreditation cycle. The Program has in place a policy and procedure that ensures oncology nursing competency is reviewed each year per hospital policy.

6.1.2.2.10. Cancer Registry Staff Credentials: Ensures documentation of current CTR credentials for all certified cancer registry staff. A plan is in place for non-credentialed staff who perform case abstracting in the cancer registry and documentation is done of cancer-related continuing education for non-credentialed members of the cancer registry staff.

6.1.2.2.11. Genetic Counseling and Risk Assessment: Ensures cancer risk assessment, genetic counseling, and testing services are provided to patients either on-site or by referral, by qualified genetics professional. A process is in place pursuant to evidence-based national guidelines for

the annual genetic assessment of a selected cancer site. A policy and procedure is in place for providing and referring cancer risk assessment which contains all the required elements. Genetic testing services are evaluated annually and documented in the cancer committee minutes.

6.1.2.2.12. Palliative Care Services: Ensures palliative care services are available to patients either on-site or by referral. A policy and procedure is in place regarding palliative care services that includes all required elements. An annual report is given to cancer committee and documented in the minutes.

6.1.2.2.13. Rehabilitation Care Services: Cancer committee develops policies and procedures to guide referral to appropriate rehabilitation care services on-site or by referral and the activities and processes are presented to the cancer committee annually and documented in the minutes.

6.1.2.2.14. Oncology Nutrition Services: Ensures oncology nutrition services are provided, on-site or by referral, by a Registered Dietitian Nutritionist. The process for referring or providing oncology nutrition services to cancer patients is presented to the cancer committee annually and documented in the minutes.

6.1.2.2.15. Survivorship Program: The cancer committee identifies a survivorship program team, including its designated coordinator and members. An annual report is given to the cancer committee contains all required elements, and is documented in the minutes

6.1.2.2.16. College of American Pathologists Synoptic Reporting: Ensures ninety percent of the eligible cancer pathology reports are structured using synoptic reporting format as defined by the College of American Pathologist (CAP) cancer protocols, including containing all core data elements within the synoptic format. Operative Reports 5.3-5.8: Ensures that Operative reports for sentinel node biopsies, and axillary lymph node dissections for breast cancer document the required elements in synoptic format. Operative reports for wide local excisions of primary cutaneous melanomas document the required elements in synoptic format. Operative reports for resections for colon cancer document the required elements in synoptic format. Total mesorectal excision is performed for patients undergoing radical surgical resections of mid and low rectal cancers, resulting in complete or near-complete total mesorectal excision. Pathology reports for resections of rectal adenocarcinoma document the quality of TME resection (complete, near complete, or incomplete) in synoptic format. Pulmonary resections for primary lung malignancy include lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations. Pathology reports for curative pulmonary resection document the nodal stations examined by the pathologist documented in synoptic format.

6.1.2.2.17. Cancer Registry Quality Control: The cancer committee implements a quality control policy and procedure to evaluate the required areas of the cancer registry. The Cancer Registry Quality

Control Coordinator, under the direction of the cancer committee, performs or oversees the required quality control review as outlined in the policy and procedure. The results, recommendations, and outcomes of recommendations are reported to the cancer committee and documented in the minutes.

6.1.2.2.18. Rapid Cancer Reporting System (RCRS), Data Submission and Accuracy: Ensures complete data for all requested analytic cases are submitted to the NCDB in accordance with the annual Call for Data specifications. Cases meet the quality criteria as defined in the annual Call for Data on the initial submission, and if cases do not meet quality criteria on initial submission, then identified errors in submitted cases and rejected records are corrected and resubmitted by the due date specified. RCRS data and required quality measures performance rates are reviewed at least twice per year and documented in the minutes.

6.1.2.2.19. Follow Up of Patients: Ensures that 80 percent follow-up rate is maintained for all eligible analytic cases from the most current year of completed cases through 15 years before or the program's first accreditation date, whichever is shorter. A 90 percent follow up rate is maintained for all analytic cases diagnosed from the most current year of completed cases through five years before or the program's first accredited date, whichever is shorter.

6.1.2.2.20. Accountability and Quality Improvement Measures: Monitors expected Estimated Performance Rates (EPR) for accountability and quality improvement measures selected by the CoC. For each accountability and quality improvement measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the expected EPR specified by the CoC. If the expected EPR is not met, the program implements an action plan that reviews and addresses program performance below the expected EPR.

6.1.2.2.21. Monitoring Concordance with Evidence-Based Guidelines: Ensures that each year, a physician member of the cancer committee performs an in-depth analysis to determine whether initial diagnostic evaluation and first course of treatment provided to patients is concordant with evidence-based national treatment guidelines. The report detailing all required elements of the study, including the results of the analysis and any recommendations for improvement, are reported to the cancer committee and documented in the cancer committee minutes.

6.1.2.2.22. Quality Improvement Initiative: Ensures one quality improvement initiative based on an identified quality-related problem is initiated each year. The QI initiative documentation includes how it measured, evaluated, and improved performance through implementation of a recognized, standardized performance improvement tool. Status updates are provided to the cancer committee two times. Reports are documented in the cancer committee minutes. A final presentation of a summary of the quality improvement initiative is presented after the QI initiative is complete. The summary

presentation includes all required elements.

6.1.2.2.23. Cancer Program Goal: Ensures one cancer program goal is established and documented in the cancer committee minutes. At least two substantive status updates on goal progress are documented in the cancer committee minutes in the same calendar year as its establishment. For any goal extended into a second year, at least one status update is documented in the minutes during the second year to indicate whether the goal was completed or retired.

6.1.2.2.24. Addressing Barriers to Care: The cancer committee identifies at least one barrier to focus on for the year and identifies resources and processes to address the barrier. At the end of the year, the cancer committee evaluates the resources and processes adopted to address the barrier to care and identifies strengths and areas for improvement. The cancer committee minutes include all required elements.

6.1.2.2.25. Cancer Prevention Event: The cancer committee offers at least one cancer prevention event. Where applicable, the cancer prevention event is consistent with evidence-based national guidelines and interventions. A summary of the cancer prevention event is presented to the cancer committee and documented in the cancer committee minutes.

6.1.2.2.26. Cancer Screening Event: The cancer committee offers at least one cancer screening event. Where applicable, the cancer screening event is consistent with evidence-based national guidelines and interventions. The cancer screening event has a process for follow up on all positive findings. A summary of the cancer screening event is presented to the cancer committee and documented in the cancer committee minutes.

6.1.2.2.27. Clinical Research Accrual: The program has a screening policy and procedure to identify participant eligibility for clinical research studies and how to provide clinical trial information to subjects. These processes are assessed to identify and address barriers to enrollment and participation. The number of accruals to cancer-related clinical research studies meets or exceeds the required percentage. The Clinical Research Coordinator reports all required information to the cancer committee and the report is documented in the cancer committee minutes.

6.1.2.2.28. Commission on Cancer Special Studies: The program participates in each special study. Complete data and documentation are submitted by the established deadline for each special study.

6.1.2.2.29.

6.1.2.2.30. .

6.1.2.2.31. Psychosocial Distress Screening: Ensures policies and procedures are in place to provide patient access to psychosocial services either on-site or by referral. The cancer committee implements a policy and procedure that includes all requirements for providing and monitoring psychosocial distress screening and referral for psychosocial care. Cancer

patients are screened for psychosocial distress at least once during the first course of treatment. The psychosocial distress screening process is evaluated, documented, and the findings are reported to the cancer committee by the Psychosocial Services Coordinator. The coordinator's report includes all required elements and is documented in the cancer committee minutes.

6.1.3 Breast Program Leadership Committee (BPLC)/Breast Care Team (BCT) (Board 1.2019)

Structure. The organizational structure of the breast center gives the Breast Program Director (BPD) and the BPLC responsibility and accountability for provided services. The breast center must consist of a designated Breast Care Team (BCT) who contribute to the active assessment, treatment, and/or dissemination of information to a breast center patient. BCT membership consists of a minimum of one appointed physician member from each of the following specialties: surgery, pathology, radiology, medical oncology, and radiation oncology.

2. Duties. The Breast Program Leadership Committee (BPLC) shall be a standing subcommittee of the BCH Cancer Committee. The BPLC's responsibility shall be to assume compliance with all current National Accreditation Program for Breast Centers (NAPBC) standards for accreditation of the breast program

    6.1.3.2.1. Meet a minimum of four times per year

    6.1.3.2.2. In conjunction with the Breast Program Director (BPD), plan, develop, implement, and evaluate all activities of the breast center

    6.1.3.2.3. Oversee and monitor compliance with the NAPBC Standards, including all participating satellite centers

    6.1.3.2.4. Review all center data annually

    Duties also include demonstrating the following services and compliance with the following standards:

    a. A multidisciplinary team approach to coordinate the best care and treatment options available
    b. Access to breast-specific information, education, and support
    c. Breast center data collection on quality indicators for subspecialties involved in breast cancer diagnosis and treatment
    d. Ongoing monitoring and improvement of care
    e. Information about participation in clinical trials and new treatment options
    f. Standard 1.1: Level of Responsibility and Accountability
    g. Standard 1.2: Multidisciplinary Breast Cancer Conference
    h. Standard 2.1: Multidisciplinary Patient Management

3. Membership. BPLC Membership Requirements.
    a. The physician committee members have current specialty board certification in their area of specialty or be in the process of obtaining board certification as applicable
    b. The physician committee members possess current medical licensure and appropriate active medical staff appointment
    c. The non-physician committee members have appropriate qualifications/certifications in their field and hold appropriate breast program relationships and accountability as outlined in the applicable standards
    d. The committee members establish and maintain an environment of professional development and scholarship

e. The committee members regularly participate in organized clinical discussions, journal clubs, and conferences

BCT Membership Requirements.

a. Have appropriate qualifications/certifications/registrations in their field
b. Collaborate and develop a treatment plan that will lead to the best possible quality outcome for the breast disease patient
c. Provide patient care in accordance with institutional policies and in compliance with National Accreditation Program for Breast Centers (NAPBC) Standards
d. Attend the multidisciplinary conference as appropriate
e. Participate in annual continuing education sessions in compliance with NAPBC requirements
f. All professionally credentialed members of the BCT must have appropriate certification.
g. All physician team members are required to be board certified or in the process of obtaining board certification

6.1.3. Credentials Committee (CREDS).

1. Composition. There will be a medical staff/hospital credentialing committee, which will be composed of approximately ten to twelve members of the medical staff. The members of the Credentials Committee will be selected based upon their expertise and interest in the credentialing activity. The Medical Executive Committee will appoint the chairperson of this committee. The Medical Staff President and at least one member of the Board will be ex-officio members without vote. 1/2013

   Ideal candidates for Credentials Committee include past department chairpersons, past Credentials Committee chairpersons, past Medical Executive Committee chairpersons, as well as other individuals who have substantial knowledge of the credentialing process. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The members may serve two consecutive terms, which may be staggered as determined by the chair. Members of the Credentials Committee will, by virtue of participation in this activity, automatically fulfill all other medical staff committee obligations.
2. Duties. The Credentials Committee will function pursuant to policies and procedures adopted and documented in the credentialing manual.
3. Meetings. The Credentials Committee shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

6.1.4. Medical Executive Committee (MEC)

1. Composition and duties as defined in Bylaws Part 1 – Governance; See Section 6.

6.1.5. New Technology Committee (NTC)

1. Composition. There will be a medical staff/hospital New Technology committee which will be composed of approximately three permanent members of the medical staff. The Chair and members of the Committee will be selected by the Credentials Committee, based upon their expertise and interest in medical staff and credentialing activities. Additional members,

including physicians, administration, and director(s), will be added on an ad hoc basis, pertinent to the specialty(s) involved in the new technology. Each member of the New Technology Committee will commit to at least three years in staggered terms.

2. Duties. The New Technology Committee will be responsible the Credentials Committee and will function pursuant to policies and procedures adopted and documented in the Credentialing Manual. If the proposed new technology or procedure is significantly outside of the scope of current practice at BCH the Committee will act only after notification of Board's approval to proceed. Responsibilities will include:
    a. Research & investigation by utilizing such sources as local expertise, ABMS positions; white papers; local, state and national standards, as applicable; and other related documentation
    b. Interdepartmental procedure: Criteria for procedures that cross specialty lines will be the same. Representatives of the specialties involved will be invited to collaborate in the development of standard criteria. If no agreement can be reached, the Committee will consider the recommendations of each specialty involved and a recommendation will be forwarded to the Credentials Committee. Further evaluation and recommendations will be conducted according to the interdepartmental procedures noted in the Credentialing Manual
3. Meetings. The New Technology Committee shall meet as needed and maintain a permanent record of its proceedings and actions.

6.1.6. Pharmacy and Therapeutics Committee (P&T)

1. Composition. This Committee is a multidisciplinary committee that shall include at least three (3) representatives of the Medical Staff, one of which will be the Co-Chair along with the Clinical Coordinator of the Pharmacy. It will have at least one representative from each of the following services of the Hospital: nursing services, pharmacy, hospital medicine, information technology and administrative services.
2. Duties. The responsibilities of this Committee shall be (8/2018)
    - Develop and monitor policies to evaluate the prophylactic, therapeutic and empiric use of drugs to promote drugs in the Hospital being used appropriately, safely and effectively. These policies shall include objective criteria that reflect current knowledge, clinical experience and the relevant literature on the use of drugs and shall include screening mechanisms to identify problems with use of drugs as well as opportunities to improve the use of drugs. Policies shall also be developed by the Committee related to the selection, storage, distribution, handling and administration of drugs and diagnostic testing materials.
    - Serve as an advisory group to the Medical Staff and the pharmacists and other Hospital Departments on the selection of drugs including substitution of medications.
    - Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
    - Maintain and review periodically a formulary or drug list for use in the Hospital.

- In cooperation with other PI/PS activities of the Hospital, identify and evaluate clinical data concerning adverse reactions of patients to specific drugs and interactions of drugs that present a significant health hazard, as well as an evaluation of the most frequently prescribed drugs.
- Participate in establishing standards concerning the use and control of investigational drugs, where appropriate, and evaluate clinical data concerning new drugs requested for use in the Hospital.

3. Meetings. This committee shall meet at least quarterly.

6.1.7. Practitioner Health and Well-Being Committee (PHWB)

1. Composition. This Committee will consist of at least five members, a majority of which, including the Chair, shall be physician members of the Medical Staff, appointed by the President of the Medical Staff and approved by the Medical Executive Committee. The Medical Staff Department Director will be an ex-officio member without vote and will provide support and resources to the Committee. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The members may serve two or more consecutive terms, which may be staggered as determined by the chair. Members of this committee shall not hold membership on other peer review or quality assurance/improvement committees while serving on the Committee.
2. Duties. To serve as a source of consultation for medical staff members identified or suspected to have impairments or require peer support. The Committee may provide suggestions and advice to other committees or individuals regarding reasonable safeguards, such as monitoring arrangements concerning a practitioner. Education of the Medical Staff, hospital personnel and the Board regarding illness and impairment recognition issues specific to practitioners is a duty of the committee, when deemed appropriate.
3. Meetings. The Committee shall meet as often as necessary, but at least quarterly.

6.1.12. Professional Practice Review Committee (PPRC) (11/29/11)

1. Composition. The medical staff's professional practice review committee shall consist of the immediate past medical staff president or president-elect, chief medical officer, ambulatory medical director and specialty representatives who are appointed by the PPRC chair and approved by the medical staff president. Ad Hoc members will be requested on an as needed basis. Representatives from the medical staff services department, quality department, nursing services and hospital administration will serve as ex officio members. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The members may serve two consecutive terms, which may be staggered as determined by the chair. The chair and vice chair will be elected by the PPRC will serve for a one-year term and may serve up to five (5) consecutive terms. They must have served at least one year on the PPRC prior to election.
2. Duties. Pursuant to the Professional Practice Review Plan duties include, but are not limited to:
    1. Setting peer review policy;
    2. Establishing guidelines/criteria for triage of cases;

3. Educating medical staff on peer review and practice improvement activities;
4. Reviewing and approving OPPE/FPPE forms
5. Oversight of all levels of practice and peer review

3. Meetings. The PPRC shall meet at least eight (8) times per year.

6.1.8. Physician Advisory Council (PAC) (8/2018)

1. Composition: There will be a medical staff EHR Physician Advisory Council which will be comprised of approximately fifteen to twenty members of the medical staff, ideally one physician or provider per specialty. The members of committee will be selected based upon their expertise and interest in the EHR project. The Chief Medical Information Officer will be the Chair of this committee. Ex officio ad hoc members of the Committee without vote shall include the Chief Information Officer (CIO), Chief Medical Officer, and clinical project managers.
2. Duties: The duties of the Committee are:
    1. Assist the hospital in the development, implementation, maintenance and enhancement of the electronic medical record
    2. Provide leadership and guidance to develop a user-friendly, integrated electronic documentation and order entry system.
    3. Provide input and direction into all decisions affecting physician workflows and patient care quality as a result of implementation of the electronic medical record
    4. Define and/or approve system configuration for all modules which impact physician workflows including but not limited to such items as: Provider order sets; provider documentation and clinical alerts
    5. This committee shall be responsible to the Medical Executive Committee. It shall record its findings, conclusions, recommendations, and actions taken in minutes filed in the office of the Medical Staff Department, a report of which is sent to the MEC.
3. Meetings. The Committee shall meet monthly and maintain a permanent record of its proceedings and actions

6.1.13. Stroke Services Committee (SSC)

1. Composition. This Committee will consist of the following physician members, the Medical Director of stroke services who serves as chair, a neurologist, emergency medicine physician, a radiologist, a neurosurgeon, and the medical director of the critical care unit and ED as needed. A pathologist will be asked to serve on an as needed basis.
2. Duties. The responsibilities of this Committee shall be:
    1. Review Policies and Procedures for Stroke
    2. Case Studies
    3. Statistics of Standard Measures and Process Matrix for Stroke
    4. Program Evolution
    5. Preparation for TJC stroke survey
3. Meetings. This committee shall meet at least quarterly.

6.1.14. Multidisciplinary Trauma Committee (MTC) (BOD 1/2013)

1. Composition. This Committee shall include at a minimum the trauma medical director who serves as chair, all core general surgeons, liaisons from anesthesiology, emergency medicine, neurosurgery, orthopedic surgery, and radiology (each of these liaisons shall attend at least 50% of the meetings); the EMS medical director. Ad hoc members include the clinical care unit medical director and pathology section chief, pediatric section chief. Other members include the clinical directors over the OR, emergency department/trauma, and critical care, medical staff department director, trauma program manager, trauma coordinators, core measure quality data manger, medical quality supervisor, and EMS outreach representatives.
2. Duties. The responsibilities of this Committee shall be (not all inclusive):
    1. Address trauma program operational issues
    2. Continual evaluation of program's processes and outcome's
    3. Monitor compliance with required time frames for availability of trauma personnel (i.e., general surgery, orthopedics, neurosurgery, anesthesiology, radiology, and MRI or CT techs).
    4. Monitor availability of anesthesia services and the absence of delays in airway control or operations.
    5. Review and address issues related to the availability of necessary personnel and equipment to monitor and resuscitate patients in the PACU
    6. Review disaster critiques biannually.
    7. Review indicators identified for further evaluation (ref. Trauma Services Quality Management Indicators).
    8. Identify educational opportunities identified by case review and coordinate CME activities through CME Committee.
    9. Develop and periodically review policies, procedures and standards. Radiologists shall be involved in protocol development and trend analysis that relate to diagnostic imaging.
    10. Review and monitor the organ donation rate
    11. Monitor changes in interpretation of diagnostic information
    12. Compliance with performance improvement activities as outlined in the Trauma PI Plan
    13. Review benchmarks, develop/document action plan, if needed.
3. Meetings. This committee shall meet, at a minimum, quarterly and provide a summary of their actions to the MEC.

6.1.15. Trauma Peer Review/Performance Improvement Committee (TPR/PI) (BOD 1/2013)

1. Composition. This Committee shall include, at a minimum, the trauma medical director who serves as chair, the core group of general surgeons and the physician liaisons from anesthesiology, emergency medicine, neurosurgery, orthopedic surgery, and radiology. Each of these liaisons and the EMS medical director shall attend at least 50% of the meetings, 75% is desired. Additional staff will include the trauma program manager, and the medical quality supervisor.
2. Duties. The responsibilities of this Committee shall be:
    1. Review the overall quality of care for trauma services, selected deaths, complications and sentinel events with the objective of identifying issues and appropriate responses.
    2. Review of identified problem trends recognized through departmental review.

Identified problem trends will be forwarded to the Professional Practice Review Committee to undergo review.

3. Provide for morbidity and mortality review of trauma cases. All trauma deaths shall be systematically reviewed and categorized as preventable, non-preventable or potentially preventable.
4. When consistent problem or inappropriate variation is identified, the committee will evaluate through root cause, take and document appropriate action.

3. Meetings. This committee shall meet, at a minimum, quarterly.

In addition to the above committees, officers, department chairs, section chiefs and other members of the Medical Staff shall serve, as representatives of the Medical Staff, on the Patient Safety Council, or other similar committee as outlined in the hospital's Patient Safety Quality Plan and on the Joint Conference Committee, as outlined in the bylaws of the hospital's governing board. (1.2019)

SECTION 7. DUTIES OF OFFICERS

7.1. The President shall serve as the chief administrative officer of the Medical Staff to:

7.1.1. Act in coordination with the Chief Executive Officer in all matters of mutual concern within the hospital;

7.1.2. Call, preside at, and be responsible for the agenda of all General Staff meetings of the Medical Staff;

7.1.3. Preside at the Medical Executive Committee meetings;

7.1.4. Serve as ex officio member on all other Medical Staff committees;

7.1.5. Be responsible for the enforcement of Medical Staff bylaws, rules and regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards herein provided with regard to appointments, corrective actions, summary suspensions, hearing and appeals;

7.1.6. Be responsible for the Medical Staff's clinical activities, performance improvement measures, and/or implementing its administrative functions. Administrative responsibilities include maintaining an effective credentialing system and up-to-date policy on Medical Staff membership;

7.1.7. Appoint committee chairpersons for standing, special and multi-disciplinary Medical Staff committees;

7.1.8. Represent the views, policies, needs and grievances of the Medical Staff to the Chief Executive Officer and, if necessary, to the Hospital Governing Board;

7.1.9. Receive and interpret to the Medical Staff the policies of the Hospital Governing Board, as transmitted by the Chief Executive Officer, and report to the Chief Executive Officer on the performance of the Medical Staff's responsibility to provide medical care;

7.1.10. Support the concept that educational activities of the Medical Staff be adequately funded and housed, and that appropriate programs are planned by the departments and committees of the Medical Staff;

7.1.11. Be the spokesperson for the Medical Staff in its external professional and public relations;

7.1.12. Perform all other duties required of the President under these bylaws and the rules and regulations of the Medical Staff.

SECTION 8. FUNCTIONS OF DEPARTMENT CHAIRPERSONS AND SECTION CHIEFS

8.1. Each Chairperson shall:

8.1.1. be accountable to the Medical Executive Committee and to the President for all clinical and administrative activities within his/her department, as delineated in the Department Functions; and, particularly for the integration of quality of patient care rendered by appointees of the department and for the effective conduct of the patient care evaluation and monitoring functions delegated to his/her department;

8.1.2. submit written reports to the Medical Executive Committee as required concerning: (1) findings of the department's review, evaluation and monitoring activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the department and Boulder Community Health; and (3) such other matters as may be required from time to time by the Medical Executive Committee;

8.1.3. develop and implement departmental programs consistent with the provisions as stated in these Bylaws and associated manuals, for continued assessment and improvement of patient care, quality control of clinical practice, credentials review and privileges delineation, orientation and education of healthcare practitioners and personnel, and utilization review;

8.1.4. give guidance on the medical policies and make specific recommendations regarding the care, treatment and services rendered his/her department;

8.1.5. maintain continuing surveillance of the professional performance of all practitioners with clinical privileges and of all allied health professionals with specified services in his/her department and report regularly thereon to the President and to the Medical Executive Committee;

8.1.6. transmit to the appropriate authorities as required by the credentials policies, her/his recommendation concerning appointment and classification, reappointment, delineation of clinical privileges or specified services, and correction action with respect to practitioners assigned to her/his department;

8.1.7. appoint such committees as are necessary to conduct the functions of the department.

8.1.8. enforce the Medical Staff Bylaws, Rules, Regulations, and Policies within his department, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or to be sought when necessary;

8.1.9. implement within his/her department actions taken by the Medical Executive Committee and the Board;

8.1.10. participate in most phases of administration of the coordination and integration of his/her department, through cooperation with the nursing service and the Hospital Administration in matters affecting patient care, to include sufficient and competent personnel, adequate supplies, efficient space, standing clinical orders and treatment techniques;

8.1.11. assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Medical Executive Committee, the President or the Board;

8.1.12. perform such other duties as set forth in the position description approved by the President of the Medical Staff and as commensurate with her/his office as may from time to time be reasonably requested of him/her by the President, the Medical Executive Committee or the Board.

8.2. Section Chiefs shall perform the functions set forth in their position descriptions approved by the

President of the Medical Staff. (1.2019)