

MEDICAL STAFF

RULES AND REGULATIONS

REVISED 2011

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PART ONE: MEDICAL STAFF FAIR HEARING PLAN

This Part One may be referred to as the “Fair Hearing Plan” or “Plan”

1.0 FAIR HEARING AND APPELLATE REVIEW

1.1. EXCLUSIVE REMEDY

If an adverse ruling is made with respect to a Medical Staff Membership, Staff status or clinical privileges at any time, regardless of whether the individual is an Applicant or a Member, the individual shall follow and abide by the remedies afforded by the Bylaws and this Fair Hearing Plan before resorting to a formal legal action.

1.2. RIGHT TO REQUEST HEARING

1.2-1 Right to Request Hearing

A Member or Applicant may request a hearing upon one or more of the following actions or recommended actions relating to professional competence or professional conduct in the care of patients:

- (a) Denial of initial appointment or reappointment, termination or revocation of any appointment.
- (b) Denial of requested clinical privileges, suspension of clinical privileges for more than fifteen (15) days (other than precautionary suspension) or revocation of privileges.
- (c) Denial of reinstatement from a leave of absence if the reason is related to professional competence or conduct.
- (d) Any other professional review action that must be reported to the Michigan Department of Community Health under MCLA § 333.20175(5) and/or to the Data Bank under the federal Health Care Quality Improvement Act, 42 USC § 11101 *et seq.* and implementing regulations.

1.2-2 A Member or Applicant who is not entitled to a hearing or appeal may dispute an ECCA finding or determination by requesting that a written rebuttal be attached to his or her file and by submitting the rebuttal within thirty (30) days of ECCA’s action.

1.3. REQUIRED NOTICE OF RECOMMENDATION TRIGGERING HEARING RIGHT AND REQUEST FOR HEARING

1.3-1 The COS must promptly give Special Notice of a recommendation or action that entitles a Member or Applicant to request a hearing. This

notice must include at least: (i) a statement of the recommendation or action and general reasons for it; (ii) a statement that the Member or Applicant has a right to request a hearing on the recommendation or action within thirty (30) days of receipt of the notice; and (iii) a copy of or internet link to the Medical Staff Bylaws. Copies of this notice will be distributed to the CEO and the Member's Department Chair and Service Chief.

- 1.3-2 A request for a hearing must be made in writing and delivered to the COS within thirty (30) days after the Member or Applicant receives the Special Notice described above.

1.4. HEARING NOTICES

- 1.4-1 Notice of Hearing. The CEO is responsible for scheduling the hearing and providing by Special Notice, the following information to the Member or Applicant at least thirty (30) calendar days prior to the date scheduled for the hearing:

- (a) The time, place and date of the hearing.
- (b) A copy of this Fair Hearing Plan.

- 1.4-2 Second Notice. The CEO is responsible for providing the Member or Applicant by Special Notice, at least fifteen (15) calendar days prior to the hearing, the following:

- (a) A proposed list of witnesses who will give testimony.
- (b) The names of the Hearing Panel members and Presiding Officer (or Hearing Officer).
- (c) A statement of the specific reasons for the recommendation, including a list of patients whose records support the recommendation (if applicable) and a list of other supporting documents. The statement may be revised or amended at any time, even during the hearing, as long as the additional information is relevant to the recommendation or otherwise to the Member's or Applicant's professional competence or conduct, or his or her qualifications for Membership or clinical privileges.

- 1.4-3 Member's or Applicant's Witness List

At least fifteen (15) days before the hearing date the Member or Applicant must send via certified mail to the CEO, a written list of the names of witnesses expected to offer testimony on his or her behalf, together with a brief summary of the anticipated testimony of each.

1.5. HEARING PANEL AND OFFICERS

1.5-1 The CEO, after consulting with the COS, will appoint a Hearing Panel consistent with the following guidelines:

- (a) The Hearing Panel will consist of at least three (3) Active Members, one of whom shall be designated as the chair.
- (b) The Hearing Panel may include any combination of one or more Member(s) and/or physicians or laypersons unaffiliated with the UMHC. Knowledge of the underlying professional review matter, in and of itself, does not preclude an individual from serving on the Hearing Panel; nor does employment by, or other contractual arrangement with, UMHS or any of its affiliates.
- (c) As determined by the CEO, the Hearing Panel may not include any individual who:
 - (i) Is in direct economic competition with the Member or Applicant.
 - (ii) Is demonstrated to have an actual bias, prejudice or conflict of interest that would prevent him or her from fairly and impartially considering the matter.

1.5-2 Presiding Officer

The chair of the Hearing Panel shall serve as the Presiding Officer, unless the CEO appoints a Hearing Officer. The Hearing or Presiding Officer shall:

- (a) Provide the Member or Applicant with a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination.
- (b) Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive, or that causes undue delay.
- (c) Maintain decorum throughout the hearing.
- (d) Determine the order of the proceeding.
- (e) Rule on all matters of procedure and the admissibility of evidence.

- (f) Conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Hearing Panel by a majority vote requests to be present.

The Presiding Officer and the Hearing Panel may be advised by internal or external UMHS legal counsel with regard to the hearing procedure. He or she may participate in the private deliberations of the Hearing Panel and serve as a legal advisor to the Hearing Panels.

1.5-3 Hearing Officer

The CEO, after consulting with the COS, may appoint a Hearing Officer. Where a Hearing Officer is used in conjunction with a Hearing Panel, the Hearing Officer shall not act as an advocate for either side at the hearing, and will conduct the hearing, maintain decorum and rule on all evidentiary and witness matters. A Hearing Officer will be an attorney at law experienced in conducting such hearings. The Hearing Officer may not be, or represent clients, in direct economic competition with the Member or Applicant.

1.6. OBJECTIONS TO HEARING PANEL AND OFFICERS

Any objections to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing, within ten (10) days of receipt of notice, to the CEO. A copy of such written objections must be provided to the COS and must include the basis for the objections. The COS shall be given a reasonable opportunity to comment. The CEO shall rule on the objections and give notice to the parties. The CEO may request that the Hearing Officer make a recommendation as to the validity of the objections.

1.7. HEARING RIGHTS

1.7-1 In the hearing the Member or Applicant has the following rights:

- (a) To representation by an attorney or other person of the requestor's choice.
- (b) To have a record made of the proceedings. The Hearing Officer or Presiding Officer shall determine the nature of the record including whether the hearing will be transcribed. Copies of the record may be obtained by the Member or Applicant upon payment of any reasonable charges associated with the preparation thereof.
- (c) To call and question witnesses.
- (d) To present evidence determined to be relevant by the Hearing Officer regardless of its admissibility in a court of law.

- (e) To submit a written statement at the close of the hearing.

The Member or Applicant has no right to request or receive, during or in connection with a hearing, appeal or any subsequent proceeding, information or data concerning other Medical Staff Members or individuals with clinical privileges in connection with the requestor's dispute or in any subsequent litigation.

- 1.7-2 The Hearing Panel at its own initiative, may question witnesses, request the presence of additional witnesses and/or request additional documentary evidence. If the Member or Applicant does not testify, he or she may be called and questioned by the Hearing Panel.

1.8. PRE-HEARING CONFERENCE

The Hearing Officer (or Presiding Officer, if there is no Hearing Officer) will require a representative (who may be counsel) for the Member or Applicant and for the Medical Staff to participate in a pre-hearing conference. The COS or designee shall be the representative of the Medical Staff. At the pre-hearing conference, the Hearing Officer will resolve all procedural questions, including any objections to exhibits or witnesses and the time to be allotted to each witness's testimony and questions.

1.9. PROVISION OF RELEVANT INFORMATION

Prior to receiving any confidential documents, the Member or Applicant shall agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The Member or Applicant must also provide a written representation that his/her representative and any expert(s) have executed business associate agreements compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996, implementing privacy and security regulations, and applicable state law in connection with any identifiable patient information contained in any documents provided.

1.10. BURDEN OF PROOF

- 1.10-1 In a hearing relating to appointment, reappointment or the granting of clinical privileges, the Member or Applicant shall have the burden of proof to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges. If the Hearing Panel finds that the Member or Applicant has proved, by clear and convincing evidence, that the Member or Applicant has met his or her burden and that the recommendation or action that prompted the hearing was arbitrary or capricious, then the Hearing Panel shall find in favor of the Member or Applicant.

1.10-2 In all other hearings, the committee or body that proposed the recommendation or action that is the subject of the hearing will have the duty to produce evidence in support of the recommendation or action, but the Member or Applicant will have the ultimate burden of proving, by clear and convincing evidence, that the recommendation or action is arbitrary, unreasonable or has no basis in fact.

1.11. ADMISSIBILITY

The hearing will not be conducted according to rules of evidence. There shall be no right of discovery. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of the evidence in a court of law.

1.12. PRESENCE OF HEARING PANEL MEMBERS

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances, when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire record of the portion of the hearing from which he or she was absent.

1.13. RECOMMENDATION OF THE HEARING PANEL

1.13-1 Within twenty (20) days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing record or transcript or any post-hearing statements, whichever is later), the Hearing Panel shall render a recommendation, accompanied by a written report stating the basis for the recommendation, to the CEO and HHCEB which shall contain a concise statement of the basis for its recommendation.

1.13-2 The Member or Applicant shall be provided a copy of the Hearing Panel recommendation and report. Within fifteen (15) days after the delivery of the copy of the Hearing Panel recommendation and report to the Member or Applicant, the Member or Applicant may submit a written statement specifying the recommendations to which the Member or Applicant disagrees and the reasons for such disagreement.

1.14. DISPOSITION OF HEARING PANEL REPORT

The Hearing Panel shall deliver its report and recommendation, and a copy of the Member or Applicant's written statement, if any, to the CEO who shall forward it, along with all supporting documentation, to the ECCA and the HHCEB for further action. The COS shall send to the Member or Applicant a copy of these materials by Special Notice.

Within thirty (30) days after receipt (or finalization, if a committee of the whole was involved) of the report of the Hearing Panel, the ECCA or the HHCEB, as the

case may be, shall consider the same and affirm, modify or reverse the prior recommendation or action in the matter. It shall transmit the result, together with the hearing record, the report of the Hearing Panel and all other documentation considered, to the COS and CEO.

1.15. NOTICE AND EFFECT OF RESULT

1.15-1 Effect of Favorable Result Adopted by ECCA. If the ECCA recommendation is favorable to the Member or Applicant, the COS shall promptly forward it, together with all supporting documentation, to the HHCEB for its final action. The HHCEB shall take action thereon by adopting or rejecting the ECCA result in whole or in part, or by referring the matter back to the ECCA for further reconsideration.

1.15-2 Effect of an Adverse Result Adopted by ECCA. If the result of the ECCA determination continues to be adverse to the Member or Applicant, the COS shall send a Special Notice informing the Member or Applicant of the decision and the right to request appellate review by the HHCEB as provided below.

1.15-3 Effect of a Favorable Action by the HHCEB. Favorable action taken by the HHCEB is the final decision.

1.15-4 Effect of Adverse Result by HHCEB. If, based on a favorable recommendation by the ECCA, the HHCEB rejects the recommendation and renders a decision adverse to the Member or Applicant, the COS shall send a Special Notice informing the Member or Applicant of the decision and right to request appellate review by the HHCEB as provided below.

1.16. GROUND FOR APPEAL TO THE HHCEB

The grounds for appeal are limited to the following:

1.16-1 There was substantial failure to comply with this Fair Hearing Plan and/or the Bylaws of the Medical Staff during or prior to the hearing, so as to deny a fair hearing.

1.16-2 The recommendations of ECCA were made arbitrarily or capriciously.

1.17. TIME FOR APPEAL

Within ten (10) days after the Member's or Applicant's receipt of the Special Notice under Section 1.15 above, the Member or Applicant may request an appeal. The request shall be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further

review. If an appeal is not requested within such ten (10) day period, an appeal is deemed to be waived and the decision is final.

1.18. HHCEB APPELLATE REVIEW

Whenever an appeal is requested as set forth in the preceding Section, the chair of the HHCEB shall schedule and arrange for an appeal. The Member or Applicant shall be given Special Notice of the time, place and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

1.18-1 Nature of Appellate Review

- (a) The HHCEB may consider the appeal as a whole body, or the chairperson of the HHCEB may appoint a Review Panel composed of not less than three (3) persons, either members of the HHCEB or others, including, but not limited to, reputable persons outside the hospital, to consider the record upon which the recommendation before it was made and recommend final action to the HHCEB.
- (b) Each party may present a written statement of no more than ten (10) pages, single space typing, 12 (twelve) point or greater font, in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten (10) days to respond. In its sole discretion, the HHCEB (or Review Panel) may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes.
- (c) The HHCEB (or Review Panel) may review the entire record of the hearing and, in its discretion, accept additional written or oral evidence that it determines to be relevant.

1.18-2 HHCEB Decision

The HHCEB shall make the final decision and the COS shall send Special Notice to the Member or Applicant of the decision.

1.18-3 Right to One Hearing and One Appeal Only

Each Member or Applicant shall be entitled to one hearing and one appellate review on any matter. If the HHCEB denies initial appointment of an Applicant to the Medical Staff or denies reappointment or revokes the appointment and/or clinical privileges of a current Member of the Medical Staff, that individual may not apply for Staff appointment or for those clinical privileges for a period of five (5) years, unless the HHCEB provides otherwise.

PART TWO: MEDICAL STAFF RULES

1.0 ALLOCATION OF PATIENT CARE, LABORATORY, EDUCATION, RESEARCH AND ADMINISTRATIVE RESOURCES

Allocation and reallocation in UMHHC of physical resources in patient care, in laboratory services, in education, in research and in administration shall be made by the CEO. Requests for such allocation and reallocation may be recommended to the appropriate committee by a Service Chief or by a Member in consultation with the Department Chair.

2.0 ADMISSIONS, TRANSFER AND DISCHARGE OF PATIENTS AND MEDICAL RECORDS

2.1. PATIENT ADMISSIONS

2.1-1 Admission Priority Categories

The admission of patients to UMHHC hospital facilities through the ABCC will be on the basis of medical necessity as determined by ABCC protocol and OCA.

2.1-2 Admission Requests and Diagnosis

Patients may be admitted to UMHHC hospital only at the request of a Medical Staff Member with admitting privileges, or designee. Except in an emergency, no patient shall be admitted to UMHHC hospital facilities until after a provisional diagnosis has been provided to the ABCC. In cases of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

2.1-3 Non-Discrimination

Admission shall not be denied because of the patient's race, sex (includes gender identity and gender expression), color, religion, creed, national origin or ancestry, age, marital status, sexual orientation, disability, special disabled veteran and Vietnam-era veteran status, height or weight and source of payment or any other basis which is legally impermissible.

2.1-4 Member Responsibilities Generally

A qualified Physician Member shall be responsible for the medical care and treatment of the patient, for the prompt completeness and accuracy of the medical record, for necessary special instructions and for transmitting reports of the condition of the patient to relatives of the patient and other concerned parties who are entitled to such information.

For patients admitted to the Oral-Maxillofacial Surgery Service, an appropriately qualified Oral Surgeon may be responsible and carry out these patient care duties if granted privileges to do so.

2.1-5 Performance of Admission History and Physical Examination

A complete admission history and physical examination shall be recorded no more than thirty (30) days before or twenty-four (24) hours after admission, but prior to surgery or a procedure requiring anesthesia services, as applicable, in accordance with this Part. If the circumstances are such that a delay is necessary, a brief admission note may be reported pending completion of the history and physical examination. Either a history and physical examination or an admission note should be recorded before surgery or any other procedure requiring anesthesia services is performed or treatment is instituted, in accordance with this Part, except in cases of bona fide emergency. Such emergency shall be documented in the medical record. Minimally, the admission history and physical should include relevant medical and surgical history (co-existing disease, review of systems, current medications, and allergies/reactions) and a focused physical examination (vital signs, pulmonary/cardiovascular).

2.1-6 Admission Information

An admitting Member shall provide the following information in the patient's medical record, when such information is available to the admitting Member:

- (a) Provisional diagnosis.
- (b) A valid reason for admitting the patient, including information to support the medical necessity and the appropriateness of the admission.
- (c) Information needed to properly care for the patient being admitted.
- (d) Information needed to protect the patient from himself/herself.
- (e) Information needed to protect UMHHC personnel and others from potential problems or dangers presented by the patient.

2.1-7 Admission of Potentially Suicidal or Dangerous Patients

If an admitting Member or designee reasonably believes a patient admitted for other purposes is potentially suicidal or dangerous to himself/herself or others, the admitting Member or designee shall promptly obtain a consultation from a suitable mental health

professional. If, in the opinion of the consultant, there is a probability that the patient is suicidal or dangerous to himself/herself or others, action shall be taken in accordance with UMHHC policy.

2.1-8 On-Call and Alternate Coverage Schedule

Active and Courtesy category Medical Staff Members, whether Provisional or not, may be required by the Service to take part in a Service on-call and alternate coverage schedule. Each Service shall furnish its Service component of the master on-call and alternate coverage schedule maintained by Central Paging and the inpatient care team website, with oversight by the OCA, including an emergency call list for the Members in the Service. The Service shall give Central Paging timely notice of any changes of the assigned Member(s), any other call order preferences (e.g., CPT assignments), and any exceptions. In the event a Service does not timely comply with these requirements, the COS, in consultation with the relevant Service Chief, a senior Member in the Service or the Department Chair, may impose an on-call schedule and protocol on Service Members until the Service demonstrates it will fully comply with the requirements.

2.2. ASSIGNMENT OF ADMITTED PATIENTS

A patient when admitted will be assigned the Active Staff category Member on call. A Member of the Medical Staff shall see each patient as soon as possible after admission.

2.3. EMERGENCY SERVICE TREATMENT

A Department of Emergency Medicine Physician Member shall be responsible for attending to the medical treatment of each Emergency Service patient, until the patient is discharged or transferred from the Emergency Service. However, when a Department of Emergency Medicine Physician reasonably believes that it is necessary, (s)he shall have the authority to require that a patient be personally seen by the admitting Member or by a CPT under supervision before the patient is formally admitted or transported from the Department of Emergency Medicine area to the designated hospital unit. If the admitting Member is required to see the patient, then the Department of Emergency Medicine Physician shall be responsible for supervising any CPT who may attend the patient in the Department of Emergency Medicine before the admitting Member arrives

2.4. PATIENT TRANSFERS

Orders authorizing the transfer from one Service to another shall be signed by the Member or designee requesting the transfer and the Member or designee accepting the transfer. In the case of the transfer of a patient from one Service or program to another, or from one Member to another, a note covering the transfer of responsibilities shall be entered in the medical record.

2.5. PATIENT DISCHARGES

2.5-1 Practitioner Order

Except as provided in Section 2.5-3, patients shall be discharged only on the documented order of a Physician, Oral Surgeon, or other authorized individual.

2.5-2 Notice of Planned Discharge

It shall be the responsibility of the attending Member, or other authorized individual, to give notice of planned discharges as soon as discharge is determined to be appropriate.

2.5-3 Exceptions to Discharge by a Physician or Oral Surgeon

No discharge order by a Physician or Oral Surgeon is required in the following circumstances:

- (a) When a patient is removed pursuant to a disaster plan.
- (b) When a patient leaves a UMHHC facility against advice.
- (c) When there is a question of a patient being removed from UMHHC hospitals or being dismissed because the patient's presence is interfering with proper care of other patients. In such a case, the attending Member and the Administrator-on-Call shall be notified.

2.5-4 Pronunciation of Death

In the event of a death at a UMHHC facility, the deceased shall be pronounced dead by a Physician, physician assistant, nurse practitioner, or certified nurse midwife. Policies with respect to autopsies and release of bodies shall conform to Michigan laws.

2.5-5 Autopsies

Every Physician Member practicing at UMHHC facilities is expected to actively seek performance of autopsies. No autopsy shall be performed without recorded consent of the legally authorized agent. This consent shall include exceptions and/or limitations to the autopsy. All autopsies shall be performed by members of the Pathology Service. Physicians seeking consent for autopsies from the next of kin of deceased patients shall explain adequately what constitutes a routine autopsy, and the extent of the consent shall not be violated. The Pathology Service shall review the consent, including any exceptions in or limitations of autopsy consent or procedures requested.

2.5-6 Unclaimed Bodies

When applicable, the official who has been designated by the CEO to have control of unclaimed bodies shall notify the Anatomy Committee of the Medical School seventy-two (72) hours after death (excluding Sundays and holidays), that an unclaimed body is available for use by the Anatomy Committee. An unclaimed body means a dead human body for which the deceased has not provided for a disposition, an estate or assets to defray costs of burial do not exist, and the body is not claimed for burial by any person, relative or court appointed fiduciary who has the right to control the disposition of the body.

2.5-7 Organ Donation Request

In appropriate cases, requests shall be made to next of kin for donation of organs, as required by state law and UMHHC organ donation policy.

2.6. PATIENT DEPARTURE AGAINST MEDICAL ADVICE

2.6-1 Notification in Reporting

If a patient threatens to leave or leaves a UMHHC facility against advice of a Member or without usual discharge, a notation of the event shall be made in the patient's medical record and a report shall be submitted to the Administrator-on-Call. If the attending Member(s) is (are) not directly involved, the attending Member(s) shall also be notified as soon as practical of the patient's anticipated or actual leaving of the facility.

2.6-2 Release Form

A patient leaving a UMHHC facility against medical advice of a Member shall be requested to sign the proper release form, which will be placed in the patient's medical record. A patient's failure or refusal to sign the proper release form shall also be recorded in the patient's medical record. A discharge note shall then be properly prepared by the Member on site with the patient at the facility.

2.6-3 Limitation on Patient's Right to Discharge Against Medical Advice

A competent patient generally has the right to leave a facility against the advice of the patient's attending Member. However, a facility has a right, in its discretion, to disallow a patient's departure under certain circumstances for safety reasons, including, but not limited to:

- (a) A patient is mentally incompetent and without assistance of a legal representative or other support person.

- (b) A patient requires involuntary commitment under the Mental Health Code in the judgment of a Physician providing care.

If it is reasonably believed that because of a question of mental incompetency that the patient's safety would be jeopardized by departure from a UMHHC facility, the patient may be restrained, chemically or physically, by a qualified Member for a specific, limited time while the matter is referred to the Administrator-on-Call for further action.

2.7. MEDICAL RECORDS

(Unless otherwise noted, references to Medical Records include both inpatient and outpatient records.)

2.7-1 Attending Member Responsibility

The attending Member shall be responsible for the inclusion of significant clinical information and the documentation of patient care rendered.

2.7-2 Content of Medical Records

(a) Medical Records Generally

The record shall include identification data, complaint; personal history; family history; history of present illness; physical examination, special reports such as consultations, laboratory, x-ray and others; diagnoses; results of medical and surgical treatment; pathological findings and progress notes, orders, informed consent, condition and disposition of patient at discharge, medications, instructions given to patient and/or family, referrals to other providers and any required reporting to authorities.

(b) Pediatric Records

Pediatric charts will also contain immunization status, evaluation of developmental age, and family participation in and expectations of care.

(c) Inpatient Discharge

On discharge of an inpatient by the attending Member or CPT, a clinical resume (summary) shall be created in the central electronic system by dictation or direct entry on all inpatient medical records excluding normal newborns and their mothers with normal labor and delivery. In all instances, the content of the

medical record shall be sufficient to support the diagnosis, justify the treatment, and document the course of treatment and results. All summaries shall be signed by the attending Physician Member.

(d) Timing and Reports

Medical record documentation generally should be created within twenty-four (24) hours and authenticated within seven (7) days after the patient encounter. A medical record Deficiency Report is sent at least monthly to the Member or SPP, appropriate Department Chair and Service Chief, indicating records, which remain incomplete or unauthenticated. In the case of medical record deficiencies associated with a Trainee, the Deficiency Report will also be sent to the GME Office and Program Director. Action to address a Member or SPP's occasional minor failure to timely complete medical records or comply with other medical record policies rests with the Department Chair or designee. Serious and/or recurrent failure to timely complete medical record completion policies (such as those which constitute a hazard to patient safety, involve regulatory compliance issues, or adversely affect payment for services) shall be referred to the OCA for review and possible action pursuant to the Bylaws.

(e) Outpatient Treatment

Medical record documentation is required for every patient who is seen in the outpatient clinic. Outpatient records will contain a summary list, which includes medical diagnoses and conditions, significant surgical/invasive procedures, adverse/allergic drug reactions, and medications prescribed for or used by the patient. This list will be initiated by the 3rd visit. Outpatient charts of children receiving primary care will contain growth charts.

(f) Obstetrical Records

The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending Member's office record transferred to the hospitals before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

(g) Payor Requirements

The medical record shall be maintained and documented consistent with current regulations and requirements of third

party payors and with UMHHC professional billing compliance policies. Delinquencies in these matters will be reported to the COS, to the concerned Service Chief and Department Chair, and to the Compliance Office.

2.7-3 Member Responsibility For Completion

When CPTs are involved in patient care, documentation is required to substantiate active participation in and oversight of patient care by the attending Member. The attending Member will countersign the discharge summary, any operative report, and sufficient progress notes to indicate personally identifiable medical service.

2.7-4 Orders

(a) Standard Orders

Patient care orders shall be signed by specifically authorized health professionals acting within the scope of their license and privileges.

(b) Verbal/Telephone Orders

Verbal and telephone orders may be given by Members and other health professionals who are authorized to sign patient care orders. Telephone and verbal orders must be transcribed, dated, timed and authenticated in compliance with UMHHC Policy .

2.7-5 Research Use

Use of medical records for research purposes shall be subject to the policies and approval of the Medical School Institutional Review Board and/or, as applicable, the Health System Privacy Board, as well as, the University's assurances to governmental agencies and research sponsors and applicable UMHS policies and procedures governing the use and disclosure of patient health information.

2.7-6 Records Owned By UMHHC

All records (regardless of the medium) developed with UMHS or under its auspices, are the property of UMHS and shall not be taken out of the UMHS jurisdiction and safekeeping except in accordance with a court order, properly authorized subpoena, other legal requirement or institutional policy or approval. The information contained within the record is the property of the patient and must be available to the patient and/or their legal representative upon appropriate request and authorization by the patient or his/her legal representative. UMHHC is

the steward or caretaker of that information and the owner of the medium of storage. All patient care records are subject to the provisions of the University of Michigan Notice of Privacy Practices and other University policies that regulate the use and disclosure of patient health information.

2.7-7 Authentication of Entries

All clinical entries in the patient's medical record shall include UMHHC's physician number and be dated, timed, and authenticated by process of a signature, identifiable initials, or an electronic signature. The use of rubber stamp signatures in the patient's medical record is not acceptable.

2.7-8 Authorization for Release of Information

Written authorization of the patient is required for release of medical information to persons not otherwise legally authorized to receive this information. Verbal authorization of the patient is sufficient for release of medical information to those primary and personal health care providers designated by the patient, whether or not affiliated with UMHHC.

2.7-9 Symbols and Abbreviations

Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations is available on line.

2.7-10 Final Diagnosis

A final diagnosis (both for in- and outpatient care) shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible Member at the time of discharge of all patients. This is a condition of discharge.

2.7-11 Other Policies

The foregoing requirements shall be supplemented by specific UMHHC or UMHS policies on medical records including those which address standing, "no code," medication, and special treatment orders.

3.0 MISCELLANEOUS

3.1. PEER-PROFESSIONAL REVIEW RECORDS

Consistent with the Bylaws, all records, data and knowledge collected for or by individuals or committees assigned to assess the quality and necessity of patient

care provided and the preventability of complications and deaths occurring in the UMHHC facilities are confidential and shall be used only for the purpose intended and shall not be made a matter of public record and shall not be available for Michigan Freedom of Information Requests, court subpoena or search warrant.

3.2. UMHHC'S POLICIES, PROCEDURES AND GUIDELINES

UMHHC's Policies, Procedures and Guidelines shall be a resource for Medical Staff Members, SPPs and Trainees.

3.3. PATIENT CONSENT FOR PHOTOGRAPHS

Photographs, digital photos and motion pictures that identify a patient must be retained and used solely for purposes of identification, diagnosis or medical treatment of the patient depicted or UMHS internal clinical activities, including documentation to support reimbursement or internal training or education, unless permission has been granted, signed by the patient or legally authorized representative and such permission has been filed in the patient's medical record.

4.0 USE OF DRUGS

Drugs used at UMHHC facilities shall be those listed by the U.S. Pharmacopeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluation, New Drugs or UMHHC Formulary, with the exception of drugs for bona fide clinical investigations, or compassionate or emergency use consistent with Federal law and institutional policy. These shall be used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospital" and all regulations of the Food and Drug Administration. The product chosen by the appropriate Medical Staff committee for inclusion in the UMHHC hospitals' formulary will be the innovator's product in each case, unless there are bioavailability and other data on hand on another manufacturer's product containing the same active ingredient(s) that are acceptable to the Committee. The "innovator" is the company that performed all the phase III studies, filed a New Drug Application with the Food and Drug Administration and obtained approval to sell the product in the United States.

5.0 GENERAL RULES REGARDING PATIENT CARE

5.1. DAILY PATIENT VISITS ADMITTED PATIENTS

An admitted patient shall be visited daily by his/her attending Member(s) or qualified health professional designee. Evidence of daily visits shall ordinarily be found in the patient's medical records through documentation in progress notes or orders with the exception of rehabilitation.

5.2. INFORMED CONSENT

A surgical operation or procedure shall be performed only after appropriate informed consent is obtained, except that in emergency cases (imminent danger to life or limb); consent need not be obtained. In emergency cases involving a minor, unconscious or mentally incompetent patient in which consent for surgery cannot be immediately obtained from a parent, a patient advocate, guardian, or next of kin, these circumstances shall be explained in the patient's medical record. Members are required to inform the patient or his/her representative of significant risks and benefits of blood transfusion before usage and document that in the chart.

5.3. REPORTS OF SURGICAL PROCEDURES

All surgical procedures performed should be fully described by the operating surgeon or designated representative immediately following the procedure.

5.4. TISSUE REMOVAL AND REVIEW

All tissues removed at the time of surgery shall be sent to the Pathology Service where such examinations as may be considered necessary will be made to arrive at a diagnosis. Reports of such examinations shall be filed in the patient's medical record and in the Pathology Service.

5.5. ATTENDING PHYSICIAN

The attending Member, for operating room purposes, is defined as that individual with overall responsibility for the procedure.

5.6. ANESTHESIA AND SEDATION

The care received by all UMHHC patients requiring anesthesia or sedation will be in accordance with clinical policies and procedures of the Department of Anesthesiology and the Sedation Analgesia Committee of UMHHC.

5.7. DENTAL AND ORAL SURGERY PATIENTS

When dental and oral surgery patients require admission to the UMHHC hospitals they will be admitted to the Oral Maxillofacial Surgery Service. The supervision

of specific medical care for inpatients will follow the guidelines of the Bylaws and these Rules and Regulations as they apply to the Service of Oral Maxillofacial Surgery.

5.8. PHYSICAL EXAMINATIONS

5.8-1 Authorized Professionals. A physical examination required by these Rules and Regulations or UMHHC policies may be performed by:

- (a) A Physician Member who has clinical privileges to do so.
- (b) A Physician CPT who is delegated the responsibility to perform a physical examination pursuant to UMHHC policy, Department rules, or specific delegation by a Member who has clinical privileges to perform the physical examination.
- (c) An Oral Surgeon for his/her own patient if (s)he has clinical privileges to do so.
- (d) A Dentist or Podiatrist for his/her own patient relating to his/her specific aspect of the patient's care if (s)he has clinical privileges to do so.
- (e) An SPP, if delegated the authority to perform all or part of a physical examination by a Member with clinical privileges to perform such physical examination, and if the SPP has clinical privileges to do so, and if UMHHC policy or Department rules specifically permit such delegation.

5.8-2 Preoperative/Preprocedure Evaluations

- (a) Procedures Requiring Anesthesia: Except as may otherwise be required in the event of a bona fide emergency, a relevant history and physical by a Physician, Oral Surgeon with appropriate privileges or SPP authorized to do so and with appropriate clinical privileges, shall be required on each patient within twenty-four (24) hours of admission or registration, but prior to the procedure. A history and physical examination may also be completed no more than thirty (30) days before the scheduled surgery, however, when the history and physical examination is completed no more than thirty (30) days before the scheduled procedure, an updated examination for any changes in the patient's condition must be completed and documented in the medical record within twenty-four (24) hours of admission or registration, but before the procedure. Minimally, this history and physical should include relevant medical and surgical history (co-existing disease, review of relevant systems, current medications, and allergies/reactions), a focused physical

examination (vital signs, pulmonary/cardiovascular) and an airway examination. This update may be completed by a member of the surgical team, including the Anesthesiologist.

- (b) **Procedures Requiring Sedation:** An assessment is required for inpatient and outpatient procedures within forty-eight (48) hours if the procedure will be performed under sedation/analgesia. If the assessment is performed by a registered nurse, the assessment will be reviewed by the responsible Physician Member or designee. Minimally, this assessment should include a notation of anesthesia risk, anesthesia drug and allergy history, and airway, pulmonary and cardiovascular assessment.
- (c) Immediately prior to the administration of sedation or anesthesia, the patient's condition will be reevaluated for significant changes.

5.8-3 High Risk Review

When a physical examination is performed by a person other than a Member who is a Physician and the diagnostic and/or therapeutic intervention planned for the patient is "high risk" in nature, a Physician Member or SPP authorized to do so shall confirm the findings, conclusions and assessment before the intervention is performed. For this purpose "high risk" means a substantial risk of death or permanent injury to the patient.

5.8-4 Outpatient Visit History and Physical Examination Requirement

The attending Medical Staff Member or designee is responsible for performing the appropriate medical history and physical examination of outpatients.

- (a) A problem-focused medical history and physical examination are performed for outpatients who present for an acute problem and for patients who are referred to a specialty consultant.
- (b) An age-specific health maintenance examination is offered for new patients who present to establish general, on-going care with a primary care provider.
- (c) A medical history and physical examination are performed prior to ambulatory surgery, as defined in Section 5.8-2 above.

5.9. TRAINEES

5.9-1 Trainee Compliance

Each Trainee shall comply with the Bylaws, the Rules and Regulations and UMHC policies. Any failure to comply with the Rules and Regulations or UMHC policies shall be reported by the training program director, to the Office of Clinical Affairs and to the GME Office.

5.9-2 Faculty Oversight of Trainees

Trainees shall be assigned to a Service and, on a rotational basis, the oversight of a Member with clinical privileges in that Service. In addition to the other requirements set forth in these Rules and Regulations, Members assigned Trainee oversight:

- (a) Have overall responsibility for the quality of services rendered by the Trainee, including invasive procedures.
- (b) Must confirm timely completion of records which are prepared by the Trainee.
- (c) Must evaluate the Trainee upon completion of a rotation.
- (d) Must notify the training program director of concerns with Trainee skills, services or compliance.

6.0 CONSULTATION REQUESTS

6.1. AUTHORIZED REQUESTOR

Only Members and their designees are authorized to sign requests for consultation, except as noted below. The patient's attending Member's name must appear on the consultation request.

6.2. SCOPE OF CONSULTATION

A consultation shall routinely mean that the consultant shall provide "consultation and concurrent care, until signoff." If transfer is also intended, it must be specified in the patient record.

6.3. RESPONSIBILITY OF CONSULTANT

- (a) A consultation shall be performed within twenty-four (24) hours after it is requested, or no later than the time the consultant and requesting Member agree.

- (b) All consultations shall include the performance and recording of a patient examination, as well as a recording of the consultant's overall impressions and recommendations into the patient's medical record.

6.4. SUPPORT STAFF REQUESTS FOR PATIENT REFERRAL

Registered nurses, as authorized and consistent with the Bylaws, these Rules and Regulations and UMHS and UMHHC policies, may, pursuant to approved protocols, request patient referrals for radiology and laboratory tests, respiratory therapy, schoolroom services, patient education services, occupational therapy, physical therapy, dietetic consultations, and social work services. Protocols shall be established by the responsible Medical Staff Member and approved by the relevant Service Chief and Department Chair.

7.0 MECHANISM FOR PROVIDING EMERGENCY SERVICES

7.1. LEVEL 1 CENTER

The Department of Emergency Medicine will function as a Comprehensive (Level 1) Emergency Service by the criteria of the State of Michigan, Department of Community Health.

7.2. RESPONSIBILITY OF SERVICE

The Emergency Service will be a responsibility of the Department of Emergency Medicine and is responsible for:

- (a) Triage and treatment of patients presented for urgent or emergent care.
- (b) Initial management and stabilization of all patients with life or limb threatening injuries or medical emergencies or with potentially serious or disabling conditions requiring urgent or emergent care.
- (c) Screening of patients for Direct Admission.
- (d) Acting as a Base Hospital in the Washtenaw-Livingston EMS Medical Alert Zone, providing medical direction for Basic and Advanced Life Support by pre-hospital personnel (paramedics) who are treating and transporting patients in the community.
- (e) Directing the critical care transportation services of UMHHC, which provide ground ambulance, helicopter, and fixed wing air transport to UMHHC or to other appropriate health care facilities.

- (f) The chair of the Department of Emergency Medicine or Member designee chairs the UMHHC Disaster Committee and directs the staging of two disaster drills annually.

7.3. SERVICE SUPPORT

7.3-1 Clinical Consultation

Consultation from all Departments and Services will be available to the Department of Emergency Medicine twenty-four (24) hours a day, seven (7) days a week, for assistance in managing emergency patients.

7.3-2 Support Services

The services of the Radiology Department, Clinical Laboratories, Blood Bank, Pediatric and Adult Operating Rooms, and Delivery Rooms will be available to the Department of Emergency Medicine twenty-four (24) hours a day, seven (7) days a week.

7.4. CODE OF CONDUCT

All Medical Staff Members, SPPs and Trainees shall abide by the UMHS Code of Conduct, available on the website of the UMHS Compliance Program.

PART THREE: COMMITTEE PROTOCOL AND ADDITIONAL STANDING COMMITTEES

1.0 GENERAL COMMITTEE PROTOCOL

In addition to the ECCA and the committees with professional review functions set forth in the Bylaws, this Part provides the details of the additional standing committees of the Medical Staff.

1.1. APPOINTMENT CRITERIA

Medical Staff committees shall be considered subcommittees of the ECCA and will be charged by the COS with approval of the ECCA. The Members on committees, except as otherwise provided (e.g., where membership based on position held), will be appointed by the chair of the committee with the ECCA's approval. Representatives from UMHHC staff that are not Members shall be appointed by the CEO in consultation with the COS where there is no selection criterion specified. Appointment and reappointment of committee members or chairs shall take into account:

- (a) Need for specific expertise on the committee.
- (b) Contributions to the committee.
- (c) Tenure on the committee.
- (d) Attendance record.

No more than fifty percent (50%) of a committee can change membership in any year. Fifty percent (50%) of voting members constitutes a quorum unless otherwise noted.

1.2. REPRESENTATION

Committees shall include, but not be limited to, representation from:

- (a) Medical Staff (no more than one at-large Member from any one Service).
- (b) Nursing
- (c) CPTs.
- (d) Administration.
- (e) Others, as needed, to complete the charge.

1.3. EXECUTIVE SESSION

The chair or a majority of voting committee members present may call an executive session for good reason. If an executive session is called, all non-voting members and staff shall be excused unless specifically invited to attend by the chair or a majority of the voting committee members.

1.4. ALTERNATIVE PROCEDURES

The chair may, upon approval of a majority of voting committee members present, establish alternative protocols for committee activity and action not inconsistent with this Part, such as electronic voting. Such alternative protocols shall be reported to the COS in committee minutes or otherwise.

1.5. ALTERNATIVE MEMBER

A regular member of a committee may, with the approval of the chair, designate an alternate to participate in committee deliberations and to vote on behalf of the regular committee member. Any such alternate shall represent the same category of staff as the regular committee member. An alternate may not designate another person to serve as alternate in his/her stead. Committee minutes or activity reports shall reflect the name and position of any alternates present.

2.0 ADULT ETHICS COMMITTEE

2.1. COMPOSITION

The Adult Ethics Committee is chaired by a Member on the committee appointed by the COS. The co-chair is appointed by the chair with majority of committee member approval. Additional committee members include at least the following:

- (a) Representatives of major medical specialties and subspecialties.
- (b) At least 1 representative from Nursing.
- (c) At least 1 representative from Social Work.
- (d) 1 representative from Pastoral Care.
- (e) 1 representative from the Compliance Office.
- (f) At least one person from the community totally unrelated to UMHHC or UMHS.
- (g) 1 CPT.
- (h) Chair/Co-Chair of Pediatric Ethics Committee.

Committee ad hoc participants may include:

- (a) For specific matters, others who may have familiarity with the medical or social issues involved may be asked to consult or serve on an episode-specific basis.
- (b) At least one medical student representative

2.2. CHARGE

To provide consultation to the treatment team, patients and families on ethical, moral or philosophical problems and issues encountered in the course of managing inpatient and outpatient care. To provide education and advice to the staff, faculty, medical students, patients and families on case-based ethical issues, as well as on ethical medical practice standards, in the provision of inpatient and outpatient care.

- (a) To formulate, review and comment, upon request, policies on the ethical aspects of clinical care at UMHHC.
- (b) To assist UMHHC in complying with ethical regulatory standards.

- (c) To represent the FGP on ethical issues encountered in clinical practice in the clinical delivery system for both inpatients and outpatients.
- (d) Provide education to community agencies and students as requested.
- (e) When appropriate and/or when requested, work in conjunction with the UMMS Bioethics Program.

2.3. MEETINGS AND RECORDS

The Adult Ethics Committee will meet when called by the committee chair, but at least twice per year. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and the ECCA. Meeting summaries will be available to the OCA. A presentation of the annual report to the ECCA will be at the discretion of the committee chair.

3.0 CARDIOPULMONARY RESUSCITATION COMMITTEE

3.1. COMPOSITION

The Cardiopulmonary Resuscitation Committee is chaired by a Member on the committee appointed by the COS. The co-chair is appointed by the chair with majority of committee member approval. Additional committee members include at least the following:

- (a) 1 Adult Cardiologist Member.
- (b) 1 Pediatric Cardiologist Member.
- (c) Chair of C.S. Mott Children's Hospital Cardiopulmonary Resuscitation Committee.
- (d) 1 CPT.
- (e) 1 Representative of Pharmacy.
- (f) 1 Representative of Security.
- (g) 1 Representative of Materials Management.
- (h) 1 Representative of Administration.
- (i) 2 At-Large Medical Staff Members.
- (j) 1 Nursing Representative from SICU.
- (k) 1 Nursing Representative from PICU.
- (l) 1 Nursing Representative from Adult General Care.
- (m) 1 Nursing Representative from Pediatrics General Care.
- (n) 1 Medical Staff Representative from Anesthesia.
- (o) 1 Medical Staff Representative from the Hospitalist Group.
- (p) 1 Clinician Representative from Ambulatory Care.
- (q) 1 Representative from Respiratory Therapy.
- (r) 1 Representative from CQI.
- (s) 1 Representative from Risk Management.
- (t) 1 Representative from Biomedical Engineering.

- (u) Chief PA, or designee.

3.2. CHARGE

- (a) Oversee and coordinate the development of cardiopulmonary resuscitation policies and procedures within UMHHC facilities.
- (b) Advise the Medical Staff regarding overall policy matters concerning cardiopulmonary resuscitation.
- (c) Monitor the functions of the cardiac arrest team; cardiac arrest call system and equipment, including defibrillators.
- (d) Monitor and update cardiopulmonary related communication procedures.
- (e) Monitor and revise, when necessary, the mobilization plan for cardiac arrest personnel and equipment.
- (f) Review and recommend changes or additions to cardiac arrest equipment; standardization of equipment; and maintenance, location, and storage of equipment.
- (g) Provide regular evaluation and reporting of the UMHHC's resuscitation program.
- (h) Recommend changes to resuscitation policy and procedures needed as indicated by evaluations.
- (i) Plan for the education and training of all UMHHC personnel in appropriate aspects of the recognition and treatment of cardiopulmonary arrest.

3.3. MEETINGS AND RECORDS

The Cardiopulmonary Resuscitation Committee will meet when called by the committee chair, but at least twice per year. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and presented to the ECCA. Meeting summaries will be available to the OCA.

4.0 CEREBRAL DEATH DETERMINATION COMMITTEE

4.1. COMPOSITION

The chair of the Cerebral Death Determination Committee is appointed by the COS.

- (a) 2 Members from Neurology.
- (b) 1 Member from Neuro-Intensive Care (Neurology or Neurosurgery).
- (c) 1 Member from Electroencephalography.
- (d) 2 Members from Neurosurgery.
- (e) 1 CPT.
- (f) 1 Representative from Nursing.
- (g) 1 Member from Nuclear Medicine.

4.2. CHARGE

- (a) Develop and publish guidelines and operational rules which are dependent upon the current scientific criteria for the determination of cerebral death and which shall conform to the laws of the state of Michigan.
- (b) Oversee the education, regarding the guidelines, of consultant neurologists, electroencephalographers or neurosurgeons who will be making cerebral death determinations.
- (c) Monitor the use of cerebral death guidelines through periodic audit.

4.3. MEETINGS AND RECORDS

The Cerebral Death Determination Committee will meet when called by the committee chair, but at least twice per year. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCCA and ECCA. Meeting summaries will be available to the OCA. A presentation of the annual report to the ECCA will be at the discretion of the committee chair.

5.0 CRITICAL CARE STEERING COMMITTEE

5.1. COMPOSITION

The chair of the Critical Care Steering Committee is appointed by the COS. The vice-chair is a member on the Committee appointed by committee members. Additional committee members include at least the following:

- (a) Medical Directors of the various Intensive Care Units (ICU's), including:
 - Coronary ICU
 - Medical ICU
 - Surgical ICU
 - Thoracic ICU
 - Neurologic ICU
 - Trauma Burn ICU
 - Post-Anesthesia ICU
 - Pediatric ICU
 - Pediatric Cardio-Thoracic ICU
 - Neonatal ICU
- (b) Nurse Manager (or designee) of each of the ICU's listed above.
- (c) Manager (or designee) from Critical Care Support Services.
- (d) Administrative Assistant (appointed by Critical Care Support Services).
- (e) At-Large Medical Staff Members as required for interaction with the various critical care environments, including, but not limited to:
 - Clinical Information and Decision Support Services (CIDSS)
 - Infection Control
 - Utilization Review
 - Risk Management
 - Quality Assurance
 - Biomedical Engineering
 - Pharmacy
 - Nutrition Support Services
 - Radiology
 - Pathology
 - Emergency Medicine

5.2. CHARGE

Review and report on current status of policies and practices in the ICUs, develop data collection and monitoring systems, develop or recommend practice and policy changes regarding equipment, supplies, personnel needs and standards or scope of care, provide a forum for dissemination of information pertinent to the intensive care environment and education of healthcare providers within the ICU and coordinate research protocols among the ICU populations/units.

(a) Specific Duties

- Provide assessment and recommendation of equipment and supply utilization.
- Develop, initiate, and conduct multi-disciplinary conferences, educational tools and programs.
- Evaluate, consult and report on best practices using accepted methodological approaches.
- Report on current data collection initiatives and assessments, technological utilization policies and practices, ICU resources, requirements and utilization.
- Evaluate and facilitate regulatory QA policies and practices that are consistent across the ICUs.

(b) Design, initiate, and facilitate the implementation of internal and externally sponsored clinical research efforts.

5.3. MEETINGS AND RECORDS

The Critical Care Steering Committee will meet when called by the committee chair, but at least twice per year. The Committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and presented to the ECCA. Meeting summaries will be available to the OCA.

6.0 DISASTER COMMITTEE

6.1. COMPOSITION

The Disaster Committee is chaired by the Emergency Medicine Department Chair, or designee. It includes at least the following additional members:

- (a) 1 Associate COS.
- (b) 1 CPT.
- (c) 2 Representatives from Nursing.
- (d) 1 Representative from Security.
- (e) 1 Representative from Operations Management Blood Bank.
- (f) Disaster Director.
- (g) 2 Representatives from Administration.
- (h) 1 Member from the Department of Emergency Medicine.
- (i) 8 At-Large Medical Staff Members.
- (j) 1 Emergency Management Specialist.

6.2. CHARGE

- (a) Oversees the development and implementation of policies and procedures for situations that require resources greater than normal operation can handle at one time.
- (b) Ensures that UMHHC is able to respond to serious disaster situations.
- (c) Supervises the disaster drills recording their results, approves policies and procedures to be included in the Emergency Procedures Manual.
- (d) Reviews and updates staff emergency procedures education program.

6.3. MEETINGS AND RECORDS

The Disaster Committee will meet when called by the committee chair, but at least twice per year. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and presented to the ECCA. Meeting summaries will be available to OCA. A written report and

critique of all drills and emergency operations will be submitted, as appropriate, to the COS, the ECCA and the CEO.

7.0 EHR STANDARDS COMMITTEE

The EHR Standards Committee provides enterprise-wide leadership, oversight, and monitoring of the quality, compliance, and design of all electronic health record systems and medical records to ensure that the UMHS/UMHHC is in compliance with all applicable standards and regulations related to health information management and the medical record, and that all EHR systems adequately support the capture of clinical information, physician efficiency, and patient safety.

7.1. COMPOSITION

The EHR Standards Committee is co-chaired by an Associate Chief from the OCA and the Chief Administrator for Health Information Management.

- (a) 1 physician representative from each of the following: Surgery, Internal Medicine, Pediatrics, Psychiatry and Ambulatory Care.
- (b) 1 Hospitalist and additional physician representative at-large, if decided.
- (c) 1 Physician Assistant.
- (d) 1 House Officer.
- (e) 1 Representative from Nursing.
- (f) Chief Medical Information Officer and the Chief Nursing Information Officer.
- (g) 1 Representative from each of the following areas: Risk Management, MCIT, CareWeb Programming, Privacy Office, Quality Improvement, Professional Billing Compliance, OCA.
- (h) 2 staff members from HIM.

7.2. CHARGE

- (a) Develop and oversee institutional policies for the medical record – paper and electronic.
- (b) Identify, review and approve policies related to medical information and medical record management.
- (c) Provide input and recommendations regarding the strategic direction for the ongoing management and development of the UMHS/UMHHC electronic health record.

- (d) Review and make recommendations regarding incremental electronic medical record selection, functionality, operations, and enhancements.
- (e) Develop and oversee processes for medical record reviews.
- (f) Develop and oversee deficiency monitoring processes and make recommendations for improvements and/or enhancements.
- (g) Develop and/or advise the organization on opportunities and practices to support efficient and effective capture and documentation of clinical information.
- (h) Provide input to UMHHC and UMHS leadership regarding medical record/EHR needs within the UMHS.
- (i) Develop/implement policies for education and training of physicians, house officers and SPPs on medical record documentation.
- (j) Oversee, review and approve all paper forms and electronic formats used to document or capture patient information for the medical record.
- (k) Recommend and support strategies for integration of electronic medical record systems and universal access to all information necessary for safe and effective patient care

7.3. MEETINGS AND RECORDS

The committee will meet when called by the chair, but at least twice per year. The Committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and presented to the ECCA. Meeting summaries will be available to the OCA.

8.0 INFECTION CONTROL COMMITTEE

8.1. COMPOSITION

Chaired by the Medical Director of Infection Control and Epidemiology, the Infection Control Committee includes at least the following additional members:

- (a) 1 or more representatives of Infection Control and Epidemiology.
- (b) 1 CPT.
- (c) 1 Representative from Safety Management Services.
- (d) 1 Representative from Pharmacy.
- (e) 1 Representative from the Microbiology Laboratories.
- (f) 1 Representative from Respiratory Care.
- (g) 1 Representative from Material Management.
- (h) 1 Representative from Environmental Services.
- (i) 1 Representative from Food and Nutritional Services.
- (j) 1 Representative from Nursing Services.
- (k) 1 Representative from Risk Management.
- (l) 1 Representative from Administration.
- (m) 4 At-Large Medical Staff Members who are representative of various Services.

8.2. CHARGE

Formulate and implement UMHHC's infection control policies. Specific activities include the following:

- (a) Review the mechanisms and parameters of a nosocomial infection control program including surveillance criteria, infection definitions and criteria of acceptance, and epidemiological follow-up.
- (b) Review UMHHC's infection control measures including isolation requirements, aseptic procedures, disinfection and sterilization procedures, etc.

- (c) Review mechanisms for obtaining and distributing information to the Medical Staff concerning antibiotic susceptibility of laboratory isolates.
- (d) Review elements of the employee health program which impacts infection control policy and procedures.
- (e) Report actual or suspected infections.
- (f) Initiate culture and sensitivity testing.
- (g) Institute appropriate isolation procedures.
- (h) Institute emergency infection control measures and quality assurance studies to define a suspected or apparent problem when indicated, which are within accepted guidelines for the given situation, and worked through, where possible, with the appropriate Members and Administration.
- (i) Institute corrective actions as appropriate.
- (j) Provide epidemiologic follow-up on all quality assurance studies to identify improvement areas.
- (k) As needed, coordinate with public health agencies.

8.3. MEETINGS AND RECORDS

The Infection Control Committee will meet when called by the chair, but at least twice per year. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and presented to the ECCA. Meeting summaries will be available to the OCA and reports will be submitted as appropriate to county health department(s) and Michigan Department of Community Health.

9.0 NOMINATING AND BYLAWS COMMITTEE

The Nominating and Bylaws Committee is responsible for assuring that all elected offices are filled, and that vacancies are addressed expeditiously. The Committee is also responsible for amending the Bylaws as necessary from time to time to assure compliance with applicable laws, regulations, and accreditation standards and the smooth operation of the Medical Staff. It is staffed by the OCA.

9.1. COMPOSITION

The Nominating and Bylaws Committee is chaired by the COS or by an ACOS designated by the COS. It includes at least the following additional members:

- (a) Dean of Medical School or Designee.
- (b) The Executive Medical Director of the Faculty Group Practice.
- (c) 4 At-Large members of the Active Medical Staff.
- (d) 1 Representative from Risk Management.
- (e) Administrative Director, OCA.

9.2. CHARGE

- (a) Reviews the Bylaws, and the Rules and Regulations at least once every three (3) years and recommends updates and revisions as appropriate to the ECCA.
- (b) Reviews new or revised laws, regulations, or accreditation standards and determines whether revisions to the above Bylaws and standards are necessary to assure ongoing compliance.
- (c) Solicits nominations for vacancies in elected Medical Staff offices (COS, other officers, HHCEB representatives, ECCA at-large representatives) and oversees the election process

9.3. MEETINGS AND RECORDS

The Nominating and Bylaws Committee convenes at the call of the chair. The OCA is responsible for documenting the agendas and minutes of all Nominating and Bylaws Committee meetings.

10.0 OPERATING ROOM POLICY COMMITTEE

The UMHHC Operating Room Policy Committee oversees operation of operating rooms (ORs) and Post Anesthesia Care Units (PACUs) and monitors the activities of local OR committees at the individual hospital facility level.

10.1. COMPOSITION

The OR Policy Committee is chaired by the Department of Anesthesiology Chair. Members include:

- (a) Chair of Department of Surgery, or designee.
- (b) Chair of Department of Anesthesiology, or designee.
- (c) Chair of Department of Ophthalmology, or designee.
- (d) Chair of Department of Medicine, or designee.
- (e) Chair of Department of Obstetrics and Gynecology, or designee.
- (f) Chair of Department of Otolaryngology, or designee.
- (g) Chair of Department of Urology, or designee.
- (h) Chair of Department of Orthopaedic Surgery, or designee.
- (i) Chair of Department of Neurosurgery, or designee.
- (j) Surgeon-in-Chief, C.S. Mott Children's Hospital.
- (k) Chief of Pediatric Anesthesiology, C.S. Mott Children's Hospital.
- (l) 1 Nursing Director of Operating Rooms.
- (m) 1 designee of the Medical Director, University Hospital.
- (n) 1 designee of the Medical Director, Kellogg Eye Center.
- (o) 1 CPT (alternate years: Surgery and Anesthesiology).

10.2. CHARGE

- (a) Monitor the actions of UMHHC operating, ambulatory surgery facilities, and the post-anesthesia care units.
- (b) Monitor the activities of the University Hospital, CVC, East Ann Arbor, Kellogg Eye Center, C.S. Mott, and Livonia OR

Operations Committees and receive recommendations from these committees which shall act as subcommittees of the OR Policy Committee for the development of OR guidelines for use within their respective hospitals, in accordance with operational protocols established by the OR Policy Committee.

- (c) Develop and recommend to the ECCA, clinical guidelines related to patient care for use in operating rooms, ambulatory surgery facilities and PACUs throughout UMHHC.
- (d) Develop and recommend to the CEO (or designee) administrative systems concerning operating rooms, ambulatory surgery facilities, and PACUs including processes for OR institutional time allocation to services, scheduling, and monitoring systems for use throughout the hospitals.
- (e) Develop institution-wide guidelines on operating and ambulatory surgery facilities and PACU asepsis regulatory requirements.
- (f) Receive and consider the recommendations of UMHHC operations committees for the facilities regarding OR times allocation by the various UMHHC Services and in turn make final recommendations on this subject to the CEO or designee.
- (g) Allocation of operating room resources in matters broader than the purview of operations committees of the various UMHHC facilities.
- (h) Advise the CEO or designees regarding the objectives and principles for OR, and ambulatory surgery facility, capital equipment and construction needs and budgets for the various UMHHC facilities.
- (i) Review and make recommendations to the CEO or designees regarding the recommendations regarding the membership on various UMHHC facilities' operations committees regarding the appointment of medical directors of the ORs.
- (j) Participate in planning for the new or renovated ORs or PACUs throughout the UMHHC facilities.

10.3. MEETINGS AND RECORDS

The OR Policy Committee will meet monthly, and as called by the chair. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and presented to the ECCA. Meeting summaries will be available to the OCA.

11.0 PAIN COMMITTEE

The Pain Committee coordinates the development of and oversees compliance with policies and practice guidelines regarding acute and chronic pain management within the UMHC.

11.1. COMPOSITION

The Pain Committee Chair is a Member on the Committee as approved by the COS. The Pain Committee also includes the following members:

- (a) 1 Medical Staff Member of the Adult Acute Pain Service.
- (b) 1 Medical Staff Member of the Pediatric Pain Service.
- (c) 1 Medical Staff Member of Hematology/Palliative Care.
- (d) 2 CPTs – 1 from Adult, 1 from Pediatrics.
- (e) 1 Representative of Pharmacy.
- (f) 1 Nurse from Pediatric Pain Service.
- (g) 1 Nurse from Adult Pain Service.
- (h) 1 Adult Medical/Surgical Nurse Manager.
- (i) 1 Pediatric Nurse Manager.
- (j) 1 Nurse from Ambulatory Care.
- (k) 1 Faculty Group Practice member in a primary care discipline.
- (l) 1 Medication Safety Nurse.
- (m) 1 Risk Management Representative.
- (n) 4 At-Large Medical Staff Members.

11.2. CHARGE

- (a) Advise the ECCA regarding policy matters concerning the management of pain, both acute and chronic, in inpatient and outpatient settings.
- (b) Monitor the functions of any designated pain management programs and advise the ECCA regarding the findings.

- (c) Monitor and review pain management education materials and programs designed for patients and staff.
- (d) Regularly evaluate the effectiveness of pain management practices at UMHHC sites and advise the ECCA regarding recommended changes to policy and practice as indicated. Evaluation will include adverse event reviews, patient satisfaction surveys, medical record audits, location audits, and/or other applicable quality improvement methods.
- (e) Members of the committee or the Medical Staff at-large will be selected to form ad hoc subcommittees to review clinical issues as needed.

11.3. MEETING AND RECORDS

The Pain Committee will meet monthly. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and to the ECCA. Meeting summaries will be available to the OCA. A presentation of the annual report to the ECCA will be at the discretion of the committee chair.

12.0 PATIENT SAFETY COMMITTEE

The Patient Safety Committee provides a multi-disciplinary forum of analysis of risk and patient safety and the dissemination of information on identified risk for the purpose of improving patient care and reducing morbidity and mortality within the UMHHC.

12.1. COMPOSITION

The Patient Safety Committee is chaired by the COS, and includes the following members:

- (a) Director, Clinical Information and Decision Support Services.
- (b) Director, Corporate Quality Improvement.
- (c) Director, Risk Management.
- (d) Patient Safety Officer.
- (e) Chief of Nursing or designee.
- (f) Chief Information Officer.
- (g) Director, Pharmacy.
- (h) 1 CPT.
- (i) 1 Representative from Public Relations and Marketing Communication.
- (j) Representatives from UMHHC Departments.
- (k) 1 Representative from Administration appointed by the CEO.
- (l) 4 or more At-Large Medical Staff Members.
- (m) Chief PA, or designee.

12.2. CHARGE

The Patient Safety Committee Plan is designed to reduce medical errors and hazardous conditions by utilizing a systematic, coordinated and continuous approach to the improvement of patient safety through the establishment of mechanisms that support effective responses to actual occurrences and hazardous conditions; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions and services.

The purpose of the Patient Safety Committee Plan is to reduce mortality and morbidity and to improve patient care by the identification, analysis and reduction of risks, which could cause or have caused preventable patient injury or impairment of patient safety.

Specific duties include:

- (a) Outline patient safety functions relating to clinical and administrative activities.
- (b) Review and investigate serious outcomes where a patient injury has occurred or patient safety has been impaired.
- (c) Review and evaluate actual and potential risk of patient safety.
- (d) Identify opportunities to improve safety performance.
- (e) Manage identified risks by timely intervention in patient occurrences when appropriate, and by timely corrective preventative action and educational activities.
- (f) Provide information on identified risk to clinical and administrative departments and committees.
- (g) Implement corrective, preventative and general medical error reduction educational programs to reduce the possibility of patient injury.
- (h) Establish a non-punitive culture that promotes awareness of safety concerns, encourages staff to raise safety concerns for consideration and empowers health center staff to address such concerns.

Subcommittees of the Patient Safety Committee include: Falls Committee, Medication Reconciliation Steering Committee and the Anticoagulation Safety Steering Committee.

12.3. MEETINGS AND RECORDS

The Patient Safety Committee will meet when called by the chair, but at least quarterly. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and presented to the ECCA. Meeting summaries will be available to the OCA.

13.0 PEDIATRIC ETHICS COMMITTEE

13.1. COMPOSITION

The chair of the Pediatric Ethics Committee is appointed by the COS. Additional committee members include at least the following:

- (a) Members representative of major pediatric sub-specialties.
- (b) 1 Physician representative.
- (c) 1 Nursing representative.
- (d) 1 Social Work representative.
- (e) 1 Spiritual Care representative.
- (f) At least one community representative of population groups served by UMHHC.
- (g) At least one CPT.

For specific matters, others who may have familiarity with the medical or social issues involved may be asked to consult or serve on a one-time basis as ad hoc participants.

13.2. CHARGE

Serve as UMHS resource in meeting moral and ethical issues confronting UMHS staff and patients. Specific duties include:

- (a) Provide consultation and advice to staff, patients and families on ethical, moral or philosophical problems and issues related to patient care.
- (b) Serve as an educational resource for the UMHS staff and students on ethical matters.
- (c) Review, interpret, and recommend on legislation, policy or operational issues as requested by the Medical Staff through the OCA.

13.3. MEETINGS AND RECORDS

The Pediatric Ethics Committee will meet for business and education meetings at least quarterly. Formal consultations will be scheduled when needed. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and to the ECCA. Meeting summaries will be available to the OCA and reports submitted as requested to the

MCHVWHEC. A presentation of the annual report to the ECCA will be at the discretion of the committee chair.

14.0 PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee is charged with development and oversight of drug utilization policies and procedures within UMHHC focusing upon clinical results and reduction of hazards.

14.1. COMPOSITION

The Medical Director of Pharmacy and an ACOS, appointed by the COS, serve as co-chairs of the Pharmacy and Therapeutics Committee. Committee members include:

- (a) Medical Director of Infection Control and Epidemiology.
- (b) Chief, Drug and Information Services.
- (c) 2 Representatives from Nursing (1 Adult, 1 Pediatrics).
- (d) 1 Clinical Pharmacist.
- (e) 1 Clinical Pharmacist, drug information.
- (f) 1 representative from Administration.
- (g) 1 CPT.
- (h) 4-7 At-Large Medical Staff Members.
- (i) 1 Nutrition Specialist.

Ex-officio members are:

- (a) Chair, MUE Committee.
- (b) 1 Risk Management Representative.
- (c) Chair, MedSafe Committee.
- (d) Chief PA.

14.2. CHARGE

The Pharmacy and Therapeutics Committee will consider issues of quality, medication safety and cost for (1) U of M Hospitals inpatient use, and (2) use in UMHHC outpatient pharmacies and ambulatory clinics. The committee makes its decisions without regard to research or educational support provided to individuals or to the institution by the pharmaceutical industry. The Committee, through the Department of Pharmacy Services, is responsible for the development and implementation of all drug use policies and practices including safety issues

related to drug ordering, dispensing and administration. This includes oversight of policies and safety of investigational drug use. The Committee will also review and make recommendations regarding drug use with consideration of clinical efficacy, safety, and cost. Recommendations will be forwarded for review to the ECCA; decisions that are expected to have a significant impact on Medical Staff require the approval of the ECCA prior to implementation. The committee will address issues of drug usage coordination and collaboration among appropriate UMHHC programs required to assure quality services across the continuum of care.

In order to ensure the safety, efficacy, and cost-effectiveness of drug use in UMHHC, the committee will oversee the activities of its subcommittees. These subcommittees are charged with the review, selection, control, use, and policies for specialized drug or patient groups. Subcommittees are advisory bodies to the Pharmacy and Therapeutics Committee. The Committee may establish additional subcommittees in order to meet its charge. Current active subcommittees include:

- (a) Antimicrobial Subcommittee: Advise the Committee on antimicrobial selection, control, and policies on antimicrobial utilization.
- (b) Anticoagulation/VTE Subcommittees: Advise the Committee on issues related to prevention and treatment of VTE and issues related to anticoagulant management including standardization of practices, transition across the continuum, and appropriate selection of formulary agents.
- (c) Cancer Pharmacy Committee: Advise the Committee on issues related to cancer chemotherapeutic and supportive medication selection, control, safety and policies on utilization in UMHHC and the Cancer Center.
- (d) Glycemic Management Subcommittee: Advise the committee on issues related to glycemic management, including standardization of practices, transition of care across the continuum, and appropriate selection of formulary agents.
- (e) MedSafe Committee: Review the medication use process and reports of adverse drug events in order to continuously improve the safety and efficiency of the medication system.
- (f) Medication Use Evaluation (MUE) Subcommittee: Review use of medications in accordance with defined criteria and recommend and implement corrective action strategies.
- (g) Pediatric MedSafe Committee: Review the medication use process and medication decisions specific to the area of pediatrics.

- (h) Product and Vendor Selection Subcommittee: Advise the committee on issues related to selection of product and vendors of formulary agents and medication safety related to product recalls and defective products.

14.3. MEETINGS AND RECORDS

The Pharmacy and Therapeutics Committee will meet at least ten (10) times per year, and as called by the chair. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and presented to the ECCA. Meeting summaries will be available to the OCA.

15.0 PRACTITIONER WELLNESS

15.1. COMPOSITION

The Practitioner Wellness Committee shall consist of the following members:

- (a) Administrative Director, OCA (staff).
- (b) Psychiatrist.
- (c) Service Chief (for the applicable clinical service) or designee determined not to have a conflict of interest.

15.2. CHARGE

- (a) Receives reports from any source of potential impairment issues.
- (b) Provides twenty-four (24) hour on-call coverage for reports of impairment so that patient safety concerns can be immediately addressed.
- (c) Provides a preliminary opportunity for:
 - The committee to confidentially present the allegations
 - The subject to hear the circumstances of the reported concern
 - The subject to present his/her perspective
- (d) Deliberates to determine whether allegations warrant proceeding according to the Peer Review Process Policy 04-06-042, the Alternative Action process or other action defined by Medical Staff Bylaws.

15.3. MEETINGS AND RECORDS

The Practitioner Wellness Committee meets on an ad hoc basis. Meetings occur only in person. The OCA is responsible for documenting, as necessary, the Committee's meetings and activities.

16.0 SEDATION ANALGESIA COMMITTEE

The Sedation Analgesia Committee coordinates the development of and oversees compliance with policies and practice guidelines regarding procedural sedation analgesia by non-anesthesiologists within the UMHHC.

16.1. COMPOSITION

Committee Chair is a Member on the Committee as approved by the COS.

- (a) 1 Medical Staff Member of Radiology/Interventional Radiology.
- (b) 1 Medical Staff Member of Emergency Medicine.
- (c) 1 Medical Staff Member of Cardiology (EP Cath Lab).
- (d) 1 Medical Staff Member of Anesthesiology – Adult.
- (e) 1 Medical Staff Member of Anesthesiology – Pediatrics.
- (f) 1 Medical Staff Member Medical Procedures Unit.
- (g) Representatives of Pharmacy.
- (h) 1 Nurse from Medical Procedures Unit.
- (i) 1 Nurse from SWAT.
- (j) 1 Nurse from Pediatric Procedures Area.
- (k) 1 Nurse from Cardiac Procedures Unit.
- (l) 1 Ambulatory Care Nurse Manager.
- (m) 1 Nurse from Radiology Procedures Unit.
- (n) 1 ACOS.

16.2. CHARGE

- (a) Advise the ECCA regarding policy matters concerning the practice of procedural sedation analgesia by non-anesthesiologists.
- (b) Monitor and review sedation education materials and programs designed for patients and staff.
- (c) Review credentialing of sedation privileging for Applicants and Members.

- (d) Regularly evaluate the effectiveness of sedation practices at UMHHC sites and advise the ECCA regarding recommended changes to policy and practice as indicated. Evaluation will include adverse event reviews, patient satisfaction surveys, medical record audits, location audits, and/or other applicable quality improvement methods.
- (e) Members of the Committee or the Medical Staff at-large will be selected to form ad hoc subcommittees to review clinical issues as needed.

16.3. MEETINGS AND RECORDS

The Sedation Analgesia Committee will meet at least quarterly and as called by the Committee chair. The Committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and to the ECCA. Meeting summaries will be available to the OCA. A presentation of the annual report to the ECCA will be at the discretion of the committee chair.

17.0 TRANSFUSION COMMITTEE

The Transfusion Committee oversees and makes recommendations on usage of blood and blood products.

17.1. COMPOSITION

Chaired by a committee member appointed by the COS, committee membership includes:

- (a) 1 representative from the Department of Surgery.
- (b) 1 representative from the Department of Internal Medicine.
- (c) 1 representative from the Department of Obstetrics and Gynecology.
- (d) 1 representative from the Department of Pediatrics.
- (e) 1 representative from the Department of Anesthesiology.
- (f) 1 CPT.
- (g) Chief Technologist of the Blood Bank.
- (h) 1 Representative from Nursing involved with the Blood Bank.
- (i) 1 Representative from Administration.
- (j) Medical Director, Blood Bank.
- (k) 1 or more At-Large Medical Staff Members.

17.2. CHARGE

- (a) Make recommendations to the ECCA, concerning the proper use of blood and blood components.
- (b) Monitor quality assurance related to the transfusion of blood and blood components and shall submit a report of these activities to the hospitals' Continuous Quality Improvement Program Coordinating Team.
- (c) Review and report all hemolytic transfusion reactions occurring in the UMHHC facilities and, based on the investigations, make recommendations, if necessary, for improvement of blood transfusion practices.

- (d) Review blood utilization and availability patterns in the UMHHC facilities and recommend changes or modifications to enhance the adequacy and efficiency of transfusion services.
- (e) Monitor the utilization of the Transfusion and Apheresis area, blood donation options and recommend institution of new procedure.

17.3. MEETINGS AND RECORDS

The Transfusion Committee will meet when called by the chair, but at least twice per year. The committee will record its activities in meeting minutes and an annual report, which will be submitted to the OCA and to the ECCA. Meeting summaries will be available to the OCA. A presentation of the annual report to the ECCA will be at the discretion of the committee chair.

Revisions to the Medical Staff Bylaws Rules and Regulations were:

Amended and Approved by the Bylaws Committee:	10/18/2010
Approved by the Medical Staff of the University of Michigan Hospitals and Health Centers:	11/9/2010
Approved by the Executive Committee on Clinical Affairs:	4/12/2011
Approved by The Hospitals and Health Centers Executive Board:	5/23/2011
Approved by the Board of Regents of the University of Michigan	6/27/2011

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