RIVERSIDE
MEDICAL CENTER

ORGANIZATIONAL MANUAL

4.23.25

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ARTICLE 1
GENERAL

1. DELEGATION OF FUNCTIONS

(a) When a function is to be carried out by the CEO, by a Medical Staff Leader, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(b) When a Medical Staff Leader is unavailable or unable to perform an assigned function, a Medical Staff Officer may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2
DIVISIONS

2. 1. DIVISIONS

Subject to the approval of the Board, the Medical Executive Committee may create or eliminate divisions or otherwise reorganize the Medical Staff structure. If a new specialty is added to the division, the Medical Executive Committee will determine the appropriate division for the specialty to be assigned.

The Medical Staff shall be organized into the following divisions:

Division of Medicine – The Division of Medicine includes:

Allergy
Dermatology
Emergency Medicine
Endocrinology
Family Medicine
Internal Medicine
Hematology/Oncology
Hospice/Palliative
Physical Medicine and Rehab
Cardiology
Electrophysiology
Gastroenterology
Pulmonology
Nephrology
Neurology
Infectious Diseases
Pediatrics
Psychiatry
Occupational Medicine
Sports Medicine
Radiation Oncology
Radiology
Rheumatology
Non-Physician Providers

Division of Surgery – The Division of Surgery includes:

General Surgery
Anesthesiology
Cardiovascular Surgery
Dentistry
Oral & Maxillofacial Surgery
Podiatry
Ophthalmology
Orthopedics
Otolaryngology
Head & Neck Surgery
Obstetrics & Gynecology
Urology

Pain Management
Plastic Surgery
Neurosurgery
Pathology
Non-Physician Providers

2.2. FUNCTIONS AND RESPONSIBILITIES OF DIVISIONS

The functions and responsibilities of the divisions are set forth in **Article 5** of the Medical Staff Bylaws.

ARTICLE 3

Service Lines

3.1. SERVICE LINES

The Medical Staff shall be organized into service lines in accordance with the Medical Executive Committee and Board approved Medical Staff Organizational Chart.

3.2. FUNCTIONS AND RESPONSIBILITIES OF SERVICE LINES

The functions and responsibilities of the service lines are set forth in **Article 5** of the Medical Staff Bylaws.

ARTICLE 4

MEDICAL STAFF COMMITTEES

Unless otherwise provided, the president of the staff appoints, subject to the approval of the Medical Executive Committee, the members and chair of any staff committee formed to accomplish staff administrative, environmental or representation functions, and staff quality improvement or monitoring functions every two years. Unless otherwise provided in the composition of the committee, each committee shall, at its first meeting following the annual staff meeting, elect a vice chair. The President and CEO shall assign hospital representatives to serve as non-voting members every two years.

4.1. BYLAWS/NOMINATING COMMITTEE

4.1-1. PURPOSE AND MEETINGS

The Bylaws Committee shall meet annually and otherwise necessary, and provide written report to the Medical Staff and Medical Executive Committee.

4.1-2. COMPOSITION

The Bylaws Committee shall consist of the Medical Staff Officers and elected Joint Conference members.

4.1-3. FUNCTIONS

The Bylaws Committee shall:

(a) Review the Medical Staff Bylaws and associated documents annually and recommend amendments to the Medical Executive Committee; and

(b) Receive and consider all recommendations for changes to these documents made by anyone.

4.1-4. REPORTS TO

All recommendations from the Bylaws/Nominating Committee shall be reported to the Medical Executive Committee.

4.2. GRADUATE MEDICAL EDUCATION COMMITTEE

4.2-1. PURPOSE AND MEETINGS

The Graduate Medical Education Committee (GMEC) works in collaboration with the DIO to oversee the accredited residency and fellowship programs and ensures compliance with ACGME requirements. It recommends policies concerning post-graduate medical training, continuing staff education, and otherwise fulfill the medical staff functions relating to education and research, including maintaining the hospital's accreditation through Illinois State Medical Society (ISMS) as a CME provider. The Committee shall meet at least ten (10) times per year with CME issues addressed as needed.

4.2-2. COMPOSITION

Voting membership shall be limited to 15 members to include the Designated Institutional Officer (DIO); Chief Executive Officer (CEO); two Residency Program Directors; three Fellowship Program Directors; one resident and one fellow representatives who have been nominated by their peers (alternating specialties each year); one Associate Program Director of Internal Medicine, one Associate Program Director of Psychiatry, one faculty representing an outpatient clinic hosting both Internal Medicine and Psychiatry residents; one faculty member

representing Gastroenterology; one faculty member representing Cardiology; and one Vice President or Director over quality and patient safety. Appointments are made by the DIO and CEO in accordance with GME policy.

4.2-3. FUNCTIONS

The functions of the program and Graduate Medical Education Committee shall include the following:

(a) Ensures quality education, a positive work environment, effective communication, standards; internal reviews, and resident well-being;
(b) Develop, plan, implement and evaluate programs of, and requirements for, continuing education that are relevant to the type and scope of patient care services delivered in the hospital to ensure that all licensed independent practitioners and others privileged through the medical staff process have an opportunity to participate in continuing education;
(b) Develop educational programs designed to keep the medical staff informed of significant new developments and new skills in medicine, and responsive to quality improvement findings; and
(c) Develop policies and procedures for the continuing medical education programs.

4.2-4. REPORTS TO

All recommendations from the Graduate Medical Education Committee shall be reported to the Medical Executive Committee and to the Board of Directors.

4.3. INSTITUTIONAL REVIEW BOARD

4.3-1. PURPOSE AND MEETINGS

The IRB shall meet at least semi-annually or more often as deemed appropriate.

(a) To assure that, in research involving human subjects at Riverside Medical Center, or in research submitted to it for review and approval involving subjects in the community, the rights and welfare of the human subjects are adequately protected. The IRB will assist the investigators to minimize potential harm to human subjects, select subjects equitably, obtain informed consent and ensure privacy and confidentiality. The IRB will review all planned research involving human subjects prior to initiation of the research, approve research that meets established criteria for protection of human subjects, and monitor approved research to ascertain that human subjects are indeed protected.

(b) To inform and assist Riverside Medical Center and the clinical researchers on ethical and procedural issues related to the use of human subjects in research, to facilitate compliance with relevant regulations of the United States Government, and to provide a framework suitable for continued support by Government agencies, private foundations and the industry for research involving human subjects at Riverside Medical Center.

4.3-2. COMPOSITION

The IRB will have at least five regular, voting members, including the chairperson. At least one IRB member will be a clinical scientist, one a non-scientist, and one a community representative. Scientist members of the IRB will have had experience in research involving human subjects, and will be recruited from among active members of Riverside's medical staff of the Medical Center. Non-scientist members will have had expertise in human rights issues and/or ethical or legal issues considered being relevant to human subject research, and will be recruited from among the community at large. These members or their families will not have

any affiliation with Medical Center. There will be both male and female members. The IRB will ascertain that its membership possesses the professional competence necessary to review human subject research in all categories encountered at the Medical Center, and can judge the acceptability of the research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice.

4.3-3. FUNCTIONS

The following categories of research involving human subjects may be initiated only after review and approval by the IRB:

(a) Research is to take place on the premises of Riverside Medical Center.

(b) Research is to take place elsewhere, utilizing data collected on patients, research subjects or staff of Riverside Medical Center, including those data stored in any form, off the premises of the Medical Center.

(c) At its discretion, the IRB may accept for review, and approve research projects that are to take place elsewhere on or off the premises of Riverside Medical Center, with or without the involvement of members of the staff of the Medical Center.

The IRB shall review and monitor any and all types of research, in which human subjects are involved, including projects that are not subject to federal oversight unless it has been exempted from review in accordance with federal regulations. The authority conveyed to the IRB includes the following:

(a) Review all research projects involving human subjects, before the involvement of human subjects may begin;

(b) Require from investigators revisions in research protocols and informed consent documents as a condition for initial or continuation approval;

(c) Approve new research projects, and continuation of previously approved projects;

(d) Disapprove the initiation of a new research project;

(e) Monitor the activities in approved projects, in any way deemed necessary, including regularly scheduled continuing review at least every twelve months, and verification of compliance with approved research protocols and informed consent procedures;

(f) Ensure prompt reporting to the IRB of any planned changes in approved projects, and that no material changes occur without prior approval by the IRB;

(g) Ensure prompt reporting to the IRB of any adverse events occurring in approved projects, or in other projects related in context to the approved projects;

(h) Suspend or terminate a previously approved project; and

(i) Review and monitor the use of test articles (investigational drugs, biologicals and devices) for the purpose of treatment of serious or life-threatening illnesses.

4.3-4. REPORTS TO

All recommendations from the Institutional Review Board shall be reported to the Quality of Care/Joint Conference Committee for action and the Medical Executive Committee for information.

4.4. QUALITY OF CARE/JOINT CONFERENCE COMMITTEE

4.4-1. PURPOSE AND MEETINGS

The Quality of Care/Joint Conference Committee ("Joint Conference") is a board committee which shall establish, maintain, support and exercise oversight of ongoing operations of the hospital and implement specific review, evaluation and monitoring mechanisms to assess, improve and preserve the overall quality and efficiency of patient care and safety activities in the hospital. It shall also serve as a bridge for direct communication between the medical staff, the hospital administration, and the board of directors. Joint Conference meets at least six times a year. It is responsible to the Board of Directors.

4.4-2. COMPOSITION

Joint Conference shall be comprised of six or more board members recommended by the Board Executive Committee and appointed by the Chairman of the Board. The Chairman of the Board of the Medical Center will be one of these appointees and will alternate chairing the Joint Conference Committee with the President of the Medical Staff. Physician members include the President of the Medical Staff, the President-Elect, Secretary-treasurer, and two medical staff members elected by the Medical Staff every two years. Members of the Committee may be removed by the Chairman of the Board, at his or her discretion.

(a) Qualifications: The members at large of the Committee must be members of the Active Hospital, Active Community or Consulting Staff for at least three years at the time of nomination and election and must remain members in good standing during their term of committee membership.

(b) Nomination: The Medical Staff Nominating Committee nominates two qualified candidates to serve in the capacity of members at large at a meeting in early July of each odd numbered year. Immediately thereafter, this list is posted on the medical staff bulletin board and communicated electronically to the medical staff. Other nominations may be offered and will be accepted if such nominations are made in writing and nominations must be presented with evidence of the candidate's qualifications and willingness to be nominated. No nominations will be accepted after August 1st.

(c) Election: The members at large of the Committee are chosen by election by majority vote cast by secret ballot by those members of the staff who are eligible and qualified to vote at general and special staff meetings and are present at the medical staff's annual meeting in September of each odd numbered year. Should an eligible voting member be unable to attend the annual meeting, they may cast their vote by absentee ballot. Absentee ballots must be obtained, marked, and returned to the medical staff office before completion of the regular voting. If no candidate for the capacity of membership receives a majority vote on the first ballot, a runoff election is held promptly between the two candidates receiving the highest number of votes.

(d) Vacancies: Vacancies in this position shall be filled by special election conducted no later than the next medical staff meeting.

4.4-3. FUNCTIONS

(a) Receive from the Medical Staff Executive Committee written recommendations on applications for staff appointment, reappointment, staff category assignment, division and other clinical unit affiliation, clinical privileges and remedial actions concerning any of the foregoing and review and make its recommendation to the Board;

(b) Cooperate with and assist the Medical Staff and receive written reports on the general findings of and specific recommendations resulting from the quality assurance program activities;

(c) Continuously assess the results and effectiveness of the quality assurance program, evaluate changes that have been or should be made to improve the quality and efficiency of patient care within the hospital, and take action as warranted by its findings;

(a) Review and recommend the annual Quality Improvement Plan, the Patient Safety Plan, and the Utilization Management Plan of the Medical Center that guide all efforts to improve the quality, safety, and efficiency of patient care at Riverside Medical Center. The plans are presented annually to Joint Conference. An annual evaluation of each program is presented at this time;

(d) Monitor quality and patient safety activities and receive reports from the medical staff committees, divisions and service lines. Joint Conference also hears regular reports on the following administrative areas: risk management, complaints and grievances, patient satisfaction, patient safety, emergency preparedness, environment of care and any other pertinent concerns. Annually, Joint Conference receives reports on staff competency, staffing effectiveness and graduate medical education (residency training programs);

(f) Receive annually medical staff recommendations and make recommendations to the Board for action on the adoption, amendment, or repeal of medical staff bylaws, rules, regulations and policies, including required staff authority and administrative needs to accomplish the hospital's quality of care objectives.

(g) Conduct itself as a forum for the discussion of matters of administrative and medical policies and procedures requiring agreement among the Board, Medical Staff and hospital administration; and review the Medical Staff reports to the Board.

(h) Oversee hospital compliance with the laws and regulations of federal, state and local governmental agencies and with the standards, rules and regulations of the various accrediting and approval agencies.

(i) Act as a general liaison between the Board of Directors and the Medical Staff.

Perform such other duties concerning professional staff matters as may be assigned to it by the Board and Executive Committee.

4.4-4. REPORTS TO

All recommendations from the Quality of Care /Joint Conference Committee shall be reported to the Board of Directors.

4.5. MEDICAL STAFF QUALITY AND PEER REVIEW COMMITTEE

4.5-1. PURPOSE AND MEETINGS

The Medical Staff Quality Committee (MSQC) shall fulfill the Staff functions relating to the quality assessment and improvement program and the various monitoring and auditing functions.

4.5-2. COMPOSITION

The Medical Staff Quality Committee (MSQC) includes a chairman and twelve (12) or more members appointed by the medical staff president to represent multiple areas of clinical activity including, but not limited to Internal Medicine, an Internal Medicine subspecialty, Family Medicine, Pediatrics, Surgery, a Surgical Specialty, OB/GYN, Emergency Medicine, Anesthesiology, Radiology, Pathology and Podiatry.

4.5-3. FUNCTIONS

The committee will meet at least 10 times per year. A quorum for purposes of making case determinations will be five voting members. A majority will consist of a majority of voting members present.

4.5-4. REPORTS TO

All recommendations from the Medical Staff Quality and Peer Review Committee shall be reported to the Medical Executive Committee.

4.6. PHARMACY & THERAPEUTICS COMMITTEE

4.6-1. PURPOSE AND MEETINGS

The Pharmacy and Therapeutics Committee shall recommend policy changes regarding formulary additions or deletions coordinate and report drug usage evaluation activities and recommend therapeutical policies and procedures. The committee meets bi-monthly or more often as needed and shall report to the MEC.

4.6-2. COMPOSITION

The pharmacy and therapeutics committee includes a chairman and eight (8) or more members appointed by the medical staff president to represent multiple areas of clinical activity.

4.6-3. FUNCTIONS

The functions of the pharmacy and therapeutics committee shall include the following;

(a) Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital;

(b) Advise the medical staff and the hospital's pharmaceutical department on matters pertaining to the choice of available drugs;

(c) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) Develop and review periodically a formulary for use in the hospital, prescribe the necessary operating rules and regulations for its use, and assure that said rules and regulations are available to and observed by all staff members;

(e) Review all adverse drug reactions and medication errors;

(f) Evaluate clinical data concerning new drugs or preparations requested for use in the hospital;

(g) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;.

(h) Submit written reports at least quarterly to the MEC concerning drug utilization policies and practices in the hospital; and

(i) Monitor the medication usage process.

4.6-4. REPORTS TO

All recommendations from the Pharmacy and Therapeutics Committee shall be reported to the Medical Executive Committee.

4.7. PRACTITIONER HEALTH COMMITTEE

4.7-1. PURPOSE AND MEETINGS

The committee serves as a resource for the medical staff for education of what constitutes practitioner health issues; and for intervention and internal or external diagnostic and treatment referrals for staff members whose functioning may be impaired by physical or emotional problems or substance abuse. The committee shall meet as often as necessary. It shall maintain only such record of its proceedings, as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee.

4.7-2. COMPOSITION

The Committee shall include at least three (3) members of the medical staff appointed by the President of the Medical Staff.

4.7-3. FUNCTIONS

Concerns and self-referral inquiries received and forwarded by the president of the medical staff regarding practitioner health issues shall be evaluated by the Committee.

Whenever the medical staff, or any of its officers or department or committee chairmen, becomes aware that a practitioner member's functioning may be impaired by physical or emotional problems or by substance abuse, including diversion or theft of drugs from the healthcare organization for the purpose of selling, redirecting to a source not as intended, or self-administration, this problem shall be immediately referred to the president of the medical staff and the chief executive officer. If the president of the staff and the CEO find sufficient reason to believe that the practitioner’s judgment or effectiveness may be impaired and constitutes a hazard or potential hazard to the practitioner’s patients, or to the practitioner himself, they shall refer the information to the Practitioner Health Committee.

The Practitioner Health Committee will evaluate the substance of the alleged impairments and will report within thirty (30) days; except that the Committee shall report back to the MEC by its next scheduled meeting regarding referrals of remedial action requests from the MEC.

The report will state one of the following:

(a) The Committee finds that no such problem exists with this practitioner; or

(b) The Committee finds that the practitioner does have an impairment problem, that treatment is indicated, but the practitioner refuses to acknowledge the problem or to accept assistance. In this case, the Committee shall refer the report to the Medical Executive Committee for action.

(c) The Committee finds that the practitioner does have an impairment problem, that treatment is indicated, and that practitioner agrees to accept treatment and assistance. In this case, the Committee shall refer subject practitioner to appropriate sources for evaluation and treatment, and establish and engage systems to monitor the practitioner as needed. If appropriate, the Medical Executive Committee shall then grant the practitioner a medical leave of absence for such length of time as the Practitioner Health Committee recommends as necessary for rehabilitation. Upon termination of the leave of absence, the practitioner may have all or part of his/her clinical privileges restored, commensurate with the degree of rehabilitation and the recommendation of the Practitioner Health Committee.

4.7-4. REPORTS TO

All recommendations from the Practitioner Health Committee shall be reported to the Medical Executive Committee.

4.8. PRACTITIONER WORKPLACE INTERACTION COMMITTEE

4.8-1. PURPOSE AND MEETINGS

The Practitioner Workplace Interaction Committee determines the severity of any behavioral incident. The Committee will report its activities to the Medical Executive Committee on a monthly basis.

4.8-2. COMPOSITION

The Practitioner Workplace Interaction Committee will consist of members as appointed by the President of the Medical Staff, plus members of the administrative staff as appointed by the President of the Medical Center.

4.8-3. FUNCTIONS

After the Practitioner Workplace Interaction Committee has evaluated the reported event, it will have options to:

(a) Clear the file

No action needs to be taken. Those issues that are cleared would be defined as behavior that is inconsequential.

(b) Monitor

This issue would be reviewed on a routine basis by the Practitioner Workplace Interaction Committee. A threshold would be determined as to the frequency or severity of issue that require further action. Those issues that are monitored would be significant issues that can be explained or are understandable under the circumstances, but could be indicative of an aberrant behavioral patter.

(c) Educate

This option would involve behavior that would disrupt the quality patient care if not corrected. An education session would require a representative from the Practitioner Workplace Interaction Committee to explain and educate the practitioner to prevent a repeat of the issue reported. The practitioner may document his or her account and actions in writing to the Practitioner Workplace Interaction Committee. The education session will be documented by memo or the appropriate form by the Practitioner Workplace Interaction Committee member(s), with a copy going to the practitioner's Practitioner Workplace Interaction Committee file. Such documentation will contain a summary of the meeting, including any expectations of the medical staff discussed with the practitioner. Education will be recommended based on one of the following levels, depending on the significance of the event/concern:

1. Level 1: For information purposes to change (improve) patterns of behavior

2. Level 2: Unacceptable behavior that is considered harassment or would predictably result in adverse outcomes

3. Document of the practitioner education will be made using the Practitioner Workplace Interaction Committee Education Documentation Form.

(d) Refer

The issues would be determined significant enough that the practitioner would require a face-to-face meeting with the Practitioner Health Committee. These issues could also have exceeded the threshold set in the monitor pathway. Issues that would be referred are those that patently interfere with the process of delivering good patient care.

A drug or alcohol screen may be required before, or at the time, the Practitioner Workplace Interaction Committee makes its recommendation or referral to the Practitioner Health Committee using the Practitioner Workplace Interaction Committee Referred to the Practitioner Health Committee Contact Form.

Non-practitioner issues: These issues would be referred to the appropriate medical staff and/or hospital committee or individual for consideration.

(e) Immediate review/action

Immediate review and/or action will be initiated on an urgent and emergent basis in the event that a clinician's egregious behavior appears to be risking the life or limb of a patient. Additionally, harassment of hospital personnel as defined in the medical staff regulations will initiate an immediate review and/or action. These events will be promptly reported to the chief of the staff and/or an administrator of Riverside Medical Center for immediate corrective action.

4.8-4. REPORTS TO

All recommendations from the Practitioner Workplace Interaction Committee shall be reported to the Medical Executive Committee.