Franciscan Health – Crown Point

MEDICAL STAFF RULES AND REGULATIONS

Organization and Functions Manual

January 1, 2017
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Section 1. Organization and Functions of the Staff

1.1 Organization of the Medical Staff

The medical staff shall be organized as a departmentalized staff including the following departments: medicine and surgery. A Department Chair shall head each department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC.

1.2 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3 with the ultimate responsibility lying with the MEC. The MEC may create committees to perform certain prescribed functions. The medical staff officers, Department Chair, hospital and medical staff committee chairs, are responsible for working collaboratively to accomplish required medical staff functions. This process may include periodic reports as appropriate to the appropriate department or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory and accreditation compliance and appropriate standards of medical care.

1.3 Description of Medical Staff Functions

The medical staff, acting as a whole or through committee, participates in or has oversight over the following activities:

1.3.1 Governance, direction, coordination, and action

a. Receive, coordinate, and act upon, as necessary, the reports and recommendations from departments, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;

b. Account to the Board and to the staff with written recommendations for the overall quality and efficiency of patient care at the hospital;

c. Take reasonable steps to maintain professional and ethical conduct and initiate investigations, and pursue corrective action of practitioners with privileges when warranted;

d. Make recommendations on medical, administrative, and hospital clinical and operational matters;

e. Inform the medical staff of the accreditation and state licensure status of the hospital;

f. Act on all matters of medical staff business, and fulfill any state and federal reporting requirements;

g. Oversee, develop, and plan continuing medical education (CME) plans, programs, and activities that are designed to keep the staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;

h. Provide education on current ethical issues, recommend ethics policies and procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;
i. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the medical staff and governing body; and

j. Ensure effective, timely, and adequate comprehensive communication between the members of the medical staff and medical staff leaders as well as between medical staff leaders and hospital administration and the board.

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

a. Perform ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff;

b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop plans for improving the quality of clinical care provided;

c. Actively be involved in the measurement, assessment, and improvement of activities of practitioner performance that include but are not limited to the following:

   Medical assessment and treatment of patients
   Use of medications
   Use of blood and blood components
   Operative and other procedures
   Education of patients and families
   Accurate, timely, and legible completion of patients’ medical records to include the quality of medical histories and physical examinations
   Appropriateness of clinical practice patterns
   Significant departures from established pattern of clinical performance
   Use of developed criteria for autopsies
   Sentinel event data
   Patient safety data
   Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient
   Findings of the assessment process relevant to individual performance; and

d. Communicate findings, conclusions, recommendations, and actions to improve the performance of practitioners to medical staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioner improvement.

1.3.3 Hospital Performance Improvement and Patient Safety Programs

a. Understand the medical staff’s and administration’s approach to and methods of performance improvement;

b. Assist the hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed, and spread systematically across all disciplines throughout the hospital;
c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and

d. Participate as requested in the hospital’s patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.3.4 Credentials review (see Part III: Credentials Procedures Manual)

1.3.5 Information Management

a. Review and evaluate medical records to determine that they:

   i. Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, and the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and

   ii. Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the hospital.

b. Develop, review, enforce, and maintain surveillance over enforcement of medical staff and hospital policies and rules relating to medical records including completion, preparation, forms, and format and recommend methods of enforcement thereof and changes therein; and

c. Provide liaison with hospital administration, nursing service, and medical records professionals in the utilization of the hospital on matters relating to medical records practices and information management planning.

1.3.6 Emergency Preparedness

Assist the hospital administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the hospital.

1.3.7 Strategic Planning

a. Participate in evaluating existing programs, services, and facilities of the hospital and medical staff; and recommend continuation, expansion, abridgment, or termination of each;

b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services and needs and allocation of present and future resources; and

c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to medical staff members.

1.3.8 Bylaws review

a. Conduct periodic review of the medical staff bylaw, rules, regulations, and policies; and

b. Submit written recommendations to the MEC and to the Board for amendments to the medical staff bylaws, rules, regulations, and policies.

1.3.9 Nominating
a. Identify nominees for election to the officer positions and to other elected positions in the medical staff organizational structure; and

b. In identifying nominees, consult with members of the staff, the MEC, and administration concerning the qualifications and acceptability of prospective nominees.

1.3.10 Infection Control Oversight

a. The medical staff oversees the development and coordination of the hospital-wide program for surveillance, prevention, implementation, and control of infection;

b. Develop and approve policies describing the type and scope of surveillance activities including:
   i. Review of cumulative microbiology recurrence and sensitivity reports;
   ii. Compliance with definitions and criteria for healthcare acquired infections;
   iii. Review of prevalence and incidence studies, as appropriate; and
   iv. Collection of additional data as needed.

c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;

d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;

e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;

f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;

g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or administrative leader; and

h. Review all policies and procedures on infection prevention, surveillance, and control at least biannually.

1.3.11 Pharmacy and Therapeutics Functions

i. Maintain a formulary of drugs approved for use by the hospital;

j. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;

k. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, pharmacist interventions);

l. Perform drug usage evaluation studies on selected topics;

m. Perform medication usage evaluation studies as required by the Healthcare Facility Accreditation Program;

n. Perform practitioner analysis related to medication use;
o. Approve policies and procedures related to HFAP standards to include the review of nutrition policies and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the hospital;

p. Develop and measure indicators for the following elements of the patient treatment functions:
   i. Prescribing/ordering of medications;
   ii. Preparing and dispensing of medications;
   iii. Administering medications; and
   iv. Monitoring of the effects of medication.

q. Analyze and profile data regarding the measurement of patient treatment functions by service and practitioner, where appropriate;

r. Provide routine summaries of the above analyses and recommend process improvement when opportunities are identified;

s. Serve as an advisory group to the hospital and medical staff pertaining to the choice of available medications; and

t. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.12 Practitioner Health

a. Evaluate the credibility of a complaint, allegation, or concern and establish a program for identifying and contacting practitioners who have become professionally impaired, in varying degrees, because of drug dependence (including alcoholism) or because of mental, physical, or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment;

b. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;

c. Notify the impaired practitioner’s Department Chair and the MEC whenever the impaired practitioner’s actions could endanger patients. The existence of the Practitioner Health Committee does not alter the primary responsibility of the Department Chair for clinical performance within that chair’s department;

d. Create opportunities for referral (including self referral) while maintaining confidentiality to the greatest extent possible; and

e. Report to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his/her rehabilitation is complete and periodically thereafter. The hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the hospital has confidence.

1.3.13 Utilization Management

a. Study recommendations from medical staff members, quality assessment coordinators and others to identify problems in utilization and the review program;
b. Monitor the effectiveness of the review program and perform retrospective review in cases identified through the utilization management process;

c. Forward all unjustified cases in any review category to the appropriate department or committee for review and action;

d. Review case-mix financial data and any other internal/external statistical data;

e. Upon review of any data, conduct further studies, perform education or refer the data to the medical staff peer review committee for their review and action;

f. Develop, with the aid of legal counsel, policies to guide the director of utilization management, medical staff, and administration in matters of privileged communication and legal release of information.

1.3.14 Osteopathic Methods and Concepts

a. Promote the most effective methods for osteopathic diagnosis and treatment for comprehensive patient care;

b. Improve recording of osteopathic musculoskeletal findings, diagnosis, and management on patient charts;

c. Provide for the ongoing need for continuing education in osteopathic principles and practice;

d. Provide a clinical environment for osteopathic diagnosis and treatment which will assure quality care in the hospital;

e. Make recommendations to improve utilization of osteopathic principles and practice, record osteopathic findings, describe osteopathic manipulative treatment and apply such modalities as part of the comprehensive care received by patients;

f. Establish and record retrospective and current audits of patient charts relating the application of osteopathic principles and practice to patient diagnosis and treatment; and

g. Inform osteopathic physicians on the Medical Staff of the evaluations of patient charts done by the committee to improve utilization of osteopathic principles and practices.
Section 2. Medical Staff Committees

2.1 General language governing committees

The following shall be the standing committees of the medical staff: MEC, Credentials Committee, Physician Performance Improvement Committee (PIC), Osteopathic Methods and Concepts Committee, Bylaws Committee, Practitioner Assistance Committee and the Nominating Committee. A committee shall meet as often as necessary to fulfill its responsibilities. It shall maintain a permanent record of its proceedings and actions and shall report its findings and recommendations ultimately to the MEC. The President of the Medical Staff may appoint additional ad hoc committees for specific purposes. Ad hoc committees will cease to meet when they have accomplished their appointed purpose or on a date set by the President of the Medical Staff when establishing the committee. The President of the Medical Staff, the CEO, the VPMA or their designees, are ex-officio members of all standing and ad hoc committees.

Committee members may be removed from the committee by the President of the Medical Staff or by action of the MEC for failure to remain a member of the medical staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made.

Medical staff members may be appointed by the President of the Medical Staff to hospital committees. Those appointees will advise the MEC of any proposed policies that impact physician’s clinical ability to care for patients. There shall be medical staff representation on the following hospital committees: Utilization Review, Pharmacy and Therapeutics, Infection Control, Performance Improvement, Hospital Quality Assurance and Process Improvement (QAPI), Critical Care and Education. There shall also be medical staff representation on the following program committees: Cancer, Trauma, Stroke, and Chest Pain. The Utilization Review Committee shall have at least two (2) physician members.

2.2 MEC

Description of the MEC is in Part I: Governance; Section 6.2.

2.3 Credentials Committee

Description of the credentials committee is in Part III: Credentials Procedures Manual; Section 1.

2.4 Physician Performance Improvement Committee (PIC)

2.4.1 Composition: The medical staff quality committee shall consist of eleven (11) members of the medical staff. Representatives from nursing service and hospital administration will serve as ex officio members at the invitation of the chair.

2.4.2 Responsibilities: The committee shall be responsible for those functions described in section 1.3.2 a-d above.

2.5 Osteopathic Methods and Concepts Committee (OMCC)

2.5.1 Composition: The Osteopathic Methods and Concepts Committee shall consist of at least two (2) members of the Medical Staff. If possible, one osteopathic physician from each of the organized departments should serve on the committee. This committee shall function only when there are more than ten (10) osteopathic physicians on the active staff who admit and manage patients.

2.5.2 Responsibilities: The committee shall be responsible for the functions described in section 1.3.14 above.
2.5.3 Meetings: The committee shall meet at least four (4) times per year to transact its business.

2.6 Bylaws Committee

2.6.1 Composition: The bylaws committee shall consist of at least three (3) members of the medical staff, two of whom shall be the immediate past president and the Vice President of the Medical Staff along with one other Medical Staff Member.

2.6.2 Responsibilities: The committee shall be responsible for those functions described in section 1.3.8.

2.6.3 Meetings: The committee shall meet as needed.

2.7 Practitioner Assistance Committee

2.7.1 Composition: The practitioner assistance committee shall consist of at least [x] members of the Active medical staff.

2.7.2 Responsibilities: The PIC committee shall be responsible for those functions described in section 1.3.12 above.

2.8 Nominating Committee

2.8.1 Composition: The Nominating Committee shall be the MEC.

2.8.2 Responsibilities: The committee shall:

a. Provide an annual slate of nominees for the elected medical staff positions;

b. Submit recommendations for medical staff committee chairs based on the potential leaders’ needs for development and readiness to serve (the President of the Medical Staff will consider these recommendations for committee chairs but will not be bound by them);
Section 3.  Confidentiality, Immunity, Releases, and Conflict of Interest

3.1  Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential:

- Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and
- Contributions to teaching or clinical research; or
- Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges or specified services.

3.2  Immunity from Liability

No representative of this hospital shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or medical staff. No representative of this healthcare organization shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law. This release shall also cover any procedures relating to appointment, reappointment, peer review or other quality reviews.

3.3  Covered Activities

3.3.1  The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility’s or organization’s activities concerning, but not limited to:

a. Applications for appointment/affiliation, clinical privileges, or specified services;
b. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
c. Corrective or disciplinary actions;
d. Hearings and appellate reviews;
e. Quality assessment and performance improvement/peer review activities;
f. Utilization review and improvement activities;
g. Claims reviews;
h. Risk management and liability prevention activities; and
i. Other hospital, committee, department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

3.4 Releases

When requested by the President of the Medical Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

3.5 Conflict of Interest

A member of the medical staff requested to perform a board designated medical staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider’s involvement in the patient’s care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner, or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

Adopted by the Medical Executive Committee of the Medical Staff of Franciscan Health Crown Point on September 1, 2016 to be implemented January 1, 2017.

Kristine Teodori, DO
President of the Medical Staff, Medical Staff
Approved:
Vidya Kora, MD
Chairperson, Board of Directors
NIR Board