MEDICAL STAFF

RULES AND REGULATIONS

REVISED 2021

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MEDICAL STAFF RULES AND REGULATIONS

PART ONE: MEDICAL STAFF RULES

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

Allocation and reallocation in UMH of physical resources for patient care, in laboratory services, in education, in research and in administration shall be made by the UMHS President. 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 UMH hospital facilities through the Admissions and Bed Coordination Center" ("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 UMH hospital only at the request of a Medical Staff Member with admitting privileges, or designee. Except in an emergency, all patients shall be admitted to UMH hospital facilities according to UMH policy.

2.1-3 Non-Discrimination

Admission shall not be denied because of the patient's race, sex, gender identity, gender expression, color, religion, 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 completion and accuracy of the medical record, for reporting the condition of the patient and any special instructions as may be needed to relatives of the patient and other concerned parties who are entitled to such information, and in concordance with confidentiality requirements. 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, except that a Physician Member shall be consulted and is

responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

2.1-5 Admission History and Physical Examination

The requirements for a history and physical examination are found in Article XV of the Medical Staff Bylaws. If the circumstances are such that a delay is necessary, a brief admission note may be documented in the health record 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 Article XV of the Medical Staff Bylaws, except in cases of bona fide emergency. Such emergency shall be documented in the medical record. Minimally, the admission history and physical should include chief complaint, relevant medical and surgical history, current medications, allergies/reactions and a relevant focused physical examination including vital signs, pulmonary and cardiovascular.

2.1-6 Admission Information

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

(a) Provisional/admitting 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 help protect the patient from self-harm.

(e) Information needed to enable UMH personnel to protect themselves and others from potential problems or dangers presented by the patient.

2.1-7 Admission of Potentially Suicidal or Dangerous Patients

If a Member with admitting privileges or designee reasonably believes a patient admitted for other purposes is potentially suicidal or dangerous to self or others, the 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 self or others, action shall be taken in accordance with UMHS policy, which outlines safeguards that should be in place.

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

Admitted patients will be assigned to the Active Staff category Member on the designated admitting service. A Member of the Medical Staff shall see each patient as soon as possible after admission, consistent with the clinical condition of the patient.

2.3 EMERGENCY SERVICE TREATMENT

2.3-1 Emergency Medicine Physician Member Responsibility

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

2.3-2 Qualified Medical Person

For the purposes of conducting medical screening examinations, a Qualified Medical Person (QMP) is a credentialed physician, physician assistant, nurse practitioner, and in the case of a woman who may be in labor, a certified nurse midwife.

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 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 Other Authorized Individual

No discharge order by a Physician or other authorized individual is required in the following circumstances:

(a) When a patient is removed pursuant to a disaster plan.

(b) When a patient leaves a UMH facility against advice.

2.5-4 Pronouncement of Death

In the event of a death at a UMH facility, the death shall be confirmed and the deceased pronounced dead by a Physician, CPT, 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 UMH facilities is expected to actively seek to obtain permission for autopsy. With the exception of cases accepted by the Medical Examiner, 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, unless otherwise required by state law. 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

An unclaimed body means a dead human body for which the deceased has not provided for a disposition, for which an estate or assets to defray costs of burial do not exist, and that is not claimed for burial by a person, relative or court appointed fiduciary who has the right to control disposition of the body. When a decedent at UMH is identified as unclaimed, the morgue staff notifies the Washtenaw County Medical Examiner's Office (MEO). Per Michigan Compiled Law 700.3206 (9)(a), the right and powers reside with the applicable medical examiner for the county where the decedent was domiciled at the time of his or her death.

2.5-7 Organ Donation Request

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

2.6 PATIENT ELOPEMENT AND DEPARTURE AGAINST MEDICAL ADVICE

Patients at risk for or actively eloping or leaving against medical advice will be managed in accordance with UMH policy.

2.7 MEDICAL RECORDS

The standards and requirements for any medical record are determined by federal and state laws, the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (COP), regulatory agency standards such as The Joint Commission (TJC), third party payers, and institutional policies. These standards and requirements are reflected in UMH policies and thus are required to be followed by all UMH faculty and staff.

2.7-1 Attending Member Responsibility

The attending Member shall be responsible for the inclusion of pertinent 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) Inpatient Discharge

On discharge of an inpatient by the attending Member, CPT, or SPP, a discharge summary shall be created in the central electronic system by dictation or direct entry on all inpatient medical records. 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 co-authenticated and dated by the attending Physician Member.

(c) Timing and Reports

All documentation must be completed according to UMH policy, Medical Staff Bylaws, external regulatory agency requirements, and third-party payer requirements. All documentation must be completed within thirty (30) days of the date of service unless otherwise specified in UMH policy. Individual departments may set more restrictive standards but may not exceed the time frames established by current UMH policy and regulatory requirements. 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 polices 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.

(d) 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. Outpatient charts of children receiving primary care will contain growth charts.

(e) Payer Requirements

The medical record shall be maintained and documented consistent with current regulations and requirements of third-party payers and with UMH 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

For clinical services that are reported separately or as part of a global combined charge, and documented by a trainee, the documentation needs to comply with the Medicare Claims Processing Manual and all CMS guidelines for Physician Services in Teaching Settings. For clinical services that are documented by SPPs, Member authentication requirements will comply with CMS requirements and any state requirements.

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 UMH Policy.

2.7-5 Research Use

Use of medical records for research purposes shall be subject to the policies and approval of the Institutional Review Boards of the University of Michigan Medical School (IRBMED) and/or, as applicable, the Michigan Medicine 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 UMH

All records (regardless of the medium) developed with UMH or under its auspices, are the property of UMH and shall not be taken out of the UMH 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 the patient's legal representative. UMH 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 must be authenticated and have dates and times for service, documentation, and signature in accordance with UMH policy. Rubber stamp signatures or copy and paste signatures are not permitted.

2.7-8 Authorization for Release of Information

Written or accurate electronic duplicate of an 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 UMH.

2.7-9 Symbols and Abbreviations

Unapproved symbols and abbreviations will not be used.

2.7-10 Final Diagnosis

A final diagnosis (both for inpatient and outpatient care) shall be recorded in full, without the use of unapproved symbols or abbreviations, and dated and signed within thirty (30) days. All discharge summaries must be co-authenticated by the responsible Member. This is a condition of discharge.

2.7-11 Other Policies

The foregoing requirements shall be supplemented by specific UMH or UMHS policies.

3.0 MISCELLANEOUS

3.1 PEER-PROFESSIONAL REVIEW RECORDS

Consistent with law, regulation, the Bylaws, these Rules and Regulations, and policy, all records, data and knowledge collected for or by individuals or committees assigned a professional review function (to assess the quality and necessity of patient care provided and the preventability of complications and

deaths occurring in the UMH facilities) are confidential, shall be used only for the purposes intended, are not public records, are not available for Michigan Freedom of Information Requests, and are not subject to court subpoena or search warrant.

3.2 PATIENT CONSENT FOR PHOTOGRAPHS

Photography, audio and/or video recordings of a patient or a patient's body part in any medium must be handled and retained in a manner that meets the requirements of policy, state and federal law, and third party regulatory and accreditation requirements. Written consent must be obtained prior to using a photograph or recording for non-clinical purposes.

4.0 MEDICAL STAFF OVERSIGHT FOR THE USE OF DRUGS AND BIOLOGICS

Drugs and biologics used at UMH facilities shall be those approved by the Pharmacy and Therapeutics (P&T) Committee, subcommittee of the Executive Committee of Clinical Affairs (ECCA), with the exception of medications for bona fide clinical investigations, compassionate or emergency use consistent with federal law and institutional policy, or the non-formulary approval process through the chair of P&T. These shall be used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospital" endorsed by the American Hospital Association and all regulations of the Food and Drug Administration, with oversight by the Pharmacy and Therapeutics Committee. All investigational drugs and biologics will be used in accordance with an approved protocol only under the direct supervision of the principal investigator and should be approved by the Institutional Review Board.

5.0 GENERAL RULES REGARDING PATIENT CARE

5.1 DAILY PATIENT VISITS ADMITTED PATIENTS

An admitted patient shall be visited daily by the patient's 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. Patients admitted for rehabilitation shall be visited by the patient's attending Member(s) or qualified health professional designee consistent with law and regulation.

5.2 INFORMED CONSENT

Specific written informed consent is required for invasive procedures, or other treatment or procedures (including anesthesia and sedation) carrying a substantial or material risk of an adverse outcome. 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 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 the patient's

representative of significant risks, benefits and alternatives to the proposed operation or procedure 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. Procedure documentation should include sufficient detail on techniques, devices and processes to inform subsequent care and follow-up evaluation.

5.4 TISSUE REMOVAL AND REVIEW

All tissues removed at the time of a surgery or procedure that are considered necessary to arrive at a diagnosis, or are required to be sent per protocol, shall be sent to the Pathology Service for review and examination. 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

All anesthesia and sedation care will be in accordance with clinical policies and procedures of the Department of Anesthesiology and the Sedation Analgesia Committee of UMH.

5.7 DENTAL, ORAL SURGERY, AND PODIATRY PATIENTS

When dental, oral surgery, and podiatry patients require admission to UMH hospitals, a Physician Member shall be consulted and is responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

5.8 PHYSICAL EXAMINATIONS

5.8-1 Authorized Professionals.

A physical examination required by these Rules and Regulations or UMH 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 UMH policy, Department rules, or

specific delegation by a Member who has clinical privileges to perform the physical examination.

(c) An Oral Surgeon for the Oral Surgeon's own patient if they have clinical privileges to do so.

(d) A Dentist or Podiatrist for the Dentist or Podiatrist's own patient relating to the Dentist or Podiatrist's specific aspect of the patient's care if they have clinical privileges to do so.

(e) An SPP if the SPP has clinical privileges to do so.

5.8-2 Preoperative/Preprocedure Evaluations

(a) Procedures Requiring Anesthesia: The requirements for a history and physical examination are found in Article XV of the Medical Staff Bylaws. Except as may otherwise be required in the event of a bona fide emergency, a relevant history and physical by a Physician, Dentist, Podiatrist, 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. This updated examination may be completed by a member of the surgical team, including the anesthesiologist. 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). An airway examination will be performed as a component of the pre-anesthesia evaluation by a qualified individual with appropriate privileges. For outpatients, the Medical Staff authorizes a policy, pursuant to the policy development processes of the Medical Staff, for the identification of specific procedures and patients who may receive an assessment as specified in the policy, in lieu of the history and physical examination requirements above, provided that such policy and its development shall meet all applicable legal rules and hospital accreditation standards for such policies.

(b) Procedures Requiring Sedation: An assessment is required to be documented for inpatient and outpatient procedures within forty-

eight (48) hours prior to the procedure 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/sedation risk, anesthesia/sedation 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.

5.9 TRAINEES

5.9-1 Trainee Compliance

Each Trainee shall comply with the Bylaws, the Rules and Regulations and UMH policies. Any failure to comply with the Rules and Regulations or UMH policies shall be reported by the training program director, to the OCA 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 name of patient's attending Member 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

1. 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, consistent with UMH Policy.

2. 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 PROTOCOLS

Registered nurses, as authorized and consistent with the Bylaws, these Rules and Regulations and UMH policies, may, pursuant to approved protocols, implement protocols for radiology and laboratory tests, respiratory therapy, patient education services, dietetic consultations, and social work services. Protocols shall be proposed by the responsible Medical Staff Member and approved by the relevant Service Chief, and the ECCA, as applicable.

7.0 MECHANISM FOR PROVIDING EMERGENCY SERVICES

The Medical Staff supports maintaining ongoing verification and designation status as a Level 1 trauma center from the American College of Surgeons and the Michigan Department of Health and Human Services. Further, the Medical Staff supports that the trauma system will be managed in accordance with the guidelines outlined by the American College of Surgeons – Committee On Trauma for both adult and pediatric patients found in the most current version of the Resources for the Optimal Treatment of the Injured Patient document.

7.1 SERVICE SUPPORT

7.1-1 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.

7.1-2 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.

8.0 CODE OF CONDUCT

All Medical Staff Members, SPPs and Trainees shall abide by the UMHS Code of Conduct.

9.0 NON-DISCRIMINATION

No patient shall be excluded from participation in, be denied benefits of, or be subject to discrimination with delivery of medical care and services on grounds of race, sex, gender identity, gender expression, color, religion, national origin or ancestry, age, marital status, sexual orientation, disability, special disabled veteran or Vietnam-era veteran status, height, weight, source of payment or other basis that is legally impermissible.

PART TWO: COMMITTEE PROTOCOL AND ADDITIONAL STANDING COMMITTEES

1.0 GENERAL COMMITTEE PROTOCOL

In addition to the ECCA and those committees 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 with approval of the ECCA. The COS shall, except as specifically provided in these Rules and Regulations, the Bylaws, or the policies of the Medical Staff, designate the chair of Medical Staff committees. Members on committees, except as otherwise specified by these Rules and Regulations, Bylaws, or policies of the Medical Staff (*e.g.,* where membership is based on position held), will be appointed by the committee chair. Reappointment of committee members or chairs shall take into account at least the following:

1. Need for specific expertise on the committee.
2. Contributions to the committee.
3. Tenure on the committee.
4. Attendance record.

Fifty percent (50%) of voting members constitutes a quorum unless otherwise noted.

1.2 REPRESENTATION

In addition to Medical Staff Member representation, committees may include, but not be limited to, representation from:

1. SPPs
2. CPTs
3. Nursing
4. Administration
5. Others, as needed and/or required, 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.

1.5 MINUTES/MEETING SUMMARIES

Unless otherwise specified in the Bylaws or these Rules and Regulations, minutes/meeting summaries of each meeting shall be prepared and shall include a record of the attendance of committee members and the vote taken on each matter. A copy of the minutes/summary shall be available to the COS and/or the ECCA upon request.

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 Vice-Chair is appointed by the chair with the approval of a majority of committee members. Additional committee members must include at least the following:

1. Administration.
2. Representatives of major medical specialties and subspecialties.
3. 1 representative from Nursing.
4. 1 representative from Social Work.
5. 1 representative from Spiritual Care.
6. 1 representative from the Compliance Office.
7. 1 community representative (not currently employed by or under contract with Michigan Medicine; representative of a population group served by UMH).
8. 1 CPT.
9. 1 representative from the Program in Clinical Ethics Leadership.
10. 1 representative from PRCR.
11. 1 representative from of the OGC.

12. 1 representative from Institutional Review Board/Clinical Research.

2.2 CHARGE

1. 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.

2. 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.

3. Formulate, review and comment upon policies on the ethical aspects of clinical care at UMH.

4. Provide clinical ethics education and training to the UMHS community.

5. Provide oversight and review of the Clinical Ethics Consultation services.

2.3 MEETINGS AND RECORDS

The Adult Ethics Committee will generally meet monthly or as called by the committee chair. The committee will record its activities in minutes/meeting summaries and an annual report, which will be submitted to the OCA and the ECCA. 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:

1. 1 Adult Cardiologist Member.

2. 1 Pediatric Cardiologist Member.

3. 1 CPT.

4. 1 Representative of Pharmacy.

5. 1 Representative of Security.

6. 1 Representative of Materials Management.

7. 1 Representative of Administration.

8. 2 At-Large Medical Staff Members.

9. 1 Nursing Representative from SICU.

10. 1 Nursing Representative from PICU.

11. 1 Nursing Representative from Adult General Care.

12. 1 Nursing Representative from Pediatrics General Care.

13. 1 Medical Staff Representative from Anesthesia.

14. 1 Medical Staff Representative from the Hospitalist Group.

15. 1 Clinician Representative from Ambulatory Care.

16. 1 Representative from Respiratory Therapy.

17. 1 Representative from Clinical Engineering.

18. Chief PA, or designee.

3.2 CHARGE

1. Oversee and coordinate the development of cardiopulmonary resuscitation policies and procedures within UMH facilities.

2. Advise the Medical Staff regarding overall policy matters concerning cardiopulmonary resuscitation, MOVE Team and rapid response team activities.

3. Monitor the functions of the cardiac arrest team, MOVE Team, and Rapid Response Team, cardiac arrest call system and equipment, including defibrillators.

4. Monitor and update resuscitation team related communication procedures.

5. Monitor and revise, when necessary, the mobilization plan for cardiac arrest personnel and equipment.

6. Review and recommend changes or additions to cardiac arrest equipment, standardization of equipment, and maintenance, location and storage of equipment.

7. Provide regular evaluation and reporting of UMH's resuscitation program.

8. Recommend changes to resuscitation policy and procedures needed as indicated by evaluations.

9. Plan for the education and training of all UMH 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 eight (8) times per year. The committee will record its activities in minutes/meeting summaries 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 Cerebral Death Determination Committee is chaired by a Member on the committee appointed by the COS. Additional committee members include at least the following:

1. 2 Members from Adult Neurology.
2. 1 Member from Pediatric Neurology.
3. 1 Member from Neuro-Intensive Care (Neurology or Neurosurgery).
4. 1 Member from Pediatric Critical Care.
5. 2 Members from Neurosurgery.
6. 1 CPT.
7. 1 Representative from Nursing.
8. 1 Member from Nuclear Medicine.

4.2 CHARGE

1. 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.
2. Oversee the education, regarding the guidelines, of consultant neurologists or neurosurgeons who will be making cerebral death determinations.
3. 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 once per year. The committee will record its activities in minutes/meeting summaries and an annual report, which will be submitted to the OCA 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 HEALTH RECORDS STANDARDS COMMITTEE

The Health Records Standards Committee (HRSC) provides enterprise-wide leadership, oversight and monitoring of all health records at UMH to ensure both quality and compliance with all applicable standards and regulations related to health information management, and to ensure that the medical record and all health record systems adequately support the capture of clinical information, facilitate Practitioner efficiency, and promote safe patient care.

5.1 COMPOSITION

The HRSC is co-chaired by an Associate Chief from the OCA or designee and the Chief Administrator for Health Information Management. Additional committee members include at least the following:

1. At least 1 physician representative from each of the following: Surgery, Internal Medicine, Pediatrics, Psychiatry, Emergency Medicine, Obstetrics & Gynecology, and Primary Care.

2. At least 1 Hospitalist and additional physician representative at-large, if decided.

3. At least 1 Physician Assistant.

4. At least 1 House Officer.

5. At least 1 Representative from Nursing.

6. The Chief Medical Information Officer and the Chief Nursing Information Officer or their designees.

7. At least 1 Representative from each of the following areas: PRCR, Health Information Technology & Services, MiChart Health Information Management, Compliance, OGC, Quality Improvement, Revenue Cycle, Ambulatory Care, C.S. Mott Children's Hospital and Von Voigtlander Women's Hospital Leadership, University Hospitals/Cardiovascular Center Leadership, Allied Health, and OCA.

8. 2 staff members from HIM.

5.2 CHARGE

1. Ensure compliance with all relevant state and federal laws, regulations, codes, and standards for health records. Develop and oversee institutional policies for the enterprise medical record, both paper and electronic.

2. Identify, review and approve policies related to medical information and medical record management.

3. Provide input and recommendations regarding the strategic direction for the ongoing management and development of the UMH electronic health record.

4. Review and make recommendations regarding incremental electronic medical record functionality, operations, and enhancements.

5. Oversee processes for medical record reviews.

6. Oversee health record deficiency monitoring processes and make recommendations for system improvements and/or enhancements.

7. Develop and/or advise the organization on opportunities and practices to support efficient and effective documentation of clinical information.

8. Provide input to UMH leadership regarding health record requirements and functionality, including but not limited to storage, retrieval, and disclosure needs at UMH.

9. Oversee, review and approve all paper forms used to document or capture patient information for the medical record.

10. Recommend and support strategies for integration of electronic medical record systems and universal access to all information necessary for safe and effective patient care.

5.3 MEETINGS AND RECORDS

The Health Records Standards Committee will meet when called by the chair, but at least four times per year. The committee will record its activities in minutes/meeting summaries 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 INFECTION CONTROL COMMITTEE

6.1 COMPOSITION

The chair of the Committee is the Medical Director of Infection Control and Epidemiology, who is a member of the Committee with vote. Additional committee members include at least the following:

1. 1 or more representatives of Infection Control and Epidemiology (which may be the chair).
2. 1 CPT.
3. 1 Representative from Safety Management Services.
4. 1 Representative from Pharmacy.
5. 1 Representative from the Microbiology Laboratories.
6. 1 Representative from Respiratory Care.
7. 1 Representative from Supply Chain.
8. 1 Representative from Environmental Services.
9. 1 Representative from Food and Nutritional Services.
10. 1 Representative from Nursing Services.
11. 1 Representative from PRCR.
12. 1 Representative from Administration.
13. 4 At-Large Medical Staff Members who are appointed by the COS.

6.2 CHARGE

To formulate and implement UMH's infection control policies. Specific activities include the following:

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

3. Review mechanisms determined by the Antibiotic Stewardship Committee for obtaining and distributing information to the Medical Staff concerning antibiotic susceptibility of laboratory isolates.

4. Review elements of the employee health program which impacts infection control policy and procedures.

5. Report actual or suspected infections as required by Public Health and other external regulatory bodies, and internally to appropriate operational leaders as defined in the annual UMHS Infection Prevention, Surveillance and Control Program (IPSCP).

6. Initiate culture and sensitivity testing when applicable.

7. Institute appropriate isolation procedures.

8. 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.

9. Institute corrective actions as appropriate.

10. Provide epidemiologic follow-up on all quality assurance studies to identify improvement areas.

11. As needed, coordinate with public health agencies.

6.3 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 minutes/meeting summaries 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 information as appropriate and required by law will be submitted to county health department(s) and the Michigan Department of Health and Human Services.

7.0 PAIN COMMITTEE

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

7.1 COMPOSITION

The Pain Committee is chaired by a Member on the committee appointed by the COS. Additional committee members include at least the following:

1. 1 Medical Staff Member of the Adult Acute Pain Service.
2. 1 Medical Staff Member of the Pediatric Pain Service.
3. 1 Medical Staff Member of Hematology/Palliative Care.
4. 2 CPTs: 1 from Adult, 1 from Pediatrics.
5. 1 Representative of Pharmacy.
6. 1 Nurse from Pediatric Pain Service.
7. 1 Nurse from Adult Pain Service.
8. 1 Adult Medical/Surgical Nurse Manager.
9. 1 Pediatric Nurse Manager.
10. 1 Nurse from Ambulatory Care.
11. 1 UMMG member in a primary care discipline.
12. 1 Medication Safety Nurse.
13. 1 PRCR Representative.
14. 4 At-Large Medical Staff Members.

7.2 CHARGE

1. Advise the ECCA regarding policy matters concerning the management of pain, both acute and chronic, in inpatient and outpatient settings.
2. Monitor the functions of any designated pain management programs and advise the ECCA regarding the findings.
3. Monitor and review pain management education materials and programs designed for patients and staff.
4. Regularly evaluate the effectiveness of pain management practices at UMH 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.
5. Members of the committee or the Medical Staff at-large will be selected to form ad hoc subcommittees to review clinical issues as needed.

6. In order to ensure the safety and efficacy of pain management therapies, the committee will oversee the activities of its subcommittees. These subcommittees are advisory bodies to the committee. Current active subcommittees include:

   (ii) Pain Event Review Subcommittee;

   (iii) Pediatric Pain Subcommittee;

   (iv) Ambulatory Care Quality Improvement Controlled Substance Subcommittee; and

   (v) Pain and Opioid Stewardship Subcommittee.

7.3 MEETING AND RECORDS

The Pain Committee will meet monthly. The committee will record its activities in minutes/meeting summaries 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.

8.0 PEDIATRIC ETHICS COMMITTEE

8.1 COMPOSITION

The Pediatric Ethics Committee is chaired by a Member appointed by the COS. The Vice-Chair is appointed by the chair with the approval of a majority of committee members. Additional committee members must include at least the following:

1. Administration.

2. Members representative of major relevant pediatric specialties and sub-specialties.

3. 1 representative from Nursing.

4. 1 representative of Social Work.

5. 1 representative from Spiritual Care.

6. 1 community representative (not currently employed by or under contract with Michigan Medicine; representative of population groups served by UMH).

7. 1 CPT.

8. 1 representative from Compliance.

9. 1 representative from the Program in Clinical Ethics Leadership.

10. 1 representative from PRCR.

11. 1 representative from the OGC.

12. 1 representative from Institutional Review Board/Clinical Research.

8.2 CHARGE

1. 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.

2. 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.

3. Formulate, review and comment upon policies on the ethical aspects of clinical care at UMH.

4. Provide clinical ethics education and training to the UMH community.

5. Provide oversight and review of the Clinical Ethics Consultation services.

8.3 MEETINGS AND RECORDS

The Pediatric Ethics Committee generally will meet monthly or as called by the committee chair. The committee will record its activities in minutes/meeting summaries and an annual report, which will be submitted to the OCA and to the ECCA. A presentation of the annual report to the ECCA will be at the discretion of the committee chair.

9.0 PHARMACY AND THERAPEUTICS COMMITTEE

The Pharmacy and Therapeutics Committee is charged with (1) monitoring and (2) development and oversight of drug utilization guidelines, policies and procedures within UMH. The committee will review and make recommendations regarding drug use with consideration of clinical efficacy, safety and cost.

9.1 COMPOSITION

The Medical Director of Pharmacy and the Chief Pharmacy Officer serve as co-chairs of the Pharmacy and Therapeutics Committee. Additional committee members include:

1. Medical Director – Infection Control.

2. Manager, Medication Use Policy.

3. 3 Representatives from Nursing: 1 Adult, 1 Pediatric, 1 Medication Safety.

4. 2 Clinical Pharmacists: 1 Adult, 1 Pediatric.

5. 2 Medication Safety Pharmacists: 1 Adult, 1 Pediatric.

6. 1 Representative from Administration.

7. 1 CPT designated by the HOA.

8. 1 Physician Assistant (PA) Representative.

9. 7-10 At-Large Medical Staff Members.

Ex-officio members are:

1. Chair, MUE Committee.

2. 1 PRCR Representative.

3. 1 Nutrition Specialist.

4. 1 Clinical Pharmacist, Medication Use Policy.

5. 1 OCA representative.

6. 1 MiChart Representative.

7. 1 Pharmacy Operations Representative.

8. Pharmacy Coordinator, Medication Management Compliance.

9.2 CHARGE

The Pharmacy and Therapeutics Committee will consider issues of quality, medication safety and cost for (1) UMH inpatient use, and (2) use in UMH 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 UMH 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 UMH, 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:

1. Ambulatory Infusion Advisory Committee: Advise the committee on issues related to ambulatory infusions for non-oncology indications.

2. Anticoagulation Subcommittee: Advise the committee on issues related to anticoagulation management including standardization of practices, transition across the continuum and appropriate selection of formulary agents.

3. Antimicrobial Subcommittee: Advise the committee on antimicrobial selection, control and policies on antimicrobial utilization.

4. Cancer Pharmacy Committee: Advise the committee on issues related to cancer chemotherapeutic and supportive medication selection, control and safety, and policies on utilization in UMH and the Cancer Center.

5. Glycemic Management Committee: 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.

6. Medication Reconciliation Oversight Committee: Advise the committee on issues and improvements related to the medication reconciliation process.

7. Medication Safety 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.

8. Medication Use Evaluation (MUE) Subcommittee: Review use of medications in accordance with defined criteria, and recommend and implement corrective action strategies.

9. Nutrition Advisory Committee: Advise the committee on issues related to safe, effective and evidence-based nutrition therapy, including the review and approval of the Therapeutic Diet Manual at least every five (5) years.

10. Pediatric Medication Safety Committee: Review the medication use process, report of adverse drug events and medication decisions specific to the area of pediatrics.

11. 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.

12. VTE Subcommittee: Advise the committee on issues related to prevention and treatment of venous thromboembolism.

9.3 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 minutes/meeting summaries and an annual report, which will be submitted to the OCA and presented to the ECCA. Meeting summaries will be available to the OCA.

10.0 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 UMH.

10.1 COMPOSITION

The chair of the Sedation Analgesia Committee is chaired by a Member appointed by the COS. Additional committee members must include at least the following:

1. 1 Medical Staff Member of Radiology/Interventional Radiology.

2. 1 Medical Staff Member of Emergency Medicine.

3. 1 Medical Staff Member of Cardiology (EP Cath Lab).

4. 1 Medical Staff Member of Anesthesiology – Adult.

5. 1 Medical Staff Member of Anesthesiology – Pediatrics.

6. 1 Medical Staff Member Medical Procedures Unit.

7. Representatives of Pharmacy.

8. 1 Nurse from Medical Procedures Unit.

9. 1 Nurse from SWAT.

10. 1 Nurse from Pediatric Procedures Area.

11. 1 Nurse from Cardiac Procedures Unit.

12. 1 Ambulatory Care Nurse Manager.

13. 1 Nurse from Radiology Procedures Unit.

14. 1 ACOS.

15. 1 Nurse from Emergency Services.

16. 1 Representative of PRCR.

10.2 CHARGE

1. Advise the ECCA regarding policy matters concerning the practice of procedural sedation analgesia by non-anesthesiologists.

2. Monitor and review sedation education materials and programs designed for patients and staff.

3. Review credentialing requirements of sedation privileging for Applicants and Members.

4. Regularly evaluate the effectiveness of sedation practices at UMH 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.

5. Members of the committee or the Medical Staff at-large will be selected to form ad hoc subcommittees to review clinical issues as needed.

10.3 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 minutes/meeting summaries 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.

11.0 TRANSFUSION COMMITTEE

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

11.1 COMPOSITION

The chair of the Transfusion Committee is chaired by a Member appointed by the COS. Additional committee members must include at least the following:

1. 1 representative from the Department of Surgery.
2. 1 representative from the Department of Internal Medicine.
3. 1 representative from the Department of Obstetrics and Gynecology.
4. 1 representative from the Department of Pediatrics.
5. 1 representative from the Department of Anesthesiology.
6. 1 CPT.
7. Chief Technologist of the Blood Bank.
8. 1 Representative from Nursing involved with the Blood Bank.
9. 1 Representative from Administration.
10. Medical Director, Blood Bank.
11. 1 or more At-Large Medical Staff Members.

11.2 CHARGE

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

4. Review blood utilization and availability patterns in the UMH facilities, and recommend changes or modifications to enhance the adequacy and efficiency of transfusion services.

5. Monitor the utilization of the Transfusion and Apheresis area, blood donation options and recommend institution of new procedures.

11.3 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 minutes/meeting summaries 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 UTILIZATION MANAGEMENT COMMITTEE

The Utilization Management Committee (UM Committee) is a committee of the Medical Staff and operates under the authority of the ECCA. It provides oversight to the utilization review functions including medical necessity of admissions, length of stay, under-utilization, over-utilization, appropriate scheduling, and use of the medical center's resources. Professional services such as drugs and biologicals will be reviewed as needed or requested. The committee reviews and makes recommendations for improvements in cost reduction, decrease in denials, decrease in readmissions, capacity management and patient flow issues, and improved patient experience. The committee will escalate items as necessary to appropriate leadership groups, including but not limited to the ECCA, Clinical Leadership Team (CLT), Compliance Office, and OGC.

12.1 COMPOSITION

The UM Committee is chaired by the Medical Director of Care Management and comprised of Members of the Medical Staff and other representatives of the departments involved in direction and implementation of utilization management and related functions. The committee must include at least two (2) Medical Staff Members, and the Committee may also appoint representatives from:

1. Care Management.

2. Revenue Cycle.

3. Data Specialists.

4. Quality Improvement.

5. Health Information Management.

6. Capacity Management.

7. Pharmacy.

8. Lab.

9. Administration.

12.2 CHARGE

1. Identify opportunities to promote efficiency and quality in patient care.

2. Identify opportunities to improve relevant systems and processes.

3. Develop, formulate and/or recommend the revision or identification of new policies, systems and/or standards to hospital administration and Medical Staff through the Quality Improvement Committee.

4. Bring issues and opportunities for improvement of patient quality and/or utilization to the attention of the appropriate practitioner, Hospital Department and/or Medical Department Chair as expeditiously as indicated.

5. Obtain timely feedback from the practitioner, Hospital Department and/or Medical Department Chair in order to monitor further data to assure that improvement occurs.

6. Report activities and results to the Quality Improvement Committee as required by project plans or the Bylaws.

7. Recommend methods for evaluation of systems management.

8. Ensure that appropriate and effective standards, programs and processes are in place to comply with regulatory, payer, accrediting body and peer review entities consistent with its overall charge and responsibilities as assigned by the Medical Executive Committee and Administration.

12.3 MEETINGS AND RECORDS

The UM Committee meets on no less than on a quarterly basis. Special meetings will be called as needed by the chair. UM Committee minutes shall be maintained including date and time of meetings, attendees, standard reports, and action item follow-up, focused reviews, audits and action to be taken. The Utilization Management Plan and utilization review process is evaluated and approved on an annual basis. Results of the evaluations and planned actions are documented in the UM Committee minutes and reported to the ECCA.

Revisions to the Medical Staff Rules and Regulations were:

Amended and Approved by the University of Michigan Hospitals Bylaws Committee	August 5, 2021
Approved by the University of Michigan Hospitals Executive Committee on Clinical Affairs	September 14, 2021
Approved by the Medical Staff of the University of Michigan Hospitals	September 24, 2021
Approved by the University of Michigan Hospitals Executive Board	December 7, 2021