MEDICAL STAFF ORGANIZATION AND FUNCTIONS MANUAL OF ST. FRANCIS MEDICAL CENTER

Discussion Draft Revisions
April 25, 2014

Horty, Springer & Mattern, P.C.
ARTICLE I
DEFINITIONS

The following definitions shall apply to terms used in this Manual:

(1) “Board” means the Board of Trustees of St. Francis Medical Center, who have the overall responsibility for the conduct of the hospital;

(2) “Chief Executive Officer” means the President of the hospital or the President’s designee;

(3) “Executive Committee” means the Executive Committee of the Medical Staff unless specifically written “Executive Committee of the Board”;

(4) “Medical Staff” means all physicians, dentists, and podiatrists who are given privileges to treat patients at the hospital;

(5) “Physicians” shall be interpreted to include both doctors of medicine (“M.D.’s”) and doctors of osteopathy (“D.O.’s”);

(6) “Dentist” shall be interpreted to include a doctor of dental surgery and doctor of dental medicine;

(7) “Podiatrist” shall be interpreted to mean a doctor of podiatric medicine; and

(8) Words used in this Manual shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this Manual.
ARTICLE II
CLINICAL DEPARTMENTS

ARTICLE II – PART A: CLINICAL DEPARTMENTS

Section 1. List of Departments:

The following clinical departments are established at St. Francis Medical Center:

(a) Department of Anesthesiology
(b) Department of Cardiothoracic Surgery
(c) Department of Emergency Medicine
(d) Department of Medicine
(e) Department of Gynecology
(f) Department of Pathology
(g) Department of Psychiatry
(h) Department of Radiology
(i) Department of Surgery

ARTICLE II – PART A:

Section 2. Functions and Responsibilities of Departments and Department Chairpersons

Department Chairpersons:

Functions and responsibilities of departments and department chairpersons are set forth in Article IV of the Medical Staff Bylaws, Part 1.
ARTICLE III
MEDICAL STAFF COMMITTEES AND FUNCTIONS

ARTICLE III – PART A: MEDICAL STAFF COMMITTEES AND FUNCTIONS

Section 1. Committees:
This Article Manual outlines the Medical Staff committees of St. Francis Medical Center that carry out quality assessment and other functions delegated to the Medical Staff. Procedures for the appointment of committee chairpersons and members are set forth in Article V of the Medical Staff Bylaws, Part 1.

Section 2. Meetings, Reports, and Recommendations:
Unless otherwise indicated, each Committee described in this Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each Committee shall make a timely written report after each meeting to the Medical Executive Committee and to other Committees and individuals as may be indicated in this Manual or provided in the Bylaws, Rules and Regulations or policies.

ARTICLE III – PART B: PHARMACY AND THERAPEUTICS COMMITTEE

Section 1. Composition:
The Pharmacy and Therapeutics Committee shall consist of at least three (3) Medical Staff appointees, one (1) representative from pharmacy, one (1) representative from nursing services, and one (1) representative from hospital management appointed by the Chief Executive Officer. The hospital pharmacist shall be a member of the committee, ex officio, and act as secretary for the Committee.

ARTICLE III – PART B:

Section 2. Duties:
The Pharmacy and Therapeutics Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the hospital in order to
promote optimum clinical results and a minimum potential for hazard. Specifically, the Committee shall:

(a) serve as an advisory group to the Medical Staff and the pharmacists on matters pertaining to choice of available drugs;

(b) make recommendations concerning drugs to be stocked in the Nursing Units and in other services;

(c) evaluate clinical data concerning new drugs or preparations requested for use in the hospital and report decisions and/or concerns to the Executive Committee for action;

(d) review the appropriateness of the prophylactic, empiric, and therapeutic use of drugs through the analysis of individual or aggregate patterns of drug practice;

(e) develop and recommend to the Executive Committee and the Board procedures relating to the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials;

(f) review all significant untoward drug reactions;

(g) maintain a formulary or drug list;

(h) review the appropriateness, safety, and effectiveness of the prophylactic, empiric, and therapeutic use of antibiotics in the hospital; and

(i) recommend policies concerning the safe use of drugs in the hospital, including hazardous drugs and investigational drugs.

ARTICLE III – PART B:

Section 3. Meetings, Reports and Recommendations:

(a) The Pharmacy and Therapeutics Committee shall meet at least monthly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report thereof after each meeting to the Executive Committee and the Chief Executive Officer.

(b) The Pharmacy and Therapeutics Committee shall also report (with or without recommendation) to the appropriate department, chairperson/section chief for his/her consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of
ARTICLE III – PART C: INFECTION CONTROL COMMITTEE

Section 1. Composition:

The Infection Control Committee shall consist of the Infection Control Officer, at least three (3) Active Staff appointees selected by the President of the Medical Staff, one (1) representative from pathology, and representatives from nursing service and hospital management appointed by the Chief Executive Officer.

ARTICLE III – PART C:

Section 2. Duties:

The Infection Control Committee shall:

(a) be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards and the supervision of infection control in all phases of the hospital’s activities, including:
   - Operating rooms, recovery rooms, special care units;
   - Sterilization procedures by heat, chemicals, or otherwise;
   - Isolation procedures;
   - Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;
   - Testing of hospital personnel for carrier status; and
   - Disposal of infectious material.

(b) establish a system for documenting all hospital infections, including infections among patients and hospital personnel, to provide a basis for studying infection sources;

(c) monitor the standards and the bacteriological services available to the hospital; and

(d) recommend an infection control prevention program and a continuing education program for Medical Staff appointees and hospital personnel on infectious disease control.
ARTICLE III – PART C:

Section 3. Meetings, Reports and Recommendations:

(a) The Infection Control Committee shall meet at least bi-monthly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report thereof after each meeting to the Executive Committee and the Chief Executive Officer.

(b) The Infection Control Committee shall also report (with or without recommendation) to the appropriate department chairperson/section chief for his/her consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies, rules or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE III – PART D: UTILIZATION MANAGEMENT COMMITTEE

Section 1. Composition:

The Utilization Management Committee shall consist of the Utilization Management Physician Advisor, at least three (3) Active Staff appointees selected by the President of the Medical Staff and the Chief Executive Officer or his designee. The Chief Executive Officer may also assign representatives from medical records, nursing service, integrated case management, representatives shall serve as advisors, but not as members of the committee.

ARTICLE III – PART D:

Section 2. Duties:

(a) Utilization Management Review Oversight. The Utilization Management Committee shall assess results of designated utilization management audits designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practice, use of medical and hospital services and all related factors which may contribute to the effective utilization of hospital and physician services. Specifically, it shall:
• Analyze how under-utilization of each of the hospital’s services affects the quality of patient care provided at the hospital;
• Study available data related to patterns of care, lengths of stay and other significant utilization trends and provide clinical direction for education, communication and improvement when appropriate at all levels within the organization;
• Evaluate systems of utilization management employing such criteria;
• Review external utilization management trends and assess the impact on the organization and provide recommendations for revisions to the utilization management program when appropriate.

It shall also work toward the assurance of proper continuity of care upon discharge through, among other things, the accumulation of appropriate data on the availability of other suitable health care facilities and services outside the hospital. The committee shall communicate the results of its general studies and other pertinent data to the entire Medical Staff and shall make recommendations for the optimum utilization of hospital resources and facilities commensurate with quality of patient care and safety.

(b) Written Utilization Management Plan. The Committee shall also formulate a written utilization management plan for the hospital. Such plan, approved by the Medical Staff and Board of Trustees, must be in effect at all times and must include all of the following elements:
• The organization and composition of all committee(s) which will be responsible for the utilization management function;
• Frequency of meetings;
• The types of records to be kept;
• The method to be used in selecting cases on a sample or other basis;
• The definition of what constitutes the period of extended duration;
• The relationship of the utilization management plan to claims administration by a third party;
• Arrangements for committee reports and their dissemination; and
• Responsibilities of the hospital’s administration staff in support of utilization management.

(c) Extended Duration Evaluations. The Committee shall evaluate the medical necessity for continued hospital services for particular patients, where appropriate. In making such evaluations, the committee shall be guided by the following criteria:

• No physician shall review responsibility for any extended stay cases in which he has demonstrated to have an actual bias, prejudices, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

• All decisions that further inpatient stay is not medically necessary shall be made by physician members of the committee and only after opportunity for consultation has been given the attending physician by the committee and full consideration has been given to the availability of out-of-hospital facilities and services.

• Where there is a significant divergence in opinion following such consultation regarding the medical necessity for continued in-hospital services for the patient, the judgment of the attending physician shall be given great weight.

• All decisions that further inpatient stay is not medically necessary shall be given by written notice to the chairman of the appropriate department, to the Chief Executive Officer and to the attending physician, for such action, if any, as may be warranted.

Section 3. Meetings, Reports and Recommendations:

(a) The Utilization Management Committee shall meet at least monthly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report thereof after each meeting to the Executive Committee and the Chief Executive Officer.

(b) The Utilization Management Committee shall also report (with or without recommendation) to the appropriate department chairperson/section chief for his/her consideration and appropriate action any situation involving questions of
clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies, rules or unacceptable conduct on the part of any individual appointed to the Medical Staff.

ARTICLE III – PART E: CANCER COMMITTEE

Section 1. Composition:

The Cancer Committee is a standing multidisciplinary committee, whose membership includes the Medical Director of the Cancer Program who shall serve as chairperson. The President of the Medical Staff shall appoint the following active staff representatives: diagnostic radiologist, pathologist, general surgeon, medical oncologist, radiation oncologist, and cancer liaison physician. Other required representatives, who will be appointed by the Medical Director of the Cancer Program, include the cancer program administrator, oncology nurse, social worker or case manager, certified tumor registrar, quality management professional, breast program coordinator and community services representative. The Cancer Program Director or designee shall serve as secretary to the committee.

Section 2. Duties:

The Cancer Committee shall:

(a) Develop and evaluate the annual goals and objectives including clinical, community outreach, quality improvement and programmatic initiatives.

(b) Establish the cancer conference frequency and format on an annual basis.

(c) Establish the multidisciplinary attendance requirements for cancer conferences on an annual basis.

(d) Ensure the required number of cases are discussed at the cancer conferences on an annual basis and that at least 75% of the cases discussed are presented prospectively.

(e) Monitor and evaluate the cancer conference frequency, multidisciplinary attendance, total case presentation and prospective case presentation on an annual basis.
(f) Establish and implement a plan to evaluate the quality of cancer registry data and activity on an annual basis. The plan includes procedures to monitor case-finding, accuracy of data collection, abstracting timeliness, follow up and data reporting.

(g) Analyze patient outcomes and disseminate the results of the analysis.

ARTICLE III – PART E:
Section 3. Meetings, Reports and Recommendations:

(a) The Cancer Committee shall meet as often as necessary to transact its business, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report thereof after each meeting to the Executive Committee. Each appointee shall be required to attend at least fifty percent (50%) of all regular Cancer Committee meetings.

(b) The Cancer Committee shall also report (with or without recommendation) to the appropriate department chairperson/section chief for his/her consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or medical staff bylaws, policies, rules or unacceptable conduct on the part of any individual appointed to the medical staff.

ARTICLE III – PART F: MEDICAL RECORDS COMMITTEE
Section 1. Composition:

The Medical Records Committee shall consist of at least four (4) medical staff appointees, the medical records director, and one (1) representative each from nursing service and hospital management appointed by the Chief Executive Officer. The medical records director shall act as committee secretary.

Section 2. Duties:

The Committee shall:

(a) determine that each medical record, or a representative sample of records, is complete, consistent, and reflects the diagnosis, results of diagnostic tests, therapy
rendered, condition and in-hospital progress of the patient, and condition of the patient at discharge;

(b) conduct periodic reviews of summary information regarding the timely completion of all medical records;

(c) review and recommend all forms proposed for inclusion in the permanent medical record; and

(d) develop and recommend policies regarding medical record administration.

ARTICLE III – PART F:
Section 3. Meetings, Reports and Recommendations:

(a) The Medical Records Committee shall meet at least monthly, shall maintain a permanent record of its proceedings and actions, and shall make a written report thereof after each meeting to the Executive Committee and the Chief Executive Officer.

(b) The Medical Records Committee shall also report (with or without recommendation) to the appropriate department chairperson/section chief for his/her consideration and appropriate action any situation involving a question of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies, rules or regulations, or unacceptable conduct on the party of any individual appointed to the Medical Staff.

ARTICLE III – PART G: TRANSFUSION AND TISSUE REVIEW COMMITTEE
Section 1. Composition:

The Transfusion and Tissue Review Committee shall consist of at least four (4) Active Staff appointees as selected by the President of the Medical Staff and a representative appointed by the Chief Executive Officer or his designee.

ARTICLE III – PART G: TRANSFUSION AND TISSUE REVIEW COMMITTEE
Section 2. Duties:

The committee shall review blood transfusions for proper utilization, particular attention being given to the use of whole blood versus component blood elements. Each actual or
suspected transfusion reaction shall be evaluated and a report completed. The evaluation of blood use should include a review of the amount of blood requested, the amount used, and the amount of wastage.

ARTICLE III – PART G:

Section 3. Meetings, Reports and Recommendations:

(a) The committee shall meet at least quarterly, shall maintain a permanent record of its proceedings and actions, and shall make a written report thereof after each meeting to the Executive Committee and the Chief Executive Officer.

(b) The committee shall also report (with or without recommendation) to the department chairperson/section chief for his/her consideration and appropriate action any situation involving questions of clinical competency, patient care and professional ethics, infractions of hospital or Medical Staff bylaws, policies, rules or regulations or unacceptable conduct on the part of any individual appointed to the Medical Staff.
ARTICLE IV
AMENDMENTS

(1) This Manual may be amended by a majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that copies of the proposed amendments are posted on the Medical Staff bulletin board and made available to all members of the Executive Committee fourteen (14) days before being voted upon. No such amendment shall be effective unless and until it has been approved by the Board.

(2) If significant changes are made in the medical staff bylaws, rules and regulations, or policies, medical staff members and other individuals who have delineated clinical privileges are provided with revised texts of the written materials.
ARTICLE V
ADOPTION

This Manual is adopted and made effective upon approval by the Board, superseding and replacing any and all other Medical Staff bylaws, rules or hospital policies pertaining to the subject matter thereof; and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges at the hospital shall be taken under and pursuant to the requirements of this Manual.

Adopted by the Medical Staff
May 17, 1994

Approved by the Board of Trustees
June 14, 1994
ARTICLE VI
REVISIONS

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Approved by Medical Staff – 5/18/1999
Approved by Board of Trustees – 6/15/1999

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Approved by Medical Staff – 2/20/2001
Approved by Board of Trustees – 3/13/2001

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Approved by Medical Staff – 9/16/2003
Approved by Board of Trustees – 10/14/2003
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