

HAYSMED

**MEDICAL STAFF
ORGANIZATIONAL MANUAL**

Horty, Springer & Mattern, P.C.

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HAYS MEDICAL CENTER

ADOPTION

This Medical Staff Organizational 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, and henceforth all department and committee activities of the Medical Staff and of each individual serving as a member of a department or staff committee shall be undertaken pursuant to the requirements of this manual.

Adopted by the Medical Staff:

By: /s/ Gregory A. Woods, MD

Chief of Staff

Date: 2/23/98

Revised: _____

Approved by the Board of Hays Medical Center:

By: /s/ Darrell Werth

Chairperson of the Board

Date: 3/19/98

Revised: _____

ARTICLE I

DEFINITIONS

- A. The following definitions shall apply to terms used in this manual:
- (1) "Appointee" means any physician and dentist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the hospital.
 - (2) "Board" means the Board of Directors of Hays Medical Center, which has the overall responsibility for the conduct of the hospital.
 - (3) "Chief Executive Officer" means the President of the hospital or the President's designee.
 - (4) "Clinical Privileges" or "privileges" means the authorization granted by the Board to an applicant, Medical Staff appointee, other independent practitioner or advanced dependent practitioner to render specific patient care services in the hospital within defined limits.
 - (5) "Dentist" shall be interpreted to include a doctor of dental surgery ("D.D.S.") and doctor of dental medicine ("D.M.D.").
 - (6) "Director of Medical Affairs or Chief Medical Officer" refers to any physician appointed by the hospital Chief Executive Officer acting as a physician executive.
 - (7) "Executive Committee" means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board."
 - (8) "Ex Officio" means service as an appointee of a body by virtue of an office or position held and, unless otherwise specified in these bylaws or the Medical Staff Organizational Manual, means without voting rights.
 - (9) "Good standing" means that Medical Staff appointee who is not under suspension or any restriction regarding staff appointment or admitting or clinical privileges at this hospital and/or at any other health care facility or organization.
 - (10) "Hospital" means Hays Medical Center.

- (11) "Medical Staff" means all physicians, dentists and podiatrists who are given privileges to treat patients at the hospital.
- (12) "Patient encounters" means the number of inpatient admissions, inpatient surgeries, inpatient visits as admitting or attending physician, outpatient surgeries, physician clinic visits, anesthetic cases, radiology interpretations, pathology interpretations, emergency department patients, observation admissions, consultations, which are defined as face-to-face contacts, telemedicine, or supervision of licensed master-level psychologists, temporary licensed psychologists, licensed psychologists, licensed master-level social workers, licensed clinical psychologists, licensed clinical marriage and family therapists, and licensed clinical professional counselors.
- (13) "Physicians" shall be interpreted to include both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- (14) "Professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional peer review activity, which is based on the competence or professional conduct of a staff appointee, and which affects or may affect adversely the clinical privileges or appointment of the staff appointee.
- (15) "Professional review activity" means a peer review activity of the hospital with respect to an individual Medical Staff applicant or appointee (a) to determine whether the Medical Staff applicant or appointee may have clinical privileges with respect to his/her appointment; (b) to determine the scope or conditions of those clinical privileges and appointment; and (c) to change or modify such privileges and/or appointment.
- (16) "Professional review body" means the Board of the hospital or any Board committee which conducts professional peer review activity, and includes any committee of the Medical Staff when assisting the Board in a professional peer review activity.
- (17) "Unassigned patient" means any individual who comes to the hospital for care and treatment who does not have an attending physician; or whose attending physician or designated alternate is unavailable to attend the patient; or who does

not want the prior attending physician to provide him/her care while a patient at the hospital.

(18) "Voluntary" or "automatic relinquishment" of Medical Staff appointment and/or clinical privileges means a lapse in appointment and/or clinical privileges deemed to automatically occur as a result of stated conditions.

B. Words used in this manual shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this manual.

ARTICLE II

MEDICAL STAFF ORGANIZATIONAL PLAN

ARTICLE II - PART A: DEVELOPMENT AND ANNUAL REVIEW OF PLAN

Each year, the Executive Committee shall review the structure of the Medical Staff as set forth in this manual with reference to appropriate legal guidelines and accrediting agency standards. This plan shall describe the organization of the Medical Staff and specify the duties of each Medical Staff standing committee. A special or ad hoc committee may be created by the Executive Committee from time to time to assist with the development of an organizational plan.

ARTICLE III

CLINICAL DEPARTMENTS

ARTICLE III - PART A: LIST OF CLINICAL DEPARTMENTS

- (1) The following clinical departments are established:

Department of Medicine, including the specialties of:

Cardiology
Dermatology
Emergency Medicine
Family Medicine
Internal Medicine
Medical Oncology
Medical Hematology
Nephrology
Neurology
Pediatrics
Physical Medicine and Rehab
Psychiatry
Pulmonology/Critical Care
Radiology
Radiation Oncology

Department of Surgery, including the specialties of:

Anesthesiology
Cardiothoracic and Vascular Surgery
Dental/Oral and Maxillofacial Surgery
General Dentistry
General Surgery
OB/GYN

Ophthalmology

Orthopaedics

Otololaryngology

Pathology

Plastic and Reconstructive Surgery

Radiation Oncology

Urology

- (2) Additional clinical departments, sections or divisions of departments may be established by the Board after considering recommendations from the Executive Committee. In the event sections or divisions are formed, minutes of and attendance at meetings of the sections or divisions shall be recorded.

ARTICLE III - PART B: FUNCTIONS AND RESPONSIBILITIES OF CLINICAL DEPARTMENTS

The functions and responsibilities of clinical departments and clinical department chairpersons, including medical directors or chiefs of clinical sections or divisions, shall be those set forth in Article V of the Medical Staff Bylaws, which are herein incorporated by reference.

ARTICLE IV

MEDICAL STAFF COMMITTEES

This article shall outline those Medical Staff committees responsible for the performance of quality assessment/evaluation or other review functions delegated to the Medical Staff by the Board.

ARTICLE IV - PART A: GENERAL INFORMATION

Section 1. Committee Chairpersons:

- (a) All committee chairpersons, unless otherwise provided for in the Medical Staff Bylaws, Article VI, Part A, Section 1 and/or this manual, shall be appointed by the Board upon recommendation of the Chief of Staff for an initial term of one (1) year. All committee chairpersons shall be appointed based on the criteria set forth in Article III, Part A, Section 4 of the Medical Staff Bylaws. Such appointments will be made by the Board at its last meeting prior to the end of the Medical Staff year.
- (b) After serving an initial term, a chairperson may be reappointed by the Board from year to year for a maximum of three (3) additional yearly terms upon recommendation from the Chief of Staff and the Chief Executive Officer.

ARTICLE IV - PART A:

Section 2. Members:

- (a) Except as otherwise provided for in the Medical Staff Bylaws or this manual, members of each committee shall be appointed yearly by the Chief of Staff, in consultation with the Chief Executive Officer, not more than thirty (30) days after the annual meeting of the Medical Staff, and there shall be no limitation in the number of terms they may serve. All appointed members may be removed and vacancies filled at the discretion of the Chief of Staff.
- (b) The Chief of Staff and the Chief Executive Officer or their respective designees shall be members, *ex officio*, without vote, on all committees, except the Executive Committee on which the Chief of Staff shall serve as chairperson, with vote.

ARTICLE IV - PART A:

Section 3. Committee Meetings:

- (a) All Medical Staff committees, except the Executive and Credentials Committees, shall meet at least quarterly, unless otherwise specified in this manual, at a time set by the chairperson of the committee. The agenda for the meeting and its general conduct shall be set by the committee chairperson.
- (b) All committee chairpersons shall have the authority to convene their committees for special meetings as needed, in addition to those regular meetings required by this manual. The notice requirements set forth in the Medical Staff Bylaws, Article III, Parts B and D, shall apply.

ARTICLE IV - PART A:

Section 4. Quorum for Committee Meetings:

No quorum shall be required to convene a regular or special meeting of a committee, but in no event shall a meeting be convened with less than two (2) members, including the chairperson in attendance.

ARTICLE IV - PART A:

Section 5. Attendance by Medical Staff Appointees:

Active Staff appointees may attend any staff committee meetings, except for portions of such meetings during which confidential credentialing and/or peer review matters are discussed.

ARTICLE IV - PART A:

Section 6. Designation and Substitution:

- (a) There shall be an Executive Committee and such other standing and special committees of the Medical Staff responsible to the Executive Committee as may from time to time be necessary and desirable to perform the staff functions set forth in this manual and the Medical Staff Bylaws.
- (b) The Chief of Staff shall appoint Medical Staff appointees to participate in interdisciplinary hospital committees.

ARTICLE IV - PART B: EXECUTIVE COMMITTEE

Section 1. Composition:

- (a) The Executive Committee shall consist of the officers of the Medical Staff, the chairperson of each clinical department, one (1) Allied Health Professional, a member of the Advanced Practice Provider Council; and two (2) members elected at large from the Active Staff, with vote. The Chairperson of the Credentials Committee shall be a member, *ex officio*, with vote.
- (b) The Executive Committee members at large shall be elected at the annual Medical Staff meeting. Members at-large shall be eligible for re-election but shall not serve more than three (3) consecutive years.
- (c) The Chief of Staff shall be Chairperson of the Executive Committee.
- (d) The Chairperson of the Board may attend meetings of the Executive Committee and participate in its discussions, but without vote.

ARTICLE IV - PART B:

Section 2. Duties:

The duties of the Executive Committee shall be:

- (a) to represent and act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the staff, subject only to any limitations imposed by this manual and/or the Medical Staff Bylaws;
- (b) to coordinate the activities and general policies of the various clinical departments;
- (c) to receive and act upon those department, committee, and other assigned activity group reports as specified in this manual and the Medical Staff Bylaws, and make recommendations concerning them to the Chief Executive Officer and the Board;
- (d) to implement policies of the hospital that affect the Medical Staff;
- (e) to provide liaison among the Medical Staff, the Chief Executive Officer and the Board;
- (f) to keep the Medical Staff abreast of applicable accreditation and regulatory requirements affecting the hospital;

- (g) to enforce hospital and Medical Staff rules in the best interest of patient care and of the hospital, with regard to all persons who hold appointment to the Medical Staff;
- (h) to refer situations involving questions of the clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff appointee to the Credentials Committee for appropriate action;
- (i) to be responsible to the Board for the implementation of the hospital's quality/performance improvement plan as it affects the Medical Staff;
- (j) to review, at least once a year, the bylaws, policies, rules and regulations, and associated documents of the Medical Staff, including, but not limited to, the mechanisms designed to evaluate the credentials and to delineate the clinical privileges of Medical Staff applicants and appointees, to terminate Medical Staff appointment and clinical privileges, to provide a fair hearing, and to recommend such changes as may be necessary or desirable to the Board;
- (k) to determine minimum continuing education requirements for appointees to the staff;
- (l) to review all reports and recommendations of the Credentials Committee regarding situations involving questions of clinical competence, patient care and treatment, case management, or inappropriate behavior of any Medical Staff appointee and, as a result of such reviews, take appropriate action as warranted;
- (m) to review all reports and recommendations of the Credentials Committee regarding appointments to the Medical Staff, assignment to departments and delineation of clinical privileges and, as a result of such reviews, make recommendations to the Board for appointment and clinical privileges;
- (n) to review all reports and recommendations of the Credentials Committee regarding the performance and clinical competence of persons who hold appointments to the Medical Staff and, as a result of such review, make recommendations to the Board for reappointments, clinical privileges and/or changes in clinical privileges; and
- (o) to organize and monitor the Medical Staff's performance improvement activities and establish a mechanism to conduct, evaluate, and revise such activities.

ARTICLE IV - PART B:

Section 3. Meetings, Reports and Recommendations:

- (a) The Executive Committee shall meet monthly or more or less often if, necessary, to transact pending business. The Secretary-Treasurer will maintain reports of all meetings, which reports shall include the minutes of the various committees and departments. Copies of all minutes and reports of the Executive Committee shall be transmitted to the Chief Executive Officer routinely as prepared. Recommendations of the Executive Committee shall be forwarded to the Board with a copy to the Chief Executive Officer. The Chairperson of the Executive Committee shall be available to meet with the Board or its applicable committee on all recommendations that the Executive Committee may make.
- (b) Between meetings of the Executive Committee, an ad hoc committee composed of the officers of the staff, the Chairperson of the Credentials Committee and the Director of Medical Affairs shall be empowered to act in situations of urgent or confidential concern where not prohibited by this manual or the Medical Staff Bylaws herein incorporated by reference.

ARTICLE IV - PART C: CREDENTIALS COMMITTEE

Section 1. Composition:

- (a) The Credentials Committee shall consist of the Chief Designate, Chief of Staff, and the three (3) most recent Chiefs of Staff who are still appointees to the Active Staff; and one (1) Allied Health Professional, a member of the Advance Practice Provider Council, with vote. The Chairperson shall be the Immediate Past Chief of Staff. Service on this committee shall be considered as the primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere. If at any time the continued workability of the committee is threatened by the inability or unwillingness of any member to serve, the Chief of Staff shall appoint additional member(s) from the Active Staff to fill the vacancies.
- (b) Members of the Credentials Committee shall serve a maximum of five (5) years with staggered terms. Any member who has served the maximum term shall not be eligible for reappointment to the committee for a period of one (1) year.

ARTICLE IV - PART C:

Section 2. Duties:

The duties of the Credentials Committee shall be:

- (a) to review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations;
- (b) to review the credentials of all applicants who request to practice at the hospital as licensed independent allied health professionals, to make investigations of and interview such applicants as may be necessary, and to make a written report of its findings and recommendations;
- (c) to review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as licensed independent allied health professionals and, as a result of such review, to make a written report of its findings and recommendations;
- (d) to review and recommend revisions to the Document on Medical Staff Appointment, Reappointment and Clinical Privileges and the Policy on Allied Health Professionals; and
- (e) to coordinate and recommend appropriate criteria for the delineation of clinical privileges.

ARTICLE IV - PART C:

Section 3. Meetings, Reports and Recommendations:

The Credentials Committee shall meet monthly or more or less often if necessary to accomplish its duties, shall maintain a permanent record of its proceedings and actions, and shall report its recommendations to the Executive Committee, the Chief Executive Officer and the Board. The Chairperson of the Credentials Committee shall be available to meet with the Executive Committee and the Board or its committee on all recommendations that the Credentials Committee may make.

ARTICLE IV - PART D: UTILIZATION MANAGEMENT COMMITTEE

Section 1. Composition:

The Executive Committee shall assume the duties of Utilization Management. The Chief Executive Officer may also assign representatives from health information management, nursing service, continuing care service, and other departments of the hospital to assist the Executive Committee in its functions. Such representatives shall serve as advisors to, and not members of, the Executive Committee.

ARTICLE IV - PART D:

Section 2. Duties:

- (a) Utilization Review Functions: The Executive Committee shall:
 - (1) monitor utilization to evaluate the appropriateness of hospital admissions, length of stays, discharge practices, use of medical and hospital services and resources, and other factors related to utilization of hospital and physician services;
 - (2) formulate a written utilization review plan for the hospital to be approved by the Chief Executive Officer and the Board. Such plan shall at least be in accordance with all applicable accreditation, regulatory and third-party payor requirements; and
 - (3) evaluate the medical necessity for continued hospital services for particular patients, where appropriate, and make recommendations on the same to the attending physician and the Chief Executive Officer. No physician or other staff appointee shall have review responsibility for any extended stay cases in which that individual has been professionally involved.

- (b) Medical Records Functions: The Executive Committee shall:
 - (1) review Medical Staff and departmental policies and/or rules pertaining to medical records, including medical record completion, filing, indexing, storage, destruction and availability, and recommend changes as appropriate and/or necessary;
 - (2) review annually the policies and procedures of the medical records department and make recommendations as appropriate and/or necessary; and
 - (3) recommend a medical record abbreviation list.

ARTICLE IV - PART D:

Section 3. Meetings, Reports and Recommendations:

- (a) The Executive Committee shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Risk Management Committee and the Board.
- (b) The Executive Committee shall also report (with or without recommendation) to the Credentials Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

Final determination appeals will be reported to the Executive Committee.

ARTICLE IV - PART E: PHARMACY AND THERAPEUTICS COMMITTEE

Section 1. Composition:

The Pharmacy and Therapeutics Committee shall consist of the hospital pharmacist, who shall be a member and chairperson of the committee; the Pharmacy Medical Director, Chief Nurse Officer, Infection Control Nurse, all to serve with vote, and a representative(s) from hospital management appointed by the Chief Executive Officer who shall serve, *ex officio*, without vote.

ARTICLE IV - PART E:

Section 2. Duties:

The Pharmacy and Therapeutics Committee shall:

- (a) review the appropriateness of the prophylactic, empiric and therapeutic use of drugs through the review and analysis of individual or aggregate patterns or variations of drug practice;
- (b) develop and recommend to the Executive Committee and the Board policies relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;
- (c) define and review all significant untoward drug reactions;

- (d) maintain and periodically review the hospital formulary or drug list;
- (e) review the appropriateness, safety, and effectiveness of the prophylactic, empiric and therapeutic use of antibiotics in the hospital;
- (f) recommend drugs to be stocked on the nursing unit floors and by other services;
- (g) recommend policies concerning the safe use of drugs in the hospital, including new drugs, drug preparations requested for use in the hospital, hazardous drugs and investigational drugs; and
- (h) monitor guidelines for automatic stop orders for drugs as specified in the Medical Staff Rules and Regulations or other relevant hospital policies as herein incorporated by reference.

ARTICLE IV - PART E:

Section 3. Meetings, Reports and Recommendations:

- (a) The Pharmacy and Therapeutics Committee shall meet as often as necessary to transact its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee, Risk Management Committee, and the Chief Executive Officer.
- (b) The Pharmacy and Therapeutics Committee shall also report (with or without recommendation) to the Credentials Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE IV - PART F: INFECTION PREVENTION COMMITTEE

Section 1. Composition:

The Infection Prevention Committee shall consist of the Infection Prevention Officer, representatives from nursing service and hospital management appointed by the Chief Executive Officer to serve with vote. Any non-employed groups serving on the committee shall serve, ex officio, without vote.

ARTICLE IV - PART F:

Section 2. Duties:

The Infection Prevention Committee shall:

- (a) be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection Prevention in all phases of the hospital's activities;
- (b) establish a system for documenting all hospital infections, including infections among patients and hospital personnel, to provide a basis for studying infection sources;
- (c) monitor the standards and the bacteriological services available to the hospital;
- (d) recommend specific immunization programs;
- (e) review and recommend proper isolation techniques; and
- (f) recommend an infection prevention program and a continuing education program for Medical Staff appointees and hospital personnel on infectious disease control.

ARTICLE IV - PART F:

Section 3. Meetings, Reports and Recommendations:

The Infection Prevention Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee, the Risk Management Committee, the Chief Executive Officer, and the Director of Nursing Services.

ARTICLE IV - PART H: BYLAWS COMMITTEE

Section 1. Composition:

The Bylaws Committee shall consist of five (5) persons appointed from the Active Staff. The chairperson of the committee shall serve as parliamentarian of the Medical Staff. A representative from hospital management shall serve on the committee, ex officio, without vote.

ARTICLE IV - PART H:

Section 2. Duties:

The Bylaws Committee shall:

- (a) review the bylaws of the Medical Staff, the Document on Appointment, Reappointment and Clinical Privileges, and other associated documents at least annually and recommend amendments as appropriate to the Executive Committee. This review shall include, but not be limited to, the Medical Staff Rules and Regulations, and appointment and reappointment application forms; and
- (b) receive and consider all recommendations for changes in these documents made by the Board, any committee or clinical department of the Medical Staff, any individual appointed to the Medical Staff, and the Chief Executive Officer.

ARTICLE IV - PART H:

Section 3. Meetings, Reports and Recommendations:

The Bylaws Committee shall meet as often as necessary to fulfill its duties, but at least annually, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report of its recommendations after each meeting to the Executive Committee and the Chief Executive Officer.

ARTICLE IV - PART I: ONCOLOGY COMMITTEE

Section 1. Composition:

The Oncology Committee shall consist of Medical Staff appointees who are actively interested in the diagnosis and treatment of cancer. The committee shall include at least one (1) physician representative from general surgery, urology, pathology, radiology; all medical oncologists, and a radiation oncologist shall be assigned to the committee. The cancer committee chair is a physician who may also fulfill the role of one of the required physician specialties. Additional non-physician members to be appointed by the Chief Executive Officer to serve, *ex officio*, without vote shall include the cancer program administrator, who is responsible for the administrative oversight or who has budget authority for the cancer program; oncology nursing (both inpatient unit and outpatient clinic); social worker or case manager (can be administrator in charge of these services); certified cancer registrar; performance improvement /quality

management; community outreach, the quality control of registry data professional, cancer meeting coordinator, administration, and one Advanced Practice Provider (PA or APRN-C) from the outpatient oncology clinic and one Advanced Practice Provider (PA or APRN-C) from the Breast Care Clinic. The cancer registrar shall serve as secretary of the Oncology Committee.

ARTICLE IV - PART I:

Section 2. Duties:

The Oncology Committee shall:

- (a) be responsible for goal setting for, as well as planning, initiating, implementing, evaluating and improving all clinical, educational, community outreach, quality improvement and programmatic cancer-related activities in the facility;
- (b) promote a coordinated, multidisciplinary approach to patient management;
- (c) ensure that educational and consultative cancer conferences cover all major sites and related issues;
- (d) ensure that an active supportive care system is in place for patients, families and staff;
- (e) monitor quality management and performance improvement through completion of quality management studies that focus on quality, access to care, and outcomes;
- (f) promote clinical research;
- (g) supervise the cancer registry and ensure accurate and timely abstracting, staging and follow-up reporting;
- (h) perform quality control of registry data;
- (i) encourage data usage and regular reporting;
- (j) ensure that the content of the annual report meets requirements;
- (k) publish the annual report by November 1 of the following year; and
- (l) uphold medical ethical standards.

ARTICLE IV - PART I:

Section 3. Meetings, Reports and Recommendations:

The Oncology Committee shall meet as often as necessary to transact its business, but at least semi-annually, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee, the Risk Management Committee and the Chief Executive Officer.

ARTICLE IV - PART J: RADIATION SAFETY COMMITTEE

For purposes of this Article, the term "radiation" applies specifically to ionizing radiation.

Section 1. Composition:

The Radiation Safety Committee shall consist of at least one (1) authorized physician user of each type of use permitted by the license, and the Radiation Safety Officer. One (1) representative each from nursing service and hospital management who is neither an authorized user nor a radiation safety officer, shall be appointed by the Chief Executive officer to serve, *ex officio*, without vote. The chairperson of the committee shall be an individual listed as an authorized user on the Kansas Radioactive Materials License.

ARTICLE IV - PART J:

Section 2. Duties:

The Radiation Safety Committee shall:

- (a) monitor and make recommendations concerning the safe handling of radioactive isotopes utilized within the hospital pursuant to the standards set forth in the applicable policy and regulatory manual;
- (b) maintain a policy manual in keeping with guidelines and recommendations of appropriate state and federal governmental agencies and NIAHO Accreditation;
- (c) review all proposals for research, diagnostic, and therapeutic uses of radioisotopes and unsealed radionuclides;
- (d) develop a policy and procedures for the use, transport, storage and disposal of radioactive materials;

- (e) develop quality control procedures to guide personnel in the standardized performance of diagnostic studies and therapeutic processes in order to maintain the identity, strength and integrity of radiopharmaceutical agents;
- (f) establish policies to guide nursing and other health care practitioners who are in contact with patients receiving therapeutic amounts of unsealed radionuclides;
- (g) maintain a file of special rules and regulations wherever radioactive materials are used or dispensed;
- (h) review the training and experience of proposed authorized users, the Radiation Safety Officer, and teletherapy physicists to determine that their qualifications are sufficient to enable the individuals to perform their duties safely;
- (i) prescribe special conditions that will be required during the use of radioactive materials and radiation producing devices, such as requirements for bioassays, physical examinations of users, and special monitoring procedures;
- (j) establish an ongoing educational and safety program for all persons whose duties may require them to work in or to frequent areas where radioactive materials or radiation producing equipment are used;
- (k) review summary reports prepared by the Radiation Safety Officer concerning the occupational radiation exposure records of all personnel, with particular attention to those individuals or groups whose occupational exposure appears excessive;
- (l) review, at least annually, summary reports of the entire Radiation Safety Program to determine that all activities are being conducted safely, in accordance with state regulations, and the conditions of license;
- (m) recommend remedial action to correct any deficiencies identified in the Radiation Safety Program;
- (n) establish a table of investigational levels for individual occupational radiation exposures based upon state regulations;
- (o) provide technical advice to the Radiation Safety Officer on matters pertaining to radiation safety; and

- (p) make recommendations concerning safe use of non-ionizing radiation.

ARTICLE IV - PART J:

Section 3. Meetings, Reports and Recommendations:

- (a) The Radiation Safety Committee shall meet as often as necessary to conduct its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee, the Risk Management Committee and the Chief Executive Officer.
- (b) At least one-half of the committee's membership, including the Radiation Safety Officer and the representative from hospital management, must be present at any meeting of the Radiation Safety Committee to establish a quorum and to conduct business.
- (c) The Radiation Safety Committee shall also report (with or without recommendation) to the Credentials Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies, rules or regulations, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE IV - PART K: CREATION OF STANDING COMMITTEES

The Executive Committee of the Medical Staff may, by resolution and upon approval of the Board, without amendment of the bylaws, establish additional committees to perform one or more staff functions. In the same manner, the Executive Committee may, by resolution and upon approval of the Board, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by the bylaws, which is not assigned to a standing or special committee shall be performed by the Executive Committee.

ARTICLE IV - PART L: SPECIAL COMMITTEES

Special committees shall be created, and their members and chairpersons shall be appointed, by the Chief of Staff with the approval of the Board as required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee.

ARTICLE V

BOARD APPROVAL AND INDEMNIFICATION

Any Medical Staff officer, department chairperson, committee chairperson, committee member, and individual staff appointee who acts for and on behalf of the hospital in discharging duties, functions or responsibilities stated in this manual, the Medical Staff Bylaws and/or the Document on Medical Staff Appointment, Reappointment and Clinical Privileges and/or the Policy on Allied Health Professionals, shall be indemnified, to the fullest extent permitted by law, when the appointment and/or election of the individual has been approved by the Board.

ARTICLE VI

AMENDMENTS

This Medical Staff Organizational Manual may be amended or repealed by vote of the Executive Committee at any regular or special meeting, provided that copies of the proposed amendments, additions or repeals are posted on the Medical Staff bulletin board and/or electronic information system, and/or delivered, either in person or by mail, to each Medical Staff appointee and made available to all members of the Executive Committee at least fourteen (14) days before being voted upon, and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff are brought to the attention of the Executive Committee before the change is voted upon. When notice of proposed amendments, additions or repeals are mailed, they shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to committee members at their addresses as they appear on the records of the hospital. Such posting and mailing shall be deemed to constitute actual notice to the persons concerned. Adoption of and changes to this Medical Staff Organizational Manual shall become effective when approved by the Board.

Revisions approved by Board: 2/25/08; 10/26/09; 5/24/10; 10/25/10; 11/22/10; 1/31/11; 5/23/11; 11/21/11; 1/30/12; 7/30/12; 1/28/13; 7/28/14; 7/27/2020; 1/31/2022

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