APPENDIX E TO BYLAWS
OF
McLAREN GREATER LANSING
PROFESSIONAL STAFF

COMMITTEE POLICIES

McLAREN GREATER LANSING
PROFESSIONAL STAFF

COMMITTEE POLICIES

1. COMMITTEES OF THE PROFESSIONAL STAFF

1.1 General Purposes of Clinical and Professional Review Committees

An essential purpose of the PSEC and all other created committees which have clinical or professional review functions, is to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency available by the state of the healing arts and the resources locally available. In an effort to achieve this purpose, Professional Staff committees review the professional practices of the Hospital for the purposes of reducing morbidity and mortality and to improve the care of patients provided in the Hospital.

All data and knowledge of these committees shall and must be kept in a confidential manner and shall, pursuant to MCL 333.20175, MCL 333.21513, MCL 333.21515, MCL 331.531, MCL 331.532, MCL 331.533 and other State and Federal statutes, not be subject to disclosure or to being subpoenaed.

1.2 Record Maintenance and Accessibility

All Professional Staff committees shall record complete minutes of their meetings and, except for the PSEC and Joint Conference Committee, make reports and recommendations to the PSEC. Minutes shall be kept in the custody of the CEO. Committee Members shall have access to minutes for review of the committees of which they are a Member. All Members in an Active category shall have access to all minutes that do not involve confidential information. The CEO and Co-Chiefs after mutual consultation, shall determine what constitutes confidential information subject only to contrary action of the Board.

1.3 General Purposes of Standing Committees

Standing committees of the Professional Staff are established as a formal mechanism to assure performance of ongoing professional review functions as identified in Section 12.7 of the Bylaws of the Professional Staff as well as other responsibilities of the Professional Staff, including medical education and continuing medical education. Standing committees shall include: Cancer, Continuing Medical Education, Credentials, Critical Care, Infection Control, Institutional Review, Medical Education, Pharmacy and Therapeutics, Professional Staff Executive, Radiation Safety, Utilization of Osteopathic Methods and Concepts, and Utilization Review.

Composition, duties, and reporting mechanisms for Credentials, Bylaws and Professional Staff Executive Committees are addressed in the Bylaws of the Professional Staff, Article XII.

2. STANDING COMMITTEES

2.1 Cancer Committee

2.1-1 *Composition*

The Cancer Committee shall be a standing committee of the Professional Staff and shall be composed of multi-disciplinary Physician Members from the diagnostic and therapeutic specialties as well as Allied Health Professionals involved in the care of cancer patients. The committee will include at least one physician representation from Surgery, Medical Oncology, Radiation Oncology, Pathology, Diagnostic Radiology, Urology, liaison physician and additional Medical Staff representatives of the top five (5) major sites seen at McLaren Greater Lansing and/or additional clinical areas as appointed by the CoChiefs of the Professional Staff. The Committee will include an Oncology Fellow if available. The Committee will also include non physician membership and must include Administration, Nursing, Social Services, Cancer Registry, Quality Assurance, Pharmacy, Rehabilitation, Clinical Educator, Home Care-Hospice, Performance Improvement and other hospital and community representatives related to the top five major sites seen at McLaren Greater Lansing. The Co-Presidents of the Professional Staff will make appointments from Professional Staff Departments.

2.1-2 *Duties*

The Cancer Committee's duties include:

a. Develop and evaluate the annual goals and objectives for the clinical educational and programmatic activities related to cancer;

b. Promote and coordinate multi-disciplinary approach to patient management;

c. Ensure that educational and consultative cancer conferences cover 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 improvement through completion of quality management studies that focus on quality, access to care and outcomes;

f. Promote clinical research under of the auspices of the Institutional Review Committee;

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 content of the annual report meets accreditation requirements;

k. Publish the annual report by November 1 of the following year; and

l. Uphold medical ethical standards.

2.1-3 *Meetings*

The Cancer Committee shall meet as necessary to accomplish its responsibilities.

2.2 Continuing Medical Education Committee

2.2-1 *Composition*

The committee shall consist of at least one (1) representative from each Professional Staff department, the Vice President of Medical Affairs or his designee and other hospital representatives as determined by the CEO.

2.2-2 *Duties*

The committee, in cooperation with the Vice President of Medical Affairs or his designee, is responsible for developing and evaluating programs for the education of the Professional Staff based on its identified education needs. Such programs shall be in compliance with accrediting and medical practice licensing standards and shall report as is required to such bodies.

2.2-3 Meetings

The Continuing Medical Education Committee shall meet as necessary to perform its duties..

2.3 Critical Care Committee

2.3-1 *Composition*

The Critical Care Committee shall consist of institution-designated medical directors of critical care units, at least eight (8) Professional Staff Members, including one Member each from the Departments of Anesthesiology, Cardiology, Emergency Medicine, Family Practice, Internal Medicine, and Surgery, as well as the Patient Care Managers of each critical care unit, a Critical Care Clinical Nurse Specialist, the Chief Nursing Officer, and a respiratory therapist. The Chair, appointed by the Co-Chiefs, shall select a Vice-Chairman from among its physician Members.

2.3-2 *Duties*

The duties of the committee include:

(a) Review of the appropriateness of care provided in critical care units;

(b) Evaluate performance of multi-disciplinary quality assessment/improvement activities specifically focused on the provision of care to critically ill patients, and addressing clinical as well as non-clinical factors that impact the care provided; and

(c) Development and recommendation of policies, rules, and procedures for the effective operation of the units and provision of patient care, including admission

and discharge criteria.

2.3-3 *Meetings*

The Critical Care Committee shall meet as necessary to perform its duties

2.4 Infection Control Committee

2.4-1 *Composition*

The Infection Control Committee shall be a multi-disciplinary committee. Minimum membership shall include the MD/DO program coordinator, the Infection Control Officer, the Chief Nursing Officer, an operating room nurse, an ICU nurse, a pharmacist, a laboratory/microbiology staff representative, an environmental services representative, a sterile processing department representative, and three to five medical staff representatives (i.e., Surgery, Orthopedics, Obstetrics, Internal Medicine, Cardiology/Cardiovascular Surgery). Additional representation may be added at the discretion of the chair on an as-needed basis for a specific project or on a continuous basis in consultation with the Co-Chiefs.

2.4-2 *Duties*

The Infection Control Committee shall be responsible for the ongoing surveillance of inadvertent institution infection potentials, the review and analysis of actual infections, the promotion of preventive and corrective programs designed to minimize infection hazards, and the supervision of infection control measures for activities including, but not limited to:

(a) Surgical/invasive procedures and intensive care;

(b) Equipment sterilization by heat, chemicals, or otherwise;

(c) Isolation;

(d) Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;

(e) Testing of personnel for carrier status of contagious disease within applicable law or regulation;

(f) Disposal of infectious material; and

(g) Specific activities as may be identified through quality assessment/improvement activities and as otherwise requested by the PSEC.

(h) Specific activities as required by regulatory agencies.

The committee is responsible for written policies and procedures that describe the types of surveillance carried out to monitor nosocomial infections and the systems used to collect and analyze data and for assessing the effectiveness of surveillance, prevention, and control. Written policies and procedures shall be reviewed at least three (3) years.

2.4-3 *Meetings*

The Infection Control Committee shall meet as necessary to perform its duties; at a minimum, the committee will meet quarterly.

2.4-4 *Reports*

Statistics of hospital-acquired infections shall be reported to the Infection Control Committee as available, but no less than quarterly. Reports will be provided to the professional medical staff at least quarterly.

2.5 Institutional Review Board

2.5-1 *Composition*

The Institutional Review Board shall be composed of at least five (5) Members, three (3) Members of the Active Professional Staff one of which will be the Vice President of Medical Affairs who may serve as the Chairman, a consumer and a representative of Pharmacy, Nursing and Administration. A Member may satisfy more than one membership category. Other ancillary personnel may be invited to attend specific meetings as appropriate.

2.5-2 *Duties*

The duties of the Institutional Review Board shall be to:

(a) Review, as considered necessary to the committee, all proposed and ongoing research activities related to the organization in accordance with, but not limited to, the following criteria:

(1) Safety of human subjects;

(2) Informed consent of participating subjects;

(3) Scientific merit;

(4) Experimental design;

(5) Capability of investigator(s) to conduct the research; and

(6) Such other criteria as may be deemed appropriate by the committee and/or required by the Department of Health and Human Services (DHHS) and Food and Drug Administration (FDA) when applicable.

(b) Recommend action to the PSEC regarding the implementation and approval of proposed research.

2.5-3 *Meetings*

The Institutional Review Board shall meet as necessary to perform its duties.

2.6 Medical Education Committee

2.6-1 *Composition*

The Medical Education Committee shall be composed of at least four (4) Members of the Professional Staff and shall include the program directors for all established formal post-graduate medical programs as well the Director for Medical Education. Additionally, three house officers, one of whom will be a member of the internship class, shall serve as members of the committee.

2.6-2 *Duties*

The Medical Education Committee shall be responsible for developing standards and evaluating programs of education for House Staff and medical students in cooperation with the Vice President of Medical Affairs.

2.6-3 *Meetings*

The Medical Education Committee shall meet as necessary to fulfill its duties.

2.7 Pharmacy and Therapeutics Committee

2.7-1 *Composition*

Membership shall consist of at least four (4) representatives of the Professional Staff and one (1) each from Pharmacy, Nursing, and Administration. The pharmacist directing the institutions pharmaceutical services shall be a Member and act as Secretary.

2.7.2 *Duties*

The Pharmacy and Therapeutics Committee is responsible for development of drug utilization policies and practices within the institution to assure optimum clinical results and minimum hazard potential; evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs. It shall also perform these specific functions:

(a) Serve as an advisory group to the Professional Staff and the pharmacy on matters pertaining to the choice of available drugs;

(b) Make recommendations concerning drugs to be stocked on the nursing floors and other service areas;

(c) Develop and periodically review the formulary, detailing drugs for use in the institution;

(d) Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

(e) Evaluate clinical data concerning new drugs or preparations requested; and

(f) Monitor adverse drug reactions and perform drug utilization evaluation.

2.7-3 *Meetings*

The Pharmacy and Therapeutics Committee shall meet as necessary to perform its duties.

2.8 Radiation Safety Committee

2.8-1 *Composition*

The Radiation Safety Committee shall consist of at least three (3) Members of the Professional Staff, including a radiologist, the radiation safety officer, the individual responsible for management of radiology services, and Administration.

2.8-2 *Duties*

The duties of the Radiation Safety Committee include:

(a) Maintenance of appropriate records of receipts, transfers, and disposal of radionuclides in the institution;

(b) Evaluation of all uses of by-product material within the institution with regard to radiological health and safety of patients and occupational personnel as well as other factors as determined appropriate;

(c) Recommend policies, rules, and procedures and/or modifications to conform with all State and Federal regulations; and

(d) Evaluate the use of new radiopharmaceuticals for routine use and/or the use of radiopharmaceuticals for new procedures/application.

2.8-3 *Meetings*

The Radiation Safety Committee shall meet as necessary to perform its duties.

2.9 Stroke Committee

2. 9-1 Composition

The composition of the Stroke Committee shall consist of at least (1) representative from the Department of Emergency Medicine, Department of Internal Medicine – Neurology, Department of Internal Medicine – Physical Medicine & Rehabilitation, Department of Radiology and other hospital representatives as determined by the CEO.

2. 9-2 Duties

The Stroke Committee's duties include:

(a) Provide state of the art primary stroke care within the capabilities of the institution from acute stroke care to inpatient rehabilitation.

(b) Operate Primary Stroke Center that enhances stroke and neurological services through the implementation of standardized stroke care with dedicated nursing and ancillary staff, and strict adherence to written protocols.

(c) Develop and evaluate annual goals and objectives for the clinical education and programmatic activities related to stroke care for the Professional Staff and nursing.

(d) Develop and evaluate annual goals and objectives for community education related to stroke care.

2. 9-3 Meetings

The Stroke Committee shall meet as necessary to perform its duties.

2.10 Surgical Executive Committee

2. 10-1 *Composition*

The composition of the Surgical Executive Committee shall include the Chairmen of the Departments of Anesthesia, Obstetrics and Gynecology, Orthopedics and Surgery, Section Chairs or discipline representatives of the Department of Surgery, the Director of Operating Room Services and a representative of Senior Administration. The Chairman shall be selected by the Committee and shall be a Chairman of one of the Departments represented on the Committee.

2. 10-2 *Duties*

The duties of the Surgical Executive Committee shall be to consider and make recommendations on issues of an interdepartmental nature specific to surgical practice at the Hospital to include operational policies and protocols, equipment and facility needs assessment and clinical standards. The Surgical Executive Committee shall report directly to the Professional Staff Executive Committee.

2. 10-3 *Meetings*

The Surgical Executive Committee shall meet as needed to fulfill its duties.

2.11 Utilization of Osteopathic Methods and Concepts Committee

2.11-1 *Composition*

The committee shall consist of at least five (5) Osteopathic Professional Staff Members.

2.11.2 *Duties*

The duties of the committee are to:

(a) Evaluate the utilization of distinctive osteopathic methods and practice in the institution and recommend means of improved or extended application;

(b) Improve the recording of distinctive osteopathic findings, diagnoses, and therapy;
(c) Provide for continuing education in the use of osteopathic principles and practice.

(d) Establish and maintenance of retrospective and current audits of patient charts relating to the application of osteopathic principles and practice to patient diagnosis and treatment; and

(e) Inform osteopathic physicians of the evaluations of patient charts done by the committee to improve utilization of osteopathic principles and practices.

2.11.3 *Meetings*

The Utilization of Osteopathic Methods and Concepts Committee shall meet as necessary to fulfill its duties.

2.12 Utilization Review Committee

2.12-1 *Composition*

The Utilization Review Committee shall consist of at least six (6) Professional Staff Members representative of a cross-section of the Professional Staff, the Utilization Review Coordinator, the Discharge Coordinator, a representative of Social Work, Nursing Services, and Administration. Six (6) additional Professional Staff Members will be appointed as consultative Members to assist in concurrent case review.

2.12-2 *Duties*

Duties of the Utilization Review Committee shall include:

(a) Evaluation of the use of institutional resources. The committee shall evaluate the medical necessity for use of institutional resources for particular patients when appropriate. Such evaluations will be guided by the Utilization Review Plan.

(b) Facilitate the written Utilization Review Plan for the institution. Such Plan, as approved by the PSEC and the Board, must be in effect at all times. The Plan must include:

(1) The organization and composition of committee(s) that will be responsible for the utilization review function, as consistent with these Rules;

(2) Frequency of meetings;

(3) The 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;

(6) The relationship of the Utilization Review Plan to claims administration by third party payors;

(7) Arrangement for committee reports and their dissemination;

(8) Responsibilities of the organization's administrative staff in support of utilization review;

(9) Conflict of interest policy;

(10) Confidential nature of activities, findings, and recommendations to include:

- Admissions to the institutions;
- Duration of Stays;
- Professional Services furnished including drugs and biologicals;
- Review of "outlier" cases; denials;
- Utilization Review activities which are kept as peer review

(11) A mechanism for the provision of discharge planning; and

(12) Annual review of the Utilization Review Plan with recommendations for revision as appropriate to reflect findings of its activities.

2.12-3 *Meetings*

The Utilization Review Committee shall meet as necessary to perform its duties.

3. STANDING SPECIAL JOINT COMMITTEES

3.1 General Purposes of Standing Special Joint Committees

The Professional Staff shall participate as vital and integral Members of combined membership committees not solely under the auspices of the Professional Staff. These committees shall be considered on an equivalent basis with standing Professional Staff committees for purposes of the Bylaws and Rules. Such combined committees include, but are not limited to, the Joint Conference Committee, Ethics Committee and the Performance Improvement Steering Committee.

3.2 Ethics Committee

3.2-1 *Composition*

The committee shall be composed of a minimum of four (4) physicians, an equal number of nurses, an ethicist, a clergyman, a social worker, a representative of Administration, a representative of Risk Management, and a lay person(s) representing the community. The total complement shall be not be less than twelve (12) Members or greater than eighteen (18);

however, other individuals may be invited on an ad hoc basis as deemed appropriate by the Chairman.

Qualification for membership on the committee includes a degree of interest in the broad ethical implications in the delivery of health care that supports a commitment to serve on the committee. Non-Professional Staff Members shall be appointed by the CEO.

The Co-Chiefs shall appoint one of the physicians Members as Chairman, who, in turn, shall appoint the remaining physician Members.

3.2-2 *Duties*

The purpose of the Ethics Committee is to:

(a) Enhance communication and provide educational leadership among interested parties regarding treatment decisions;

(b) Assist, when requested, in the resolution of ethical conflicts;

(c) Retrospectively review the ethical implications of treatment decisions for educational purposes; and

(d) When appropriate, recommend bio-ethical policies and guidelines.

(e) Provide consultation on bio-ethical patient treatment issues consistent with the Professional Staff Bylaws.

The Ethics Committee is an advisory body focusing on ethical issues only. It shall not make final decisions as to medical treatment; such decision(s) are to be made by the patient, if competent, or if not, by the attending physician in close consultation with the family or legal representative when at all possible.

3.2-3 *Meetings*

The Ethics Committee shall meet as necessary to perform its duties.

3.3 Joint Conference Committee

3.3-1 Composition

The Joint Conference Committee shall be composed of a minimum of two (2) Trustee Members; one of who is to be designated Chairman by the Chairperson of the Board, the Co-Chiefs and Co-Chiefs-Elect of the Professional Staff and the CEO and/or his designee(s). The Committee shall elect its own Vice- Chairman. Appointments shall be every two years by the Chairperson of the Board.

3.3-2 *Duties*

The Joint Conference Committee shall be a forum for the discussion of matters of Hospital policy and practice, especially those pertaining to patient care, and shall provide medico-administrative liaison with the Board and the CEO. All policy recommendations of the PSEC to the Board shall first be sent to the Joint Conference Committee for its consideration

and recommendation. The Committee shall perform such other duties as shall be given it by the Board and shall also have the following specific duties:

(a) Provide and make available adequate intercommunications among the Board, Professional Staff and Administration. Discuss significant issues affecting the discharge of Professional Staff responsibilities.

(b) Make recommendations to the Board regarding any communication, request, or recommendation presented by the Professional Staff, which has been received directly from the Professional Staff or referred to the Committee by the Board.

(c) Serve as a reference committee for any problem confronting the institution that would require input of Board, Professional Staff and Administration prior to final resolution by the Board.

(d) Review and make recommendations on all Professional Staff Bylaws changes, amendments, and revisions prior to submission to the Board.

3.2-3 *Meetings*

The Joint Conference Committee shall meet when requested by the CEO, or his designee or by a Co-Chief.

3.2-4 *Reports*

A written record (minutes) of the Joint Conference Committee meetings shall be transmitted to the Board.

4. SPECIAL STANDING COMMITTEES

4.1 Endoscopy Committee

4.1-1 *Composition*

The Endoscopy Committee shall be composed of Members appropriately credentialed to perform gastrointestinal endoscopy. As an interdepartmental committee representing respective disciplines, the composition of the committee shall at a minimum consist of five (5) Members from the Department of Internal Medicine, including three (3) gastroenterologists, one (1) Member from the Department of Surgery and one (1) Member from the Department of Family Practice.

4.1-2 *Duties*

The Endoscopy Committee shall function in an advisory capacity to address operational issues and to serve as an interdepartmental forum to consider quality/performance improvement activities specific to gastrointestinal endoscopy. The Scope of the Committee's activities does not include (1) credentialing individual practitioners or (2) specific peer review action except as stated herein. Activities shall include:

(a) Equipment and facilities needs assessment and planning;

(b) Development of operational policies and procedures specific to the performance of gastrointestinal endoscopy;

(c) Assignment of observers from among Committee Members for provisionally privileged practitioners when requested by a Department Chairman; and

(d) Establishment of quality/performance improvement projects to include invasive procedure/surgical case review, and assessment and recommendations for improvement.

4.1-3 *Meetings*

The Endoscopy Committee shall meet as frequently as necessary to accomplish its functions.

4.2 Physician Information Technology Advisory Committee

4.2-1 *Composition*

Membership shall consist of at least four (4) Members of the Active Professional Staff. In addition, there shall be representation from the Information Services Department and other representation at the discretion of the Chairman.

4.2-2 *Duties*

The Physician Information Technology Advisory Committee shall be responsible for consultation to the information Services Department regarding acquisition of new information technologies.

4.2-3 *Meetings*

The Physician Information Technology Advisory Committee shall meet as needed to fulfill its duties.

5. AD HOC COMMITTEES

5.1 General Purposes of Ad Hoc Committees

Ad Hoc committees may be established by the Co-Chiefs, in consultation with the PSEC, or by the PSEC to address special needs. Such committees shall be established in compliance with the Bylaws, requiring a written charge of their authority and responsibility, and shall be dissolved when their purpose has been fulfilled.

6. ADOPTION

6.1 Professional Staff

The foregoing policy was adopted and recommended to the Board by the PSEC in accordance with and subject to the Bylaws of the Professional Staff.

ADOPTED AND APPROVED ON**:** January 27, 2014

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CO-CHIEF OF THE PROFESSIONAL STAFF

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CO-CHIEF OF THE PROFESSIONAL STAFF

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SECRETARY OF THE PROFESSIONAL STAFF

6.2 Board of Trustees

The foregoing Policy was adopted and approved by resolution of the Board of Trustees after considering the PSEC's recommendation and in accordance with and subject to the McLaren Greater Lansing's Corporate Bylaws.

ADOPTED AND APPROVED ON: March 17, 2014

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CHAIRMAN OF THE BOARD

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SECRETARY OF THE BOARD