Medical Staff Bylaws
UC San Diego Health
Organizational Policy
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PREAMBLE

This Organizational Policy is adopted in recognition of the University of California San Diego Health Medical Staff’s responsibility for overseeing, on behalf of the Governing Body, the quality of patient care, treatment, and services provided by Members of the Medical Staff at UCSDH. Through this Policy, the Medical Staff provides a comprehensive list of all Services and committees of the Medical Staff. This Policy also sets forth the process to grant membership to the various committees, outlines each committee’s role and responsibilities, and provides guidance regarding the conduct of meetings by each Service and committee of the Medical Staff.

DEFINITIONS

The definitions that apply to the terms used in this Policy are set forth in the UC San Diego Health Medical Staff Bylaws.
ARTICLE 1
OFFICERS OF THE MEDICAL STAFF AND GOVERNANCE

The Officers of the Medical Staff and the elements of Medical Staff governance are set forth in the Bylaws.
ARTICLE 2
CLINICAL SERVICES

2.1 Clinical Services

A. These are the Clinical Services of the Medical Staff. Each Service shall be represented by one Medical Staff Service Chief:

1) Anesthesiology
2) Dermatology
3) Emergency Medicine
4) Family Medicine and Public Health
5) Medicine
6) Neurosciences
7) Neurosurgery
8) Ophthalmology
9) Orthopaedic Surgery
10) Pathology
11) Pediatrics
12) Psychiatry
13) Radiation Medicine
14) Radiology
15) Obstetrics, Gynecology, and Reproductive Sciences
16) Surgery
17) Urology

2.2 Organization of Clinical Services

Pursuant to the Bylaws, subject to the approval of the Executive Governing Body, the MSEC may create new Services, eliminate Services, or otherwise reorganize the Service structure.

2.3 Functions and Responsibilities Of Clinical Services and Medical Staff Service Chiefs

The functions and responsibilities of Services and Medical Staff Service Chiefs are set forth in Article 7 of the Bylaws.
ARTICLE 3
COMMITEES OF THE MEDICAL STAFF

3.1 Overview of the Committees of the Medical Staff

A. The composition and duties of the MSEC is detailed in the Bylaws.

B. The committees described below shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Chief of Medical Staff or the MSEC to perform specified tasks. Any committee, whether standing or otherwise, that is carrying out all or any portion of a function or activity required by the Bylaws, is deemed a duly appointed and authorized committee of the Medical Staff and subject to protections afforded under federal and state law, including, but not limited to California Evidence Code, Section 1157.

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing Medical Staff representation on UCSDH committees established to perform such functions.

C. Appointment of Standing Committee Members

1) With the exception of the MSEC and unless otherwise stated in this Policy, all committee Chairs and committee members shall be appointed by the Chief of Medical Staff.

2) With the exception of the Interdisciplinary Practices Committee (IPC), all Chairs shall be Active Staff. The IPC shall be chaired by an APP.

3) Each standing committee of the Medical Staff is composed of members as described in this Policy. Except as otherwise provided, committees established to perform Medical Staff functions may include any category of Members, APPs, and/or any other individuals at UCSDH with special expertise, depending upon the functions to be discharged. This shall include representatives from various UCSDH Departments, including Administration, Nursing Services, and/or Health Information Services.

4) Each Member who serves on a committee participates with a vote unless the charge of the committee states otherwise. Non-Members sitting on or consulting to the committee have no vote. Committees will consist of an appropriate number of individuals to be effective, yet manageable in size.

5) A committee Chair, after consulting with the Chief of Medical Staff, may call on outside consultants or special advisors to assist the committee.
6) The Chief of Medical Staff may appoint a Vice Chair to fulfill the duties of the committee Chair in his/her absence and to assist as requested by the Chair. Vice Chairs shall be Active Staff, unless the MSEC votes to waive the requirement for a specific committee.

7) Each committee Chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee, unless there is a Conflict of Interest and recusal is required.

D. Terms and Removal of Committee Chairs

Unless otherwise specified, the committee Chair shall be appointed by the Chief of Medical Staff at the beginning of the Medical Staff year (July 1) for a term of one year, and may be reappointed annually. Any committee Chair who is appointed by the Chief of Medical Staff may be removed at any time and for any reason by the Chief of Medical Staff or by a majority vote of the MSEC.

E. Terms and Removal of Committee Members

Unless otherwise specified, a standing committee member shall be appointed by the Chief of Medical Staff, at the beginning of the Medical Staff year (July 1) for a term of one year, and may be reappointed annually. Any committee Member who is appointed by the Chief of Medical Staff may be removed at any time and for any reason by the Chief of Medical Staff or by a majority vote of the MSEC.

F. Vacancies

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

G. Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified in Article 4 of this Policy.

H. Accountability of Medical Staff Committees

All committees shall be accountable to the MSEC and the EGB.

I. Quorum

Unless otherwise specified, three (3) voting Members will constitute a quorum.

J. Conflicts of Interest

Every committee member, regardless of whether the person serves as an ex officio member, must disclose any Conflict of Interest. Committee members
will be required to disclose in writing to the MSEC, those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a Conflict of Interest with their activities or responsibilities on behalf of the Medical Staff and/or committee. In addition, committee members must identify any Conflict of Interest relating to a particular subject matter when that subject is discussed by the committee. Prior to participation in any discussion and/or vote regarding the issue, the member shall confer with the Chair to discuss the Conflict of Interest and determine what actions, if any, are necessary to address the Conflict. The member may recuse himself/herself from any discussion or action that may be impacted by the Conflict of Interest. Additionally, the Chair or members of the committee could request that the member recuse himself/herself. To the extent the committee members request that the individual member recuse himself/herself, a majority vote of the voting members is required to mandate the recusal.

K. Appointment of Members of Ad Hoc Committees

Ad Hoc committees shall be appointed from time to time by the Chief of Medical Staff and/or the MSEC as may be required to carry out the duties of the Medical Staff. Such committees have a focused purpose and shall report to the MSEC. Ad Hoc Committees related to corrective action are specified under Article 9 of the Bylaws, and Article 9 of the Fair Hearing Plan, and Article 3 of this Policy.

3.2 Standing Committees

A. All Standing Committees of the Medical Staff, except for the MSEC, are listed below. Any changes, additions, or modifications to Standing Committees will be considered and approved by the MSEC, as needed under the circumstances.

1) Ad Hoc Investigation Committee
2) Bylaws Committee
3) Credentials Committee
4) Interdisciplinary Practices Committee (IPC)
5) Medical Staff Professionalism Committee (MSPC)
6) PARS Peer Messenger Committee
7) Patient Care and Peer Review Committee (PCPRC)
8) Pharmacy and Therapeutics Committee
9) Physician Well-Being Committee (PWBC)
3.3 Ad Hoc Investigation Committee

A. Purpose

The Ad Hoc Investigation Committee is a group of Members that can be readily assembled to serve as fact finders to investigate various Medical Staff matters.

B. Membership

1) The Chair of the Ad Hoc Investigation Committee is the Vice Chief of Medical Staff.

2) The committee will consist of Members In Good Standing, nominated by their respective Medical Staff Service Chiefs and appointed by the Chief of Medical Staff.

3) There will be approximately one Member representing each Service.

4) Members appointed to this committee shall be appointed for terms of two (2) years to ensure continuity, renewable one time, for a total of four (4) years.

C. Duties

1) When an Investigation is initiated pursuant to the Bylaws and Fair Hearing Plan, in order to ensure that the Investigation is conducted in an expeditious manner, a minimum of two (2) members from this committee may be selected to perform the Investigation.

2) If possible, at least one of the committee members selected to participate in the Investigation shall be from the same specialty as the subject of the Investigation.

3) Nothing in this Policy prohibits a non-committee member from participating in the Investigation if appointed by the Chief of Medical Staff and/or the MSEC.

4) Committee members will receive an orientation to include an overview of the Bylaws, corrective action, California Evidence Code Section 1157, confidentiality, and indemnification.
D. Meetings

The Ad Hoc Investigation Committee shall meet as often as is necessary and shall maintain a record of its proceedings.

E. Reporting Relationship

The Ad Hoc Investigation Committee will report to the MSEC as needed.

3.4. Bylaws Committee

A. Membership

1) The Chair of the Bylaws Committee is the Past Chief of Medical Staff.

2) The Bylaws Committee shall be composed of the Chief of Medical Staff, Vice Chief of Medical Staff, Past Chief of Medical Staff, and the two (2) immediate Past Chiefs of Medical Staff who are still Active Staff.

3) Chief Medical Officer and/or his/her designated alternate shall also participate *ex officio* and without vote.

B. Duties

1) Review the Bylaws, Rules, Policies, Plans, and any forms as needed for accuracy, currency, and compliance with California law, The Joint Commission, other regulatory requirements, and UCSDH policies.

2) Evaluate any requests for modifications, additions, or changes to the Bylaws, Rules, Policies, Plans, and any forms, to determine whether such requests support institutional goals, and/or the promotion of patient health and safety.

3) Ensure that the Bylaws, Rules, Policies, and Plans are consistent with California law, The Joint Commission, other regulatory requirements, and UCSDH policies.

4) Recommend to the MSEC the need for new, revised, amended, or withdrawn Bylaws, Rules, Policies, Plans, forms, or other documents of the Medical Staff.

C. Meetings

The Bylaws Committee shall meet as frequently as needed but in no event less than annually, and shall maintain a record of its proceedings.
3.5 Credentials Committee

A. Membership

1) The Chair shall serve in his/her role for a period of two (2) years, renewable up to two (2) times, for a total of six (6) years.

2) The Vice Chair shall serve in his/her role for a period of two (2) years, renewable up to two (2) times, for a total of six (6) years.

3) To the extent possible, there will be approximately one Member of Active Staff representing each Service.

4) Particular consideration is to be given to Past Chiefs of Medical Staff, past Medical Staff Service Chiefs, and other Members knowledgeable in the credentialing and quality improvement processes.

5) Members appointed to this committee shall be appointed for terms of two (2) years to ensure continuity.

6) Non-Voting Members:
   i. The Chief Medical Officer and/or his/her designated alternate
   ii. The Chair of the IPC shall also serve on the committee without vote unless the matter relates to APPs.

B. Duties

1) Review and evaluate an applicant's professional and ethical qualifications for Membership on the Medical Staff.

2) Solicit and evaluate specific information about each Practitioner related to his/her quality of care, peer review, professional liability claims, and current Board Certification status.

3) Review the Service's assessment of an applicant's qualifications in relation to the Privileges requested.

4) Review and recommend the proctoring requirements associated with Privileges.

5) Consider and recommend action following receipt of the Medical Staff Service Chief's recommendation related to an applicant's request for appointment and/or reappointment.
6) Recommend to the MSEC any actions relating to Membership, Privileges, and/or corrective action for Practitioners.

7) Review and recommend forms for application and reappointment for Members and APPs.

8) Review and recommend the criteria and forms developed by Services for the delineation of Privileges.

9) Oversee, in conjunction with the Patient Care and Peer Review Committee, the Ongoing Professional Practice Evaluation (“OPPE”) and Focused Professional Practice Evaluation (“FPPE”) processes.

C. Meetings

The Credentials Committee shall meet as frequently as needed but in no event less than four (4) times per year, and shall maintain a record of its proceedings.

D. Reporting Relationship

The Credentials Committee reports as frequently as needed but in no event less than four (4) times per year to the MSEC.

3.6 Interdisciplinary Practices Committee (IPC)

A. Purpose

The IPC is a subcommittee of Credentials Committee that is primarily responsible for overseeing all credentialing and privileging of APPs.

B. Membership

1) The committee Chair must be an APP appointed by the Chief of Medical Staff in coordination with the Chief Nursing Officer.

2) The Chief Nursing Officer or his/her designated alternate shall serve on the committee. The Chief Nursing Officer shall appoint any nursing APPs serving on the committee.

3) An equal number of Active Staff and APPs shall serve as voting members of the committee.

4) The nursing APPs shall be appointed by the Chief Nursing Officer, including:
   i. At least one (1) Nurse Practitioner;
   ii. At least one (1) Certified Registered Nurse Anesthetist; and
iii. At least one (1) Certified Nurse Midwife.

5) The non-nursing APPs shall be appointed by the Chief of Medical Staff, including:

i. At least one (1) Clinical Psychologist

6) The Active Staff shall be appointed by the Chief of Medical Staff.

7) The Chief Medical Officer and/or his/her designated alternate shall serve on the committee ex officio and without vote.

C. Duties

1) Develop and recommend policies for APPs including, but not limited to, the appropriate scope of practice, and granting of expanded role Privileges to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of patients.

2) Review APP applications and credentials, and make recommendations to the Credentials Committee for advancement to the MSEC for granting and/or revoking such Privileges. Applications and requests for granting Privileges will be reviewed by a peer. For purposes of this committee, a peer is considered to be a person with equivalent qualifications.

3) Periodically review interdisciplinary practice programs, protocols, and policies.

4) Identify functions or procedures that require the formulation and adoption of “standardized procedures” pursuant to Section 2725 of the Business and Professions Code.

5) Review and approve standardized procedures covering APP practice.

6) Recommend policies and procedures for expanded role privileges for Registered Nurses, including assessing, planning, and directing the patients’ diagnostic and therapeutic care.

7) Participate in APP peer review and quality improvement. The committee may recommend corrective action when indicated against APPs in accordance with the Bylaws, Rules, Policies, and Plans.

8) Serve as a liaison between APPs and the Medical Staff.

D. Meetings

The IPC shall meet as frequently as needed but in no event less than four (4) times per year, and shall maintain a record of its proceedings.
E. Reporting Relationship

The IPC reports as frequently as needed but in no event less than four (4) times per year to the Credentials Committee.

3.7 Medical Staff Professionalism Committee (MSPC)

A. Purpose

The Medical Staff Professionalism Committee is charged with evaluating, educating, monitoring, and where necessary, improving the professional behavior of Practitioners of the Medical Staff.

B. Membership

1) The Chair shall serve in his/her role for a period of two (2) years, renewable up to two (2) times, for a total of six (6) years.

2) The Vice Chair shall be the Vice Chief of Medical Staff.

3) The Chief of Medical Staff will appoint at least three Active Members of the Medical Staff to serve on the MSPC for a term of two (2) years.

4) Each committee member’s term shall be renewable at the discretion of the Chief of Medical Staff. No committee member shall serve more than two (2) consecutive appointments, for a total of four (4) years.

5) The Chair of the PARS Peer Messenger Committee shall also serve on the MSPC as a voting member.

6) Non-Voting Members:

i. Chief Medical Officer and/or his/her designated alternate

ii. Vice Dean for Medical Education or Associate Dean for Graduate Medical Education and/or his/her designated alternate

iii. Chief Health Counsel, UC San Diego, and/or his/her designated alternate

iv. The Chair, in consultation with the Chief of Medical Staff, may appoint additional non-voting members as warranted.

C. Duties

1) Evaluate, educate, monitor and, where necessary, improve the professional behavior of Practitioners while encouraging a culture of professionalism and safety.
2) Recommend desired professionalism values and behaviors to the MSEC, and identify methods for educating Practitioners to achieve such values and behaviors.

3) Develop policies, procedures, and processes for the evaluation, review, and management of professionalism incidents.

4) Oversee the Vanderbilt Center for Patient and Professional Advocacy’s Colleague Observation Reporting System (“CORS”) program.

5) Identify opportunities for the Medical Staff, MSEC, and Chief of Medical Staff to improve professionalism and professional fulfillment at UCSDH, which may include education, training, feedback, and/or identifying operational issues.

6) Identify opportunities for the Medical Staff, MSEC, and Chief of Medical Staff to promote and improve equity, diversity, and inclusion among Members, Practitioners, and other members of the care team at UCSDH.

7) Receive, evaluate, and manage complaints regarding behavior exhibited by Practitioners.

8) Refer Practitioners, as necessary, to the Physicians’ Well-Being Committee, Patient Care and Peer Review Committee, MSEC, and/or any other Medical Staff committee as is appropriate.

9) Recommend and implement various interventions including collegial counseling, requiring that a Practitioner enter into a voluntary Professionalism Agreement, recommending courses or coaching, and/or provide referrals for assessments and monitoring.

D. Meetings

The MSPC shall meet as frequently as needed but in no event less than four (4) times per year, and shall maintain a record of its proceedings.

E. Reporting Relationship

The MSPC will report to the MSEC as needed.

3.8 PARS Peer Messenger Committee

A. Purpose

The PARS Peer Messenger Committee is a group of Members that serve as PARS peer messengers to conduct PARS intervention meetings with Practitioners associated with high numbers of patient experience complaints.
The messengers deliver feedback to the identified Practitioners, allowing those Practitioners the opportunity to self-correct.

B. Membership

1) The Chair of the PARS Peer Messenger Committee shall serve in his/her role for a period of two (2) years, renewable up to two (2) times, for a total of six (6) years.

2) The Vice Chair of the PARS Peer Messenger Committee is the Chief Experience Officer and/or his/her designee.

3) The committee will consist of Members In Good Standing appointed by the Chief of Medical Staff.

4) Non-Voting Members:
   i. Chief Medical Officer and/or his/her designated alternate
   ii. The Chair, in consultation with the Chief of Medical Staff, may appoint additional non-voting members as warranted.

C. Duties

1) Oversee the Vanderbilt Center for Patient and Professional Advocacy’s Patient Advocacy Reporting System (“PARS”) program at UCSDH.

2) Conduct peer to peer coaching when Practitioners are identified through the PARS program as being at greater risk for medical complications and patient/team dissatisfaction.

3) Develop policies, procedures, and processes for the evaluation, review, and management of PARS program data.

4) Conduct training and offer resources to allow Practitioners to become more aware of potential safety, quality, or risk management issues and assist in promoting positive change.

D. Meetings

The PARS Peer Messenger Committee shall meet as often as is necessary and shall maintain a record of its proceedings.

E. Reporting Relationship

The PARS Peer Messenger Committee will report to the MSEC as needed.
3.9 Patient Care and Peer Review Committee (PCPRC)

A. Purpose

The Patient Care and Peer Review Committee has oversight responsibility for patient care management at UCSDH.

B. Membership

1) The Chair shall serve in his/her role for a period of two (2) years, renewable up to two (2) times, for a total of six (6) years.

2) The Vice Chair shall serve in his/her role for a period of two (2) years, renewable up to two (2) times, for a total of six (6) years.

3) The Committee will be comprised of a Quality Improvement Representative from each Service represented on the MSEC.

4) Non-Voting Members:
   i. Chief Medical Officer and/or his/her designated alternate
   ii. Chief Nursing Officer or his/her designated alternate
   iii. Chief Quality and Patient Safety Officer or his/her designated alternate
   iv. The Chair, in consultation with the Chief of Medical Staff, may appoint additional non-voting Members as warranted.

C. Duties

1) Review and approve peer review plans including Service specific plans for UCSDH, Services, and Clinical Divisions.

2) Review and approve Service peer review reports and action plans, and refer performance issues requiring action to the MSEC, Credentials Committee, MSPC, or PWBC as appropriate.

3) Oversee Practitioner performance profiling activities and report results to the Credentials Committee and MSEC.

4) Review cases with multi-Service issues and systems failures, and direct corrective action plans.

5) Identify patient care issues that require the attention of the other Medical Staff Committees or other committees within UCSDH, and communicate findings and concerns directly with these bodies for appropriate evaluation and corrective action, if necessary.
6) Monitor corrective actions with reports to the MSEC.

7) Define and identify cases appropriate for intensive review or external peer review, and oversee those activities when necessary.

8) Oversee, in conjunction with the Credentials Committee, the OPPE and FPPE processes.

9) Review all cases involving deaths or removed tissue when the tissue is found to be normal or not consistent with the clinical diagnosis, and develop and implement measures to correct any issues identified.

D. Meetings

The PCPRC shall meet as frequently as needed but in no event less than four (4) times per year, and shall maintain a record of its proceedings.

E. Reporting Relationships

The PCPRC reports as frequently as needed but in no event less than four (4) times per year to the MSEC.

3.10 Pharmacy and Therapeutics Committee

A. Membership

1) The Chair of the Pharmacy and Therapeutics Committee is the Medical Director for Pharmacy Services.

2) At a minimum, the Committee will be comprised of Member representatives from the following Services: Anesthesiology, Medicine, Neurology, Psychiatry, Medical Oncology, Neonatology, and Surgery.

3) The following UCSDH committee chairs (or his/her designee) shall also participate as Members:

   i. Chair, Antimicrobial Utilization Committee

   ii. Chair, Oncology Pharmacy and Therapeutics Committee

   iii. Chair, Safe Medication Practices Committee

   iv. Chair, Anticoagulation Committee

4) The Chief Nursing Officer and/or his/her designee shall serve on the Committee.

5) The Chief Medical Officer and/or his/her designee shall serve on the Committee.
6) The CEO and/or his/her designee shall serve on the Committee.

7) The following UCSDH Department administrators shall also participate as members:
   
   i. Associate Chief Pharmacy Officer (Acute Care)
   
   ii. Pharmacy Specialist, Medication Use Policy
   
   iii. Director of Regulatory or his/her designee
   
   iv. Chief Pharmacy Officer

8) Members of the House Staff shall also participate *ex officio* and without vote.

B. Duties

1) Develop and review policies and procedures for establishment of safe and effective systems for procurement, storage, labeling, distribution, administration, monitoring, and use of medications.

2) Develop and maintain a formulary of medications for use throughout UCSDH to assure quality pharmaceuticals at reasonable costs.

3) Serve as an advisory group in matters pertaining to choice of medications and their dosage forms available at UCSDH.

4) Revise and make available regularly a formulary of medications available for use at UCSDH focusing on providing the most efficacious and economical selection of agents.

5) Provide oversight for the medication management systems, including identifying risks and implementing processes to reduce risk and improve patient safety.

6) Inform regularly the nursing and Medical Staff of changes in policy and the drug formulary and information on new medication products.

7) Review regularly the policies and procedures of the Pharmacy.

8) Review regularly all standing orders at UCSDH, and review and approve any new standing orders.

9) Review regularly the contents of emergency medication supplies. Review and approve any proposed changes in the content of these products, and any policies and procedures for maintaining and stocking them.
10) Review medication utilization, Adverse Drug Reactions, and medication errors, provide practice pattern information to the Service Chiefs, and undertake appropriate educational processes and limitations of medication usage to ensure optimal safety, efficacy, and economy of medication use.

11) Oversee the activities and duties of the investigational drug pharmacist.

12) Serve as an advisory group in developing policies relating to the conduct of pharmaceutical manufacturer’s representatives, sampling policies, and medication displays at UCSDH.

13) Develop and promote safe medication practices that comply with regulatory requirements and reporting responsibilities.

14) Evaluate the services provided at UCSDH and make appropriate recommendations to the MSEC and UCSDH Administration.

C. Meetings

The Pharmacy and Therapeutics Committee shall meet as frequently as needed but in no event less than four (4) times per year and shall maintain a record of its proceedings.

D. Reporting Relationship

The Pharmacy and Therapeutics Committee reports as frequently as needed but in no event less than annually to the MSEC.

3.11 Physician Well-Being Committee (PWBC)

A. Purpose

The mission of the PWBC is to promote the well-being of Practitioners consistent with the obligation of the Medical Staff to protect patients, assure quality of patient care, and improve Medical Staff functioning. The PWBC strives to achieve this purpose by creating an environment and consultation mechanisms that are conducive to referral, self-referral, and rehabilitation of Practitioners who may be suffering from a medical, cognitive, mental health, behavioral, or substance-use related problem that poses or could pose a threat to patient care, self, and/or others.

B. Membership

1) The Chair shall serve in his/her role for a period of two (2) years, renewable up to two (2) times, for a total of six (6) years.

2) The Vice Chair shall serve in his/her role for a period of two (2) years,
renewable up to two times, for a total of six (6) years.

3) Members shall be selected for specific expertise, experience, and willingness to serve.

4) An effort should be made to appoint members from several specialties including Practitioners with expertise in addiction medicine and rehabilitation.

5) Insofar as possible, a member shall not serve on both on the PWBC and any peer review or quality improvement committee of the Medical Staff. Additionally, insofar as possible, a member shall not serve on PWBC if he/she is responsible for taking any disciplinary action(s) related to House Staff.

6) Members appointed to this Committee shall be appointed for terms of two (2) years to ensure continuity.

C. Duties

1) Be known by the UCSDH community as the resource where information and concern about the health of a Practitioner or House Staff can be delivered for confidential consideration and evaluation.

2) Educate Committee members, the staff of UCSDH, and Practitioners about Practitioner health, well-being and impairment, appropriate responses to different levels and kinds of distress and impairment, treatment, recovery and monitoring, the responsibilities of the Medical Staff in response to concerns about a Practitioner's health, the importance of early intervention, and appropriate resources for prevention, treatment, rehabilitation, monitoring, and re-entry.

3) Receive self-referrals by the Practitioner or House Staff, as well as referral by others while maintaining reporter confidentiality.

4) Evaluate the credibility of a complaint, allegation, or concern related to Practitioner or House Staff well-being.

5) Make recommendations and provide referral for the Practitioner or House Staff to appropriate internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

6) Monitor the Practitioner or House Staff until the rehabilitation is complete and periodically thereafter, if warranted.

7) Develop a monitoring plan for the Practitioner or House Staff, and coordinate with the appropriate resources to ensure compliance.
8) Take appropriate action when a Practitioner or House Staff fails to complete a required rehabilitation program or comply with his/her monitoring plan.

9) Assist providers with issues of re-entry to the workplace.

10) Assist the Practitioner or House Staff in meeting ethical obligations to assure quality of care and patient safety.

11) Maintain confidentiality unless the committee receives information that demonstrates that the health or impairment of the Practitioner or House Staff may pose a risk of harm to self, patients, or others, in which case the matter and information will be referred to the Chief of Medical Staff, or for House Staff, to the Associate Dean for Graduate Medical Education, who will determine whether corrective action is necessary.

D. Meetings

The PWBC shall meet as frequently as needed but in no event less than four (4) times per year, and shall maintain a record of its proceedings.

E. Reporting Relationship

The PWBC reports as frequently as needed but in no event less than four (4) times per year to the MSEC.

3.12 Quality Council

A. Purpose

The Quality Council was established to develop and accomplish the Performance Improvement & Patient Safety (“PI&PS”) Plan. The Quality Council provides direction, leadership, and oversight of the quality of services provided at UCSDH.

B. Membership

1) The Chair of the Quality Council is the ACMO for Quality & Safety.

2) The Vice Chair of the Committee will be appointed by the COMS in coordination with the ACMO for Quality & Safety.

3) At a minimum, the Committee will be comprised of Member representatives from the following Services, Clinical Divisions, and UCSDH departments: Quality and Safety, Information Services, Inpatient Operations, Medical Education, Medical Informatics, Infection Control, Population Health, Ambulatory Operations, and Medical/Surgical Specialties.
4) At a minimum, the Committee will be comprised of representatives from the following UCSDH departments: Nursing, Risk, and Regulatory Affairs.

5) Members shall be selected for specific expertise, experience, and willingness to serve.

6) Non-Voting Members:
   i. The Chief Nursing Officer or his/her designated alternate shall serve on the committee.
   ii. The Chief Medical Officer and/or his/her designated alternate shall serve on the Committee.
   iii. The Chief Administrative Officer-Operations shall serve on the Committee.
   iv. The Chief Quality and Patient Safety Officer shall serve on the Committee.
   v. The Chair, in consultation with the Chief of Medical Staff, may appoint additional non-voting Members as warranted.

C. Duties

1) Provide strategic direction, leadership, and oversight of the quality of services provided at UCSDH.

2) Oversee the implementation of the strategic plan including the mission, vision, and goals as they relate to the delivery of quality services.

3) Oversee the development of UCSDH’s annual PI&PS plan ensuring effective integration and execution of quality and patient safety activities throughout UCSDH.

4) Integrate the communication and activities of the various Medical Staff committee efforts which are directed towards performance improvement and patient safety efforts.

5) Ensure that The Joint Commission, California Title 22, and other regulatory requirements for quality of care are met.

6) Communicate to the MSEC the spectrum of quality, patient safety, and performance improvement activities of UCSDH, including activities of its reporting committees.
7) Evaluate the services provided by the Intensive Care Newborn Nursery (NICU) and make recommendations, as appropriate, to the MSEC and UCSDH Administration.

8) Determine what emergency equipment and supplies should be available in all areas of UCSDH.

9) Develop and institute, in conjunction with Medical Staff Members and other UCSDH departments, a continuing cardiopulmonary resuscitation training program.

D. Meetings

The Quality Council shall meet as frequently as needed but in no event less than four (4) times per year, and shall maintain a record of its proceedings. A quorum shall be achieved by ten (10) committee members.

E. Reporting Relationship

The Quality Council reports as frequently as needed but in no event less than annually to the MSEC.

3.13 Utilization Review Committee

A. Purpose

The Utilization Review Committee has oversight responsibility for utilization review at UCSDH. This multidisciplinary committee works collaboratively to help ensure appropriate use of resources and services for the optimal health benefit of patients and at reasonable costs to the patients, UCSDH, and third party payers.

B. Membership

1) The Chair of the Committee will be appointed by the COMS in consultation with the Chief Medical Officer.

2) Members shall be selected for specific expertise, experience, and willingness to serve.

3) At a minimum, the Committee will be comprised of at least five physician Member representatives from the following Services and Clinical Divisions: Surgery, Medicine, Emergency Medicine, OB/GYN, Family Medicine.

4) Chief Medical Information Officer and/or his/her designated alternate

5) Chief Medical Officer and/or his/her designated alternate
6) Critical Care Division Chief, Department of Anesthesia and/or his/her designated alternate

7) Physician Advisor representative(s) from Care Management

8) Representative(s) from Hospital Medicine

9) Non-Voting Members:
   i. Chief Compliance Officer and/or his/her designated alternate
   ii. Director, Care Management and/or his/her designated alternate
   iii. Chief Quality and Patient Safety Officer and/or his/her designated alternate
   iv. Nursing Representatives
   v. Decision Support Analysts
   vi. Executive Director of the Business Office and/or his/her designated alternate
   vii. The Chair, in consultation with the Chief of Medical Staff, may appoint additional non-voting Members as warranted.

C. Duties

1) Provide oversight of utilization of resources related to patient care.

2) Develop and implement institution-wide utilization improvement projects.

3) Review and evaluate data regarding resource utilization commensurate with quality patient care and safety.

4) Create focused multidisciplinary teams to develop and implement strategies to improve quality and conserve fiscal resources.

5) Establish and oversee the Utilization Review Plan.

6) Communicate pertinent data and results to the MSEC.

D. Meetings

The Utilization Review Committee shall meet as frequently as needed and as often as directed by the Utilization Review Plan. The committee shall maintain a record of its proceedings.
E. Reporting Relationship

The Utilization Review Committee reports as frequently as needed but in no event less than annually to the MSEC.

3.14 Special Committees

The Chief of Medical Staff shall appoint such special committees as may be necessary for the proper functioning of the Medical Staff. The appointment of such special committees shall be reviewed and approved annually.

3.15 Joint Conference Committee

A. Duties

The Joint Conference Committee is an ad hoc Committee that may be constituted and convened in the case of conflict between the Medical Staff and the Executive Governing Body.

B. Membership

The membership of the Joint Conference Committee shall be composed of representation consisting of current Officers, and an equal number of members of the Executive Committee of the EGB. All committee members have equal vote. The chairperson of the committee is the Vice Chancellor, UC San Diego Health Sciences.

C. Meetings

The Joint Conference Committee shall only meet when necessary to assist in dispute resolution. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee.

D. Reporting Relationship

The Joint Conference Committee is directly accountable to the MSEC and the EGB.
ARTICLE 4
MEETINGS

4.1. Medical Staff Meetings

A. Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Medical Staff, MSEC, or upon the written request of ten (10) percent of the Active Staff. The meeting must be called within thirty (30) calendar days after receipt of such request. No business shall be transacted at any Special Meeting except that stated in the notice calling the meeting.

B. Combined or Joint Medical Staff Meetings

The Medical Staff may participate in combined or joint Medical Staff meetings with other hospitals or healthcare entities owned and operated by The Regents; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff, through its authorized representative(s), maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

4.2. Clinical Service Meetings

A. Regular Clinical Service Meetings

Each Service shall meet as often as necessary to review and discuss patient care activities and to fulfill other Service responsibilities. Services may hold regular meetings and, if so, no other notice shall then be required.

B. Special Clinical Service Meetings

A special meeting of any Service may be called by, or at the request of, the Medical Staff Service Chief thereof, the MSEC, Chief of Medical Staff, or by 1/3 of the committee's current Members, but not fewer than three (3) Members. No business shall be transacted at any special meeting of the Service except that stated in the notice calling the meeting.

C. Combined or Joint Clinical Services Meetings

The Services may participate in combined or joint Clinical Service meetings with other hospitals or healthcare entities owned and operated by The Regents; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff, through its authorized representative(s), maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.
4.3. Notice of Meetings

A. Meetings of the Medical Staff

Notice stating the place, day and hour of any regular Medical Staff meeting shall be delivered, either personally, electronically or by mail, to the Active Staff no later than thirty (30) calendar days before the meeting. Written notice of a special Medical Staff meeting shall be delivered either personally, electronically, or by mail to each person entitled to be present not fewer than 2 Days nor more than forty-five (45) calendar days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

B. Other Committee Meetings

Written notice of a regular or special committee meeting, not held pursuant to resolution, shall be delivered either personally, electronically, or by mail to each person entitled to be present not fewer than one (1) Day nor more than forty-five (45) calendar days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

4.4. Quorum

A. Medical Staff Membership - Special Meetings

The presence of twenty-five (25) percent of the voting Medical Staff at any special meeting of the Medical Staff shall constitute a quorum.

B. Other Medical Staff Committee Meetings

At the discretion of the Committee Chair, individuals participating by telephone or video link shall be counted for purposes of establishing a quorum. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members.

4.5. Manner of Action

Except as otherwise specified, the action of a majority of the Members present and voting at a meeting at which a quorum is present shall be the action of the group. Valid action may also be taken without a meeting utilizing electronic vote by no fewer than three (3) of the voting members of the committee. The committee Chair shall refrain from voting except when necessary to break a tie.

4.6. Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of Members, the decision that was carried, forwarded to the MSEC or other designated Committee, and shall be available to the MSEC and Executive Governing Body. Each
Committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from civil discovery, as provided by California law.

4.7. Attendance Requirements

A. Regular Attendance Requirements

There are no specific attendance requirements for Medical Staff and Service meetings, unless expressly set forth in this Policy. Members are encouraged to attend Medical Staff and Service meetings and when unable to attend, are expected to be knowledgeable regarding Medical Staff and Service activities.

B. Required Appearance of Practitioner at Committee Meetings

A committee, at its discretion, may require the appearance of a Practitioner at a committee meeting. If possible, the Chair of the committee should give the Practitioner at least five (5) calendar days’ advance notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice and/or behavior, the notice to be given shall include a statement of the issue involved and that the Practitioner’s appearance is mandatory. Failure of a Practitioner to appear at any meeting with respect to which he or she was given such notice shall (unless excused by the MSEC upon a showing of good cause) result in an automatic suspension of the Practitioner’s privileges as the MSEC specifies. The automatic suspension shall remain in effect until the Member has provided the requested information to the satisfaction of the requesting committee and/or satisfied the special attendance requirement to the satisfaction of the requesting committee.

C. Attendance of Practitioner at Committee Meetings

Any Member who is In Good Standing may ask the Chair of any committee for permission to attend a portion of that committee’s meeting dealing with a matter of importance to that Member. The committee Chair shall grant the request unless the committee’s work is considered sensitive or confidential. If the request is granted, the invited Member shall abide by the Bylaws, the Organizational Policy, and/or any Medical Staff Rules, Policies, or Plans applicable to that committee, and shall have no vote.