HOMESTEAD HOSPITAL

ORGANIZATION AND FUNCTIONS MANUAL

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SECTION 1. ORGANIZATION AND FUNCTIONS OF THE STAFF

1.1 Organization of the Medical Staff

The Medical Staff of Homestead Hospital shall be organized as a non-departmentalized staff. The MEC may create Clinical Services as described in the Medical Staff Bylaws, Article IV. The currently recognized Clinical Services are the following:

Medicine, Surgery, Pediatrics, Obstetrics and Gynecology, Neurology and Pulmonary On-Call.

1.2 Responsibilities for Medical Staff Functions

The ultimate responsibility of Medical Staff functions as outlined in Section 1.3 lies with the MEC. The Medical Staff Officers, Clinical Services Chiefs, Hospital and Medical Staff Committee Chairs, are responsible to work collaboratively to develop a process for communication of Medical Staff function activities by providing periodic reports as appropriate to accountable individuals or committees and to elevate issues of concern to MEC as needed to ensure adherence to federal, state and local laws, regulatory/accreditation requirements and appropriate standards of medical care.

Additionally, Medical Staff Officers may appoint Designated Physician leaders to help fulfill Medical Staff functions and identify other medical and administrative resources needed to adequately fulfill these functions. A Designated Physician Leader is a member of the Medical Staff appointed by the President of the Medical Staff or by the MEC to represent the Medical Staff on hospital committees or to work on behalf of the Medical Staff with hospital personnel on specific projects or functions.

1.3 Description of Medical Staff functions:

The responsible party is listed in parentheses following each activity outlined below:

1.3.1 Governance, direction, coordination, and action:

a. Receive, coordinate and act upon, as necessary, the reports and recommendations from clinical services, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities (MEC, Medical Staff Officers, and Medical Staff committees);

b. Account to the Board and to the Staff by written recommendations for the overall quality and efficiency of patient care at Homestead Hospital (President and MEC);

c. Take appropriate steps to obtain professional and ethical conduct and initiate investigations, and pursue corrective action of Medical Staff Members, when warranted (President and MEC);

d. Make recommendations on medico-administrative and Hospital clinical and operational matters (President and MEC);

e. Inform the Medical Staff of the accreditation program and the accreditation and state licensure status of the Hospital (President and MEC);

f. Take appropriate action on all matters of Medical Staff business, and where appropriate fulfill any state and federal reporting requirements (MEC and Medical Staff committees);

g. Oversee, develop, and plan Medical Education 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 (MEC in conjunction with the Medical Education Committee of Baptist Health South Florida);

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 Practitioners when ethical conflicts occur, in order to facilitate and provide a process for conflict resolution (MEC or a Subject Matter Expert); and

i. Ensure effective, timely and adequately 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 (Medical Staff Officers, CEO)

1.3.2 Medical Care Evaluation/Performance Improvement/patient Safety Activities (Medical Quality Committee)

a. Set expectations, develop plans, educate members, and manage processes to measure, assess, and improve the quality of clinical activities;

b. Understand the adopted approach to and methods of performance improvement;

c. Ensure that important processes and activities are measured, assessed, and improved systematically across all disciplines throughout the Hospital;

d. Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body and define in writing responsibility for acting on recommendations for improvement;

e. Participate in ensuring that the processes are defined and implemented for identifying and managing sentinel events and events that warrant intensive analysis;

f. Collaborate with the Hospital on implementation of an integrated patient safety program throughout the Hospital;

g. Collaborate with the Hospital to see that an ongoing, proactive program for identifying risks to patient safety and reducing medical/health care errors is defined and implemented;

h. Provide for mechanisms to measure, analyze, and manage variation in the performance of defined processes that affect patient safety; and

i. Measure and assess the effectiveness of contributions to improving performance and patient safety.

1.3.3 Monitoring activities should include but not be limited to the following:

a. Medical assessment and treatment of patients;

b. Use of medications;

c. Use of blood and blood components;

d. Use of operative and other procedures;

e. Education of patients and families;

f. Coordination of care with other Practitioners and Hospital personnel;

g. Accurate, timely, and legible completion of patients' medical records;

h. Appropriateness of clinical practice patterns;

i. Significant departures from established patterns of clinical practice;

j. Use of developed criteria for autopsies;

k. Sentinel event data;

l. Patient safety data;

m. Coordination of care, treatment, and services with other Practitioners and Hospital personnel, as relevant to the care, treatment, and services of an individual patient; and

n. Findings of the assessment process that are relevant to an individual's performance.

1.3.4 Credentials review (see the Credentials Procedure Manual)

1.3.5 Information Management (MEC)

a. Review and evaluate medical records to determine that they:
   i. Properly describe the condition and progress of the patient, the therapy, the tests provided and 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 at least quarterly over enforcement of Medical Staff and Hospital policies and rules relating to medical record including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein.

c. Provide liaison with Hospital administration, nursing service, and medical records professionals in the employ 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 a crisis management manual that addresses disasters both external and internal to the Hospital (MEC).

1.3.7 Planning (President, MEC, Clinical Service Chiefs)

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 (MEC)

a. The MEC will directly, or through the periodic appointment of an ad hoc bylaws committee, conduct periodic review of the Medical Staff Bylaws, Manuals, Policies, Rules and Regulations and any additional Medical Staff procedures;

b. Conduct periodic review of the clinical policies and rules; and

c. Submit written recommendations to the MEC and to the Board for amendments to the Medical Staff Bylaws, Credentials Procedure Manual, Organization and Functions Manual and Rules and Regulations.

1.3.9 Nominating (MEC)

The MEC will appoint a nominating committee on an “as needed basis” to identify nominees for election to the officer positions and to other elected positions in the Medical Staff organization structure in accordance with the Medical Staff Bylaws .

1.3.10 Infection Control Oversight (MEC, Medical Staff Quality Committee)

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. Determination of definitions and criteria for nosocomial infections
   iii. Review of prevalence and incidence studies, as appropriate
   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 and revise the type and scope of surveillance annually;

e. Develop a surveillance plan for all sampling of personnel and environments;

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

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

h. Report nosocomial infection findings on a day-to-day basis to the attending physician and appropriate clinical or administrative leader; and

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

1.3.11 Pharmacy and Therapeutics Functions (MEC, Medical Staff Quality Committee, Designated Physician Leader)

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

b. Create treatment guidelines and protocols in cooperation with medical and nursing staff;

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

d. Perform drug usage evaluation studies on selected topics;

e. Perform medication usage evaluation studies as required by the Joint Commission on Accreditation of Healthcare organizations (the Joint Commission);

f. Perform blinded Practitioner profile analysis related to medication use;

g. Approve policies and procedures related to the Joint Commission Care of Patient 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 health system;

h. 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. Administrating medications; and
   iv. Monitoring of the effects of medication.

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

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

k. Serve as an advisory group to the health system and Medical Staffs pertaining to the choice of available medications; and

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

1.4 Responsibilities of Clinical Section Chiefs:

a. Clinically related activities of the department or service.

b. Administratively related activities of the department or service, unless otherwise provided by the hospital.

c. Continuing surveillance of the professional performance of all individuals in the department or service who have delineated clinical privileges.

d. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department or service.

e. Recommending clinical privileges for each member of the department or service.

f. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

g. Integration of the department or service into the primary functions of the organization.

h. Coordination and integration of interdepartmental and intradepartmental services.

i. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

j. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

k. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

l. Continuous assessment and improvement of the quality of care, treatment, and services.

m. Maintenance of quality control programs, as appropriate.

n. Orientation and continuing education of all persons in the department or service.

o. Recommending space and other resources needed by the department or service

SECTION 2.MEDICAL STAFF COMMITTEES

2.1 Medical Executive Committee:

Description of the MEC can be found in the Medical Staff Bylaws

2.2 Credentials Committee:

Description of the Credentials Committee is found in the Credentials Procedure Manual

2.3 Medical Staff Quality Committee:

2.3.1 Committee Composition:

The MSQC will be comprised of nine (9) members of the Active Medical Staff and one (1) allied health professional, and will include 1 at-large member and representative members from each of the following specialties : 2 Medicine, 1 General Surgery, 1 OB/GYN, 1 Pediatrics, 1 Emergency Medicine, 1 Anesthesiology and 1 Radiology. The President-Elect of the Medical Staff is an ex-officio member of the Committee without vote. Medical Staff members currently serving as members of the Board of Directors cannot serve on the Committee.

The Chair of the Committee will be appointed by the President of the Medical Staff. The Chair shall attend the Medical Executive Committee for reporting purposes, on a quarterly basis.

2.3.2 Committee Membership Selection and Attendance:

Committee members will be appointed by the President of the Medical Staff and approved by the MEC based on the recommendations from the Committee Chair for a three-year (3) term except for initial committee members. The initial committee will have staggered terms with a third of the committee members assigned initial terms of one (1) year, a third assigned initial terms of two (2) years and a third assigned initial terms of three (3) years. Committee members may serve up to two consecutive terms. After one (1) year off the committee, members will be eligible for reappointment.

Committee members will be expected to attend at least two-thirds (2/3) of the committee meetings over a twelve-month (12) period to maintain membership. Committee members will be expected to participate in appropriate educational programs provided by the Hospital or Medical Staff to increase their knowledge and skills in performing the Committee's responsibilities.

2.3.3 Meeting Frequency:

The committee will meet no less than quarterly. The presence of five (5) voting committee members will constitute a quorum at a regularly scheduled meeting for purposes of making case determinations. A majority will consist of a majority of voting members present.

In addition to Committee members, Quality Management and Medical Staff Services professionals supporting the Committee and invited guests may attend the Committee meetings.

2.3.4 Reporting:

The Committee will report at least quarterly to the Medical Executive Committee.

2.3.5 Responsibilities:

a. Coordinates the systematic and ongoing review of the appropriateness and quality of: blood usage, drug usage, anesthesia/operative and other invasive procedures, timeliness, completion, and accuracy of medical records;

b. Reviews and approves blood usage;

c. Coordinates, prioritizes, and monitors the Medical Staff data gathering and analysis components of the Hospital's quality review program and coordinates the Medical Staff's activities in this area with those of the other professional and support services in the Hospital;

d. Serves as a liaison for quality review issues with the Medical Staff, the Hospital staff, and the committee(s) responsible for compliance with accreditation standards and federal and state and licensure requirements;

e. Coordinates, with the administrative director, clinical information services, the Medical Staff's performance improvement activities and annually reviews the effectiveness and cost efficiency of the Medical Staff's performance improvement activities;

f. Responsible for establishing:
   i. Formats for the aggregation, display, and reporting of data and findings;
   ii. Systems for follow up to determine that corrective action taken results in problem resolution;
   iii. Formats and schedules for submission of data and findings, committee minutes, and special quality reports.

g. Receives and synthesizes information regarding critical care and utilization review on a routine basis;

h. Supervises the maintenance and analysis of data and transmits that analysis to the appropriate Clinical Service Chief to use in the periodic reappraisal of each staff member;

i. Implements a system for screening of clinical risk management issues, including unexpected patient care management events, and morbidity concerns; analyzes aggregate data on significant high risk events by identifying possible patterns and communicating same to the Clinical Service Chief and the MEC.

j. Analyzes trends of hazardous and risk management events reported, and attempts to determine effective solutions and implement appropriate systems or suggest action to enhance the quality and safety of patient care.

k. Provide for Medical Staff peer review through the following activities:
    i. Initial review of all cases of sufficient complexity of management or seriousness of outcome requiring physician peer review based on cases identified by Type II (Review) indicators through referrals from:
        a. Generic screens
        b. Blood product screening
        c. Drug use evaluation
        d. Surgical and invasive procedure pathologic findings
        e. Utilization management
        f. Risk management
        g. Department or specialty specific measures
        h. Incident reports regarding inadequate physician service

    ii. Review of diagnostic images (i.e. radiology, pathology, cardiac) will be performed by the specific specialty for quality control and general review with the aggregate results of the reviews sent to the committee. Cases with adverse outcomes where image interpretation may have contributed to outcome will be reviewed by the committee with assistance of the appropriate specialty.
    iii. Obtain reviews and recommendations from specialist when required and make recommendations to MEC regarding the need for external peer review
    iv. Communicate with the physician involved with the case prior to making final determinations.
    v. Make final determination regarding opportunities for individual or system improvements based on individual case review.
    vi. Regular review of aggregated results of Type I (Rule) indicators and of patterns, trends and outlier status for Type III (Rate) indicators relevant to physician performance for all dimensions of physician performance within the scope of the committee to identify individual or system opportunities for improvement and determine if additional analysis or focus studies are needed. The committee may delegate the routine review of rate indicator data to the Data Trends Council as described in the Data Trends Council Charter.
    vii. Communicate individual improvement opportunities to the appropriate Clinical Service Chief, who, in conjunction with the Committee Chair or designee, develops an improvement plan if necessary.
    viii. Communicate system improvement opportunities to the HQC.
    ix. Track responses and improvement plans.
    x. Report to the MEC regularly regarding actions taken to improve care and any cases where action was not taken when requested.

xi. Approve requests to the quality management department for additions or deletions to indicators, criteria or focused studies for evaluating physician performance.

xii. At least annually review the indicators, screen tools and referral systems for effectiveness and recommend changes to the MEC.

xiii. In coordination with the Credentials Committee, define the appropriate content and format for physician performance feedback reports.

2.4 Designated Physician Leaders:

Designated Physician Leaders: The President of the Medical Staff will appoint, when it will add value, an appropriate Designated Physician Leader to represent the Medical Staff and work with the Hospital management personnel on the following matters: Infection Control; Medical Records; Critical Care Medicine; and Pharmacy and Therapeutics. The President may appoint additional Designated Physician Leaders for additional areas of concern whenever he or she feels it would be appropriate. Designated Physician Leaders will report their activities to the MEC as instructed by the President of the Medical Staff.

SECTION 3. REVIEW REVISION, ADOPTION, AND AMENDMENT

This Medical Staff Organization and Functions Manual may be amended as set forth in Article VIII of the Medical Staff Bylaws.

Approved and Adopted by:

George Tershakovec, M.D.	12/06/10
President	Date
William Duquette	02/23/11
CEO, Homestead Hospital	Date
William Chambers, III	02/23/11
Chairperson, Board	Date