INFORMATION ABOUT THE POSITIONS OPEN FOR NOMINATION

Please see excerpts from our bylaws, below, which will describe the positions which are up for nominations. Feel free to contact me or Geoff Rubin directly with any questions or to nominate yourself or a colleague.

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VICE CHIEF OF STAFF

ARTICLE TEN
OFFICERS OF MEDICAL STAFF

Vice Chief of Staff Duties:

The Vice- Chief of Staff shall:

1. Assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff;
2. Serve as Chair of the Bylaws Committee.
3. Serve as Medical Staff Treasurer and Chair of the Medical Staff Finance Committee. Prepare regular financial reports and present to Medical Executive Committee.
4. Serve as a voting member of the Medical Executive Committee.
5. Serve as ex-officio member of all other Medical Staff Committees, without vote, unless so designated by the Bylaws of the Medical Staff.
6. Perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.

Chief of Staff Duties

The responsibilities of the Chief of Staff or his/her designee shall include, but are not limited to:

a. Enforcing the Medical Staff Bylaws, Rules and Regulations, implementing sanctions when indicated, and ensuring compliance with procedural safeguards where corrective action has been warranted;
b. Performing oversight of Medical Staff clinical activities within SHC, including quality improvement, credentialing and privileging, patient safety, and utilization management;
c. Calling and arranging for all meetings of the Medical Staff and the Medical Executive Committee;
d. Serving as chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

e. Developing and implementing methods for Medical Staff Performance Improvement activities within SHC, including quality assurance, credentialing and privileging, and utilization management;

f. Serving as an ex-officio member of all other Medical Staff committees, without vote, unless so designated by the Bylaws of the Medical Staff;

g. Working collaboratively with SHC Administration and the Stanford Hospital and Clinics Board of Directors in all matters of mutual concern within SHC;

h. Appointing, in consultation with the Medical Executive Committee, the members of all Medical Staff committees and designating the Chairs of the committees, unless otherwise provided for by these Bylaws;

i. Representing the Medical Staff to the Stanford Hospital and Clinics Board of Directors outside licensing and accreditation agencies, and the public;

j. Communicating and representing the opinions, needs, and grievances of the Medical Staff to the Medical Executive Committee, the President and CEO, the Medical Center Council, if applicable, and the Stanford Hospital and Clinics Board of Directors.

k. Appointing Associate Chiefs of Staff as may be necessary to fulfill the tasks of the Medical Staff after approval by the Medical Executive Committee.

l. Being a spokesperson for the Medical Staff in external professional and public relations;

m. Serving as liaison to the Hospital Board of Directors, the Executive Committee of the School of Medicine, the Graduate Medical Education Committee, and outside licensing or accreditation agencies.

n. Performing such other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, or by the Medical Executive Committee.

o. Managing and monitoring Medical Staff funds including Medical Staff dues and budget for leadership stipends.

p. In the interim between Medical Executive Committee meetings, performing those responsibilities of the Medical Executive Committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the Medical Executive Committee;

MEMBERS at LARGE of MEDICAL EXECUTIVE COMMITTEE

ARTICLE ELEVEN
MEDICAL EXECUTIVE COMMITTEE

11.1 RESPONSIBILITIES
The Medical Executive Committee is a committee of the Medical Staff which serves as the Staff’s Executive Committee and is empowered to act for the Medical Staff in the intervals between Medical Staff meetings.

A. In addition to such other responsibilities as are set forth in these Bylaws, the Medical Executive Committee shall:

1. Receive and act upon reports and recommendations from the Medical Staff Committees, Graduate Medical Education Committee, SHC Departments, Clinical Services, and ad hoc committees.

2. Designate ad-hoc Bylaws Committee to conduct annual review of the Medical Staff bylaws and present recommended revisions to Medical Executive Committee. The Vice Chief of Staff will serve as Chair of this committee.

3. Receive and act upon reports and recommendations from the Medical Staff Finance Committee.

4. Receive and act upon all quality and utilization management monitoring reports including infection control; blood and transfusion; surgical case review; mental health services; medical records; case management; and clinical laboratory.

5. Subject to the authority of the Medical Staff, determine all professional medical policies of SHC.

6. With the Service Chiefs, set Service objectives for establishing, maintaining, and enforcing professional standards within the Hospital, for the continuing improvement of the quality of care rendered in the Hospital, and assisting in developing programs to achieve these objectives.

7. Recommend to the Stanford Hospital and Clinics Board of Directors all matters relating to Medical Staff structure and mechanisms used to review credentials and to delineate clinical privileges for appointments and reappointments, recommend individuals for Medical Staff membership and clinical privileges and for Service assignments and recommend mechanisms for termination and corrective action when appropriate.

8. Request evaluations of practitioners privileged through the Medical Staff credentialing process in instances where there is doubt about an applicant’s ability to perform the privileges requested.

9. Recommend to the Board of Directors matters regarding the structure of the Medical Staff; and advise on sources of clinical services to be provided by consultation, contractual arrangements, or other agreements.

10. Be responsible for creating the appropriate Medical Staff committee structure to carry out the necessary duties.

11. Be accountable to the Stanford Hospital and Clinics Board of Directors for the quality of medical care, and for the organization of performance improvement activities of the Medical Staff including the mechanism used to conduct evaluate, and revise such activities, and reporting of outcomes of Medical Staff performance improvement programs with sufficient background and detail to assure the Board that quality of care is consistent with professional standards.

12. Take reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted.
13. Assist in obtaining and maintenance of accreditation.

14. Inform the Medical Staff regarding the status of accreditation and licensure of the SHC.

15. Develop and maintain methods for the protection and care of patients and others in the event of internal or external disaster.

16. In accordance with Section 13.5.A, and in conjunction with the Medical Staff Finance Committee, establish the amount of annual dues, if any, for each category of Medical Staff membership and an annual budget for the Medical Staff Dues Account.

17. Resolve disputes regarding expenditures from the Medical Staff Dues Account.

18. Determine a processing fee, if any, to be charged to any applicant for Medical Staff membership.

19. Recommend the mechanism for corrective action and fair hearing procedures.

20. Establish mechanism for dispute resolution between medical staff members involving the care of a patient.

21. Recommend to the Board of Directors minimum requirements for malpractice insurance coverage for members of the Medical Staff.

22. Have the right to conduct a review of any SHC policy (existing or proposed) for its implications to the Medical Staff, and, if changes are deemed necessary, consult with the SHC Vice President for Medical Affairs. If no agreement on changes is reached, the issue shall be referred to the Joint Conference Committee.

11.3 COMPOSITION

A. VOTING MEMBERSHIP

The voting membership of the Medical Executive Committee shall consist of the Chief of Staff, who shall serve as the Chairperson, the Chiefs of each of the Clinical Services, the Deputy Chiefs, the Credentials Committee Chairperson, the Division Head of Emergency Services, five (5) members at large elected by the eligible voting members of the Medical Staff, and the Deputy Chiefs of the clinical services. The Dean of the Stanford University School of Medicine, President and CEO, Vice Presidents of Patient Care Services, Clinical Services and Compliance shall be ex-officio, non-voting members of the Medical Executive Committee.

All physician members of the Medical Executive Committee must be Active members of the Medical Staff in good standing, and be Board Certified (or equivalent).

B. ELECTED MEMBERSHIP

The procedure for electing the five (5) members-at-large from the Active Medical Staff to serve on the Medical Executive Committee shall be as follows:

1. Nominations
   a. The Nominating Committee will solicit names of eligible nominees from the Medical Staff. The Nominating Committee will then review the list of nominees, determine whether they are eligible to serve on the Medical
Executive Committee and are willing to do so, and then submit a list of nominees to the Medical Executive Committee.

b. The Medical Executive Committee, after receiving recommendations from the Nominating Committee, shall submit to the Medical Staff a list of qualified nominees for the elected positions on the Medical Executive Committee.

2. Election

The elected members-at-large shall be those individuals receiving the highest number of votes of the eligible voting members of the Medical Staff voting in the election. All elections shall be held in accordance with the Medical Staff Election Policy.

The five (5) elected members-at-large shall each serve three (3) year terms. They may be re-elected. In order to provide an on-going rotation, two (2) such members shall be elected one year and three (3) the next.

MEDICAL STAFF COMMITTEES

ARTICLE TWELVE
COMMITTEES OF THE MEDICAL STAFF

12.8 MEDICAL STAFF STANDING COMMITTEES

The Standing Committees of the Medical Staff of SHC shall be the following:

A. CARE IMPROVEMENT COMMITTEE

1. Purpose

The purpose of the Care Improvement Committee is to provide a forum for the Medical Staff to assess the quality, appropriateness, and efficacy of treatment services. The committee will review the quality and appropriateness of treatment services provided by members of the healthcare team. The goal of the peer review process is to continuously improve treatment services within the system. The peer review process highlights the challenges that enhance or impede treatment providers as they strive to provide quality services. The Committee shall be responsible for overseeing the Peer Review Process for the Medical Staff.

2. Duties

In addition to the items described in Section 12.2, “Duties Generally”, the duties of the Care Improvement Committee shall include, but are not limited to:

a. Identifying opportunities for improvement in quality of care and clinical performance in both the inpatient and outpatient settings.

b. Reviewing or delegating to other appropriate committees or Departments, review of patient complaints, incident reports, or other matters involving quality of care and clinical performance, and ensuring
that appropriate action is taken for identified problems.

3. Composition

Membership of this Committee shall be composed of representatives of the major Clinical Services of the Medical Staff and the Chief of Staff, both of whom shall serve as voting members. In addition, there will be ex-officio members from Nursing, Quality Improvement and Patient Safety, Risk management, Medical Staff Services, and SHC Administration. Services not represented on the committee will be invited when cases from that service are being studies. The Committee Chair will be either the Chief of Staff or Chief of Staff designee.

4. Meeting Frequency

The Committee shall meet monthly, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting Frequency

The Committee shall report to the Medical Executive Committee, covering its activities and outcomes.

B. CANCER STEERING COMMITTEE

1. Purpose

The Cancer Steering Committee will follow the requirements outlined in the most current American College of Surgeons Commission on Cancer Program Standards.

2. Duties

In addition to the items described in Section 12.2, “Duties Generally”, the duties of the Clinical Cancer Center Steering Committee shall include, but are not limited to:

a. Is responsible and accountable for all clinical cancer program activities of Stanford Hospital and Clinics.

b. Designates one coordinator for each of the four areas of cancer committee activity: cancer conference, quality control of cancer registry data, quality improvement, and community outreach. The Cancer Liaison Physician fulfills the role of the community outreach coordinator.

c. Develops annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care.

d. Monitors and evaluates annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors on an annual basis.

e. Establishes the cancer conference frequency, format, and multidisciplinary attendance requirements for cancer conferences on an annual basis.

f. Ensures that the required number of cases are discussed at cancer conferences and that at least 75 percent of the cases discussed at cancer conferences are presented prospectively.
g. Monitors and evaluates the cancer conference frequent, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis.

h. Establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis.

i. Completes site-specific analyses that include comparisons and outcome data and disseminates the results of the analysis to the Medical Staff.

j. Reviews 10 percent of the analytic caseload to ensure that 90 percent of cancer pathology reports include the scientifically validated data elements outlined in the CAP protocols.

k. Provides a formal mechanism to educate patients about cancer-related clinical trials.

l. Reviews the percentage of cases accrued to cancer-related clinical trials each year.

m. Monitors community outreach activities on an annual basis.

n. Offers at least one cancer-related educational activity each year.

o. Completes and documents the required studies that measure quality and outcomes.

p. Implements annually two improvements that directly affect patient care.

q. Establishes subcommittees or workgroups as needed to fulfill cancer program goals.

3. Composition

The Cancer Steering Committee is multidisciplinary, representing physicians from the diagnostic and treatment specialties and non-physicians from administration and supportive services. The Committee includes at least one (1) physician member representing six major cancer sites (breast, prostate, lymphoma, lung, colon, hematology).

The cancer committee includes at least one (1) physician member from the required specialties: diagnostic radiology, pathology, general surgery, medical oncology, and radiation oncology.

The committee shall consist of at least one (1) non-physician member including: the Cancer Center administrator, an oncology nurse, a social worker, a member of the Cancer Concierge Service, a certified tumor registrar, and a representative from quality improvement and patient safety.

Additional physician or non-physician members include representatives from: pain management and palliative care, clinical research, and the American Cancer Society.

The Cancer Steering Committee chair is a physician who may also fulfill the role of one of the required physician specialties. The Cancer Liaison Physician must be a member of the cancer committee, and may fulfill the role of one of the required physician specialties.

4. Meeting Frequency

The Committee shall meet at least quarterly each year, but may meet more frequently as required to address overall program needs.
5. Reporting Frequency

The Committee shall report to the Medical Executive Committee through the QIPSC.

C. CREDENTIALS COMMITTEE

1. Purpose

The purpose of the Credentials Committee is to review the credentials of providers applying for initial appointment or reappointment to the Medical Staff at SHC, and to make recommendations for membership and delineation of privileges in compliance with the Medical Staff Bylaws, Credentialing Policies and Procedures, and Clinical Service requirements; review and approve new or revised credentials and privileges, forms and processes; review and approve credentialing policies and procedures. In addition, the Credentials Committee will review and act upon reports from the Interdisciplinary Practice Committee (IDPC) of appointment and evaluations of Allied Health Practitioners. The IDPC is a subcommittee of the Credentials Committee and is accountable to the Medical Executive Committee and the Governing Body.

2. Duties

In addition to the items described in Section 12.2, “Duties Generally”, the duties of the Credentials Committee shall include, but are not limited to:

   a. Reviewing the credentials of applicants and make recommendations for membership and delineation of privileges in compliance with these Bylaws.

   b. Reviewing reports from the Interdisciplinary Practice Committee on Allied Health Practitioners.

   c. Reporting to the Medical Executive Committee on individual applicants for Medical Staff membership or privileges, including specific consideration of the recommendations from the Chiefs of Services in which such applicant requests privileges, appointment, reappointment, and assignment of members to various Departments or Services as provided by these Bylaws.

   d. When appropriate, interviewing a member or applicant and/or the Chief of the involved Service when differences arise concerning appointment, reappointment, or change in privileges, and attempt to resolve such differences.

   e. Developing, reviewing, and revising credentialing and privileging forms and processes, and review and approve credentialing policies and procedures.

3. Composition

Voting membership of this committee shall include at least eight (8) members of the Medical Staff, including a member from the Psychiatry Service, who shall be chosen to ensure representation from major clinical areas. Ex-officio members include VP, Clinical Services; Director, Medical Staff Services; representation from Quality Improvement and Patient Safety.

4. Meeting Frequency
The Committee shall meet monthly, but may meet more frequently or be canceled as determined by the Chairman.

5. Reporting Frequency

The Committee shall make a monthly report to the Medical Executive Committee covering its activities and recommendations.

D. CRITICAL CARE COMMITTEE

1 Purpose

The purpose of the Critical Care Committee is to improve the quality of care, treatment and services for Stanford Hospital and Clinics’ patients, to provide a forum for SHC Medical Staff and employees and to provide oversight and take action on issues related to the critical care services to patients in the intensive care units, cardiac care units, and trauma units. In addition, the committee is charged with recommending policies, procedures, and process improvements for appropriate delivery of critical care services including oversight and evaluation of the code blue process throughout the hospital. The Committee is accountable to the Medical Executive Committee, through the QIPSC, and its scope includes the care provided in the East and North Intensive Care Units and in the Coronary Care Unit. Important problems and issues relating to care in these units will be evaluated and solutions identified.

2 Duties

In addition to the items described in Section 12.2, “Duties Generally”, the duties of the Critical Care Committee shall include, but are not limited to such items as are described in the Committee Charter.

3 Composition

Membership of this committee shall include the Medical Directors of the Medical/Surgical Intensive Care Unit E2, North ICU, and a broad representation of the specialties using the Intensive Care Units. It shall include, at a minimum, representation from Nursing, SHC Administration, Medical Service, Surgical Service, Anesthesia, and Cardiovascular Surgery. The committee is chaired by the Medical Director of the Intensive Care Units.

4 Meeting Frequency

The Committee shall meet quarterly, but may meet more frequently or be canceled as determined by the Chairman. Subcommittees of the Critical Care Committee, supplemented by additional members as required, will meet at least monthly.

5 Reporting Frequency

The Committee shall make a report to the Medical Executive Committee, through QIPSC, covering its activities and outcomes.

E. ETHICS COMMITTEE

1 Purpose

The purpose of the Ethics Committee is to provide advice, consultation, guidance and education about the ethical aspects of the provision of medical treatment. The Committee’s role is advisory in nature and shall not usurp the decision-making prerogative of attending physicians and their patients.
2. Duties

In addition to the items described in Section 12.2, "Duties Generally", the duties of the Ethics Committee shall include, but are not limited to:

a. Providing timely advice and consultative services, on request, to improve understanding, facilitate deliberation, and assist in the resolution of specific clinical ethical issues and value conflicts.

b. Making recommendations that would address chronic or recurring ethical issues of a systemic nature.

c. Generating and reviewing hospital and institutional policies that involve ethical issues.

d. Developing and fostering collaborative relationships with LPCH and local hospital Ethics Committees, as well as county and professional medical societies, as appropriate.

e. Providing medical ethics education to the members of the Committee, SHC, and the wider community.

3. Composition

Membership of this committee shall include members of the Medical Staff, the Chair of the Stanford SHC Committee on Ethics, and representatives from SHC Administration, Nursing, other health care professionals, chaplaincy, "in-training" house staff, and a lay member of the community. Stanford Hospital and Clinics legal services shall provide staff support for the Committee. The Committee is co-chaired by a Medical Staff Member and the Director of the Stanford Bioethics Center. The Committee may invite consultations from practitioners in various specialties on particular issues.

4. Meeting Frequency

The Committee shall meet monthly, but may meet more frequently or cancel occasional monthly meetings, as determined by the Chair(s).

5. Reporting Frequency

The Committee shall make a report to the Medical Executive Committee, through QIPSC, covering its activities and outcomes.

F. HEALTH INFORMATION MANAGEMENT COMMITTEE

1. Purpose

The purpose of the HIM Committee is to provide physician-based oversight to the acquisition, implementation, and use of Information Technology and Management Services, especially in regards to improving the overall quality of patient care, treatment, and services at SHC. The Committee is accountable to the Medical Executive Committee, through the QIPSC, and serves as a forum to identify important health information management and technology issues and develop plans and actions to address these concerns. The Committee shall operate by authorizing a set of working sub-committees which will focus on specific areas of concern. These sub-committees will report to the HIM Committee on a regular basis.
2. Duties

In addition to the items described in Section 12.2, "Duties Generally", the duties of the HIM Committee shall include, but are not limited to:

a. Developing and updating the SHC Information Management Plan.
b. Evaluating the process of computerizing health information at SHC.
c. Ensuring that SHC implements information privacy and security policies and management control procedures.
d. Reviewing and approving the development and implementation of medical record forms at SHC.
e. Monitoring how the SHC medical community documents patient care and taking actions to improve the effectiveness and usefulness of clinical documentation.
f. Providing feedback to HIM and IT Departmental operations.

3. Composition

Membership on the HIM Committee shall include representatives from Hospital Administration, Clinic Administration, the department of Health Information Management Services, the department of Information Management and Technology, the Medical Staff, and Nursing Administration.

4. Meeting Frequency

The Committee shall meet quarterly, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting Frequency

The Committee shall report to the Medical Executive Committee, through the QIPSC, covering its activities and outcomes.
G. INFECTION CONTROL COMMITTEE

1. Purpose

The Infection Control Committee oversees, in conjunction with the Infection Control and Epidemiology Department, the program for surveillance, prevention, and control of infection for Stanford Hospital and Clinics' departments/services, medical and nursing staffs, and administration. The scope of this commitment includes care of patients, personnel health, and the environment.

2. Duties

In addition to the items described in Section 12.2, “Duties Generally”, the duties of the Infection Control Committee shall include, but are not limited to:

a. Evaluating and approving the type and scope of surveillance activities, based on trend analysis of surveillance, effectiveness of prevention and control measure, and procedure instituted.

b. Approving actions to prevent or control infection, based on evaluation of trends and analysis of nosocomial infections, and of the infection potential among patients and hospital personnel.

c. Reviewing nosocomial infections where there is potential for prevention or intervention to reduce the risk of future occurrence. Special focus is given to infections due to unusual pathogens and clusters.

d. Reviewing and approving, at least every three years, all policies and procedures related to the infection surveillance, prevention, and control activities in all departments/services.

e. Assisting Occupational Health and Safety in formulating and evaluating policies and procedures regarding exposures and communicable diseases among employees.

f. Reviewing and evaluating plans for renovation of existing facilities and plans for construction of new facilities to incorporate sound infection control principles into the design and to promote implementation of aspergillosis prevention policies and monitoring compliance systems in all phases of construction/renovation plans.

g. Educating, where required, the Medical Staff and Hospital staff on the detection and control of infections.
3. Composition

Committee membership is interdisciplinary and includes representatives from Administration, Medical Staff, Patient Care Services Department and Infection Control. Representatives from other departments/services serve on the Committee on an ad hoc basis. Representatives from Clinical Microbiology Laboratory, Housekeeping, Materials Management, Laundry, Nutrition and Food Services, Operating Room Services, Pharmacy may be included on the Committee, as needed, to provide information or expertise to the Committee.

Members of the Infection Control Committee are responsible for:

a. Bringing clinical, administrative, or epidemiological expertise to the Committee.

b. Participating in data evaluation.

c. Reviewing and approving infection control policies and procedures.

4. Meeting Frequency

The Committee shall meet quarterly, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting Frequency

The Committee shall make an annual report to the Quality Improvement and Patient Safety Committee and the Medical Executive Committee concerning current activities of the Infection Control Department and the Infection Control Committee.

H. OPERATING ROOM MEDICAL COMMITTEE

1. Purpose

The Operating Room Medical Committee ("ORMC") of SHC is the governing body of Operating Room Services, and is responsible for providing oversight and taking action on issues related to the delivery of safe patient care, treatment, services, and surgical services in the operating room region including the main operating rooms, the ambulatory surgical center, and surgical procedure areas; and recommending policies, procedures, and process improvements for appropriate delivery of surgical services.

2. Duties

In addition to the items described in Section 12.2 "Duties Generally", the duties of the Operating Room Committee shall include, but are not limited to:

a. Overseeing quality improvement aspects of the Operating Room Region, as applied to all surgical patient populations.

b. Identifying new policies and procedures in the Operating Room Region, and to revise existing ones.

c. Making recommendations to SHC Administration and the Chief of Staff office.

d. Providing oversight for the Ad Hoc Block Subcommittee.
e. Serving as the authority for the allocation of block time in the Operating Room Region.

3. Composition

Voting membership of this committee shall include the Medical Director of the Operating Room, Director of the Operating Room Region, the Chairmen of the Departments of Anesthesia and Surgery, the Chiefs of the surgical division and/or designees, representation from community surgeons and anesthesiologists, the Director of Patient Care Services, and representatives of Nursing. The OR Medical Director at SHC will serve as the Chair of this Committee.

4. Meeting Frequency

The Committee shall meet monthly, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting Frequency

The Committee shall report to the Medical Executive Committee, through the QIPSC covering its activities and outcomes.

I. PHARMACY AND THERAPEUTICS COMMITTEE

1. Purpose

The purpose of the Pharmacy and Therapeutics Committee is to provide oversight and take action on issues related to the medication use process. To formulate and review policies and procedures related to the medication management process including selection, regulation, compliance, distribution, storage, administration and safe use of drugs within SHC.

2. Duties

In addition to the items described in Section 12.2, “Duties Generally”, the duties of the Pharmacy and Therapeutics Committee shall include, but are not limited to:

a. Managing the Drug Formulary system which involves evaluating clinical data on medications requested for addition and regularly evaluating current medications for possible deletion. Criteria shall include, but are not limited to, indication for use, effectiveness, risks (including propensity for medication errors, abuse potential, and sentinel events), and costs. Before a medication is added to the Formulary, the patient monitoring criteria are established and are part of the approval and communication process. The Drug Formulary is on-line with access from any clinical workstation throughout the organization.

b. Reviewing the Formulary on an annual basis for emerging safety and efficacy information.

c. Providing Medical Staff oversight for the entire medication management process (Selection and Procurement, Storage, Ordering and Transcribing, Preparing and Dispensing, Administering and Monitoring) across the continuum of care (inpatient, outpatient, and home care).

d. Providing input and approval for all medication management process procedures.
e. Providing input and approval for any new, revised, or updated policies related to the medication management procedures.

f. Evaluating the medication management system or risk points and identifying areas to improve safety.

g. Ensuring that minutes are forwarded to the Medical Executive Committee, through the QIPSC, following approval by the Committee.

h. Publishing the Drug Information Service Newsletter which communicates Committee activities to the Nursing, Medical, Pharmacy, and other appropriate staff.

3. Composition

Voting membership of this committee shall include members of the Medical Staff chosen to ensure representation of a broad range of services/individuals, in order to provide input relating to P&T issues, and the Director of Pharmacy Services. The Committee membership shall also include ex-officio, non-voting representatives from the Nursing Service, Hospital Administration, and others as appropriate. The Adverse Drug Event, Antibiotic and Parenteral/Enteral Nutrition Committees are subcommittees of the Pharmacy and Therapeutics Committee with their minutes being approved by the Pharmacy and Therapeutics Committee.

4. Meeting Frequency

The Committee shall meet every other month, but may meet more frequently or be canceled as determined by the Chair.

5. Reporting Frequency

The Committee shall make a report to the Medical Executive Committee, through QIPSC, covering its activities and outcomes.

J. QUALITY IMPROVEMENT AND PATIENT SAFETY COMMITTEE

1. Purpose

The Quality Improvement and Patient Safety Committee (QIPSC) is responsible for overseeing performance improvement activities. This committee provides guidance and support for hospital-wide performance improvement and patient safety efforts and is responsible to the Medical Executive Committee and the Quality and Service Committee of the Board of Directors.

2. Duties

The QIPSC is responsible for the following functions:

a. Fostering a culture that promotes a commitment to continually improving the quality of patient care and services and reducing healthcare errors;

b. Providing education to key personnel, as needed, on the approaches and methods of performance improvement teams and activities.

c. Assessing and prioritizing process improvement projects.

d. Monitoring, measuring, and evaluating the progress of Performance Improvement Teams.
e. Managing the flow of information to ensure follow-up.

f. Reporting performance improvement activities to the Medical Executive Committee and to the Quality and Service Committee of the Board of Directors.

g. Assigning process improvement activities to the appropriate cross-functional teams.

h. Assisting and providing guidance to teams as needed.

i. Assisting and coordinating departments and teams in the transition to Hospital-wide team efforts in performance improvement and patient safety activities.

3. Composition

Members are appointed based on the position they hold at the Hospital. The membership is interdisciplinary, composed of physicians and administrators, including the Chairs of Psychiatry, Emergency Medicine, Anesthesia and Cardiothoracic Surgery; VP’s of Ambulatory Care, Clinical Services, Patient Care Services; Directors of Quality Improvement and Patient Safety, Medical Staff Services; Department of Medicine QI/QA Physician; Medical Director, OR; Chief Operating Officer; QIPS Biostatistician; and the Chief Executive Officer and Chief of Staff as ex-officio members. The Chair of this committee is the Associate Chief of Staff.

4. Meeting Frequency

This committee meets monthly, at least ten times a year, and as deemed necessary by the Chair.

5. Reporting Frequency

The Committee shall make a monthly report to the Medical Executive Committee covering its activities and outcomes.

K. WELL-BEING OF PHYSICIANS AND PHYSICIANS-IN-TRAINING

1. Purpose

The purpose of the Medical Staff Committee on Well-Being of Physicians and Physicians-in-Training is to provide a forum focusing on:

a. The matter of the impaired physician or physician-in-training at SHC and Lucile Packard Children’s Hospital (impairment is defined for this purpose to be difficulties arising from a medical condition or the aging process, mental illness or disorder, or the abuse of alcohol or other drugs by any physician or physician-in-training).

b. Disruptive or other inappropriate behavior of Medical Staff members or physicians-in-training.

2. Duties

In addition to the items described in Section 12.2, “Duties Generally”, the duties of the Medical Staff Committee on Well-Being of Physicians and Physicians-in-Training shall include, but are not limited to:

a. Compiling a resource list of organizations and individuals who can provide professional assistance to the impaired person; reviewing and
investigating reports of physician impairment and/or behavior problems and assisting physicians in correcting these problems.

b. Developing a protocol to guide department heads in responding to specific instances of impairment. If appropriate, making recommendations to the Chief of Staff and/or the Medical Executive Committee involving individual impaired physicians and physicians-in-training, and individual behavior problems involving Medical Staff members.

c. Serving as a statistical resource for such information as incidence, mode of discovery, therapy and long-term follow-up of cases of an informational and educational resource for physician impairment and behavior problems.

d. Sponsoring and/or publicizing educational programs, when appropriate, which deal with issues of impairment; and develop policies to implement these duties.

e. Establish and monitor the efforts of a Physician Support Panel with responsibility for dealing directly and confidentially with impaired physicians and physicians in training.

3. Composition

Membership of this committee shall include at least five (5) members of the Medical Staff, including representation from the Medical Staff of Lucile Packard Children’s Hospital, and shall also have representatives from Stanford Hospital and Clinics Administration and legal services.

4. Meeting Frequency

The Committee shall meet as necessary, but at least quarterly, but may meet more frequently or be canceled as determined by the Chairman.

5. Reporting Frequency

The Committee shall make an annual report to the Medical Executive Committee covering its activities and outcomes, in accordance with the schedule established by Medical Staff Services.

Not listed are two new Medical Staff committees, formed over the past two years:

- **Cath Lab Medical Committee:** See OR Medical Committee description, above. Functions are largely similar.

- **Committee on Professionalism:** This committee assists the Chief of Staff and the Service Chiefs in dealing with various issues of professional behavior, including concerns about disruptive behavior.