MEDICAL STAFF BYLAWS, POLICIES,
AND RULES AND REGULATIONS

HSHS ST. VINCENT HOSPITAL

MEDICAL STAFF ORGANIZATION MANUAL

September 2020

TABLE OF CONTENTS

PAGE

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff Committee, the individual, or the committee, through its chairperson, may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

CLINICAL DEPARTMENTS

2.A. LIST OF DEPARTMENTS AND SERVICES

The following clinical departments and services are established:

- Department of Anesthesiology
- Department of Cardiac Medicine and Surgery
  - Cardiology
  - Cardiothoracic Surgery
- Department of Emergency Medicine
- Department of Medicine
  - Critical Care
  - Endocrinology
  - Family Medicine
  - GI
  - Infection Prevention
  - Internal Medicine
  - Nephrology
  - Pulmonology
- Department of Neuroscience
  - Endovascular Neuroradiology
  - Neurology
  - Neurosurgery
- Department of Obstetrics and Gynecology
- Department of Oncology
- Department of Pathology
- Department of Pediatrics
  - Neonatology
  - Pediatric Critical Care
- Department of Radiology
  - Diagnostic Radiology
  - Interventional Radiology
- Department of Surgery
  - Colon & Rectal Surgery

General Surgery
Plastic Surgery
Trauma Surgery
Vascular Surgery

Department of Surgical Services
Orthopaedic Surgery
Orthopaedic Trauma Surgery
Pediatric Orthopaedic Surgery
Podiatric Medicine & Surgery
Spinal Surgery
Urology

Department of Surgical Specialties
Corneal & External Eye Disease
General & Pediatric Dentistry
Ophthalmology
Ophthalmologic Plastic Surgery
Otolaryngology
Vitreous & Retinal Surgery

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND DEPARTMENT CHAIRPERSONS

The functions and responsibilities of departments and department chairpersons are set forth in Article 4 of the Medical Staff Bylaws.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of St. Vincent Hospital that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Procedures for the appointment of committee chairpersons and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

(3) Members of Medical Staff committees are expected to maintain confidentiality relating to all matters.

3.B. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet as necessary 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 Executive Committee and to other committees and individuals as may be indicated in this Manual.

3.C. CREDENTIALS COMBINED COMMITTEE

3.C.1. Composition:

The Credentials Combined Committee shall consist of at least five members of the Active Staff, one of whom shall serve as chairperson. If approved by the Committee and by the Executive Committee, an Advance Practice Clinician may serve as a voting member. The members shall serve an initial term of three years with no limits on the number of terms a member may serve. The President-Elect may also serve on the Committee, *ex officio*, with vote. The Committee shall also include the Director of Medical Staff Services and representatives of the Credentials Verification Office, *ex-officio, without vote*, as designated by the CEO/COO.

3.C.2. Duties:

The Credentials Combined Committee reports to the Executive Committee and shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make a written report of its findings and recommendations;

(b) in accordance with the Policy on Advanced Practice Clinicians, review the credentials of all applicants who request to practice at the hospital as Advanced Practice

Clinicians, conduct a thorough review of their applications, interview such applicants as may be necessary, and make a written report of its findings and recommendations;

(c) review, consider, and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges and scope of practice within the hospital, including specifically as set forth in Section 4.A.3 ("Clinical Privileges for New Procedures") and Section 4.A.4 ("Clinical Privileges That Cross Specialty Lines") of the Credentials Policy;

(d) review, as may be requested by the Executive Committee, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff and of those practicing as Advanced Practice Clinicians and, as a result of such review, make a written report of its findings and recommendations to the Executive Committee;

(e) develop, recommend, and consistently implement policies for all credentialing functions and activities; and

(f) perform such other functions as requested by the Executive Committee or Board.

3.D. EXECUTIVE COMMITTEE

The composition and duties of the Executive Committee are set forth in Section 5.D of the Medical Staff Bylaws.

3.E. INFECTION PREVENTION AND CONTROL COMMITTEE-EWD

3.E.1. Composition:

The Infection Prevention and Control Committee-EWD shall consist of members of the Medical Staff, of whom at least one shall be a pathologist. The infection preventionist and at least one representative from nursing and hospital management shall also serve on the Committee.

3.E.2. Duties:

The Infection Prevention and Control Committee-EWD shall:

(a) have oversight responsibilities for the surveillance, prevention, and control of infection risks, the review and analysis of actual infections, and the promotion of a preventive and corrective program designed to minimize infection risks; and

(b) develop, implement, and coordinate the hospitalwide program for risk assessment, surveillance, prevention, and control of infections.

3.F. PERFORMANCE MONITORING COMBINED COMMITTEE

3.F.1. Composition:

(a) The Performance Monitoring Committee shall consist of eight members of the Medical Staff, one of whom shall serve as chairperson and at least one Advanced Practice Clinician; members are appointed by the PMC Chairperson based on the recommendations of the Medical Staff Department Chairpersons and PMC members. The appointments are subject to approval by the MEC. Only physician and APP members of the committee are permitted to vote. Members shall serve an initial term of three years with no limit on the number of terms a member may serve.

practice

(b) The assistance of an appropriate specialist on the Medical Staff may be requested by the committee if additional clinical expertise is needed.

(c) The Director of Medical Staff Services and the Clinical Review Specialist or designee shall serve as support to the committee, without vote.

(d) The CEO/COO/CPE may attend meetings upon request, without vote, and other Hospital staff may be asked to attend when system or process issues are identified.

3.F.2. Duties:

The Performance Monitoring Committee is a multi-specialty peer review committee which shall:

(a) evaluate performance of individual cases of physicians and/or Advanced Practice Clinicians with clinical privileges;

(b) identify potential hospital performance improvement (PI) opportunities resulting from case review and confidentially relay such information and/or recommendations to the appropriate department or designee;

(c) make recommendations regarding improvement strategies to the department chairperson, who is responsible for directly working with the physician/APP under review on the actual improvement approach;

(d) act as the oversight committee for functions related to other measures of physician performance in addition to cases requiring peer review and report directly to the Executive Committee, thereby consolidating the quality reporting process; and

(e) meet as required to accomplish its functions.

3.G. PHARMACY AND THERAPEUTICS COMMITTEE-EWD

3.G.1. Composition:

The Pharmacy and Therapeutics Committee - EWD shall consist of members of the

Active Staff, of whom one shall serve as chairperson. The Committee shall also include one representative each from hospital management, Pharmacy, Nursing, Quality, and Administration.

3.G.2. Duties:

The Pharmacy and Therapeutics Committee-EWD shall:

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

(b) develop and recommend to the Executive Committee policies/directives relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials;

(c) define and review all significant untoward drug reactions; and

(d) maintain and periodically review the Hospital formulary or drug list.

3.H. PHYSICIAN HEALTH COMBINED COMMITTEE

3.H.1. Composition:

The Physician Health Combined Committee shall consist of at least two members of the Medical Staff who are willing to serve and are selected for specific expertise and experience, one of whom shall serve as chairperson. Initial appointments are for three-year terms, with no limits on the number of terms a member may serve.

3.H.2. Duties:

The Physician Health Combined Committee shall:

(a) be responsible for recognizing and evaluating issues related to the health, well-being, or impairment of Medical Staff members and Advanced Practice Clinicians;

(b) be the identified point within the Hospital where information and concerns about health of a Medical Staff member or Advanced Practice Clinician can be presented for consideration and evaluation;

(c) perform all functions as may be authorized in the Policy on Committee-Physician Health;

(d) be advisory to and report to the Executive Committee, and other appropriate committees as designated by the Executive Committee; and

(e) have no authority to take disciplinary action on its own.

3.I. TRAUMA COMMITTEES

3.I.1. The Trauma Peer Review committee

Composition:

(a) Medical Staff Members:
The Trauma Peer Review committee shall consist of the Trauma Medical Director, the trauma surgeons call panel and liaisons from Emergency Medicine, orthopedics, neurosurgery, anesthesia, critical care and radiology.

(b) Administrative Representatives:
The committee shall also consist of the trauma coordinator, trauma registrar, a representative from Medical Staff Services Peer Review and at least one representative from hospital administration.

Duties:

The Trauma Peer Review committee shall serve as a multidisciplinary group, responsible for the overall evaluation of trauma care, from a clinical and systems perspective, by individual specialties and to perform interdisciplinary implementation of improvement strategies. This meeting is held monthly and liaison members of the committee must attend at least 50% of all Trauma Peer Review meetings (per the American College of Surgeons- Committee on Trauma requirements). The committee functions under the auspices of the Department of Surgery, and Medical Staff Executive Committee. The Trauma Peer Review Committee provides minutes to the Medical Staff Executive Committee.

3.I.2 The Multidisciplinary Trauma Systems/ Operations Committee

Composition:

The Multidisciplinary Trauma Systems/ Operations Committee shall consist of the Trauma Medical Director, Trauma Coordinator, Trauma Registrar, and departmental representatives involved in HSHS St. Vincent's Trauma Program across the continuum of care.

Duties:

The Multidisciplinary Trauma Systems/ Operations Committee is responsible for examining trauma-related hospital operations. This committee will be data driven, system and process focused, and verification readiness will be addressed. The committee is a forum for coordinating and shaping of processes such as policy and procedures, strategic

planning, marketing, communications, quality improvement, research, public education and outreach for the trauma program.

3.I.3. Trauma Morbidity and Mortality

Composition:

Trauma Morbidity and Mortality committee shall consist of the Trauma Medical Director, Trauma Coordinator, trauma surgeons call panel, trauma Advanced Practice Clinicians, and sub-specialty liaisons, trauma registrars, one representative from Medical Staff Services and at least one representative from hospital administration.

Duties:

Trauma Morbidity and Mortality committee is an initial examination to help filter cases that need to undergo additional examination, review, discussion, intervention, and loop closure. This allows for concurrent/retrospective event identification as well as opportunities for further education. This review is held twice a month.

3.J. UTILIZATION MANAGEMENT COMMITTEE-EWD

3.J.1. Composition:

The Utilization Management Committee-EWD shall consist of at least two members of the Medical Staff, one of whom shall serve as chairperson. The Committee shall also include the Director of Health Information Management, the Director of Case Management, and other representatives from Hospital departments as may be assigned.

3.J.2. Duties:

Health Information Management Review Functions:

The Utilization Management Committee-EWD shall:

(a) conduct periodic reviews of a representative sample of records to assess compliance with hospital, state and federal regulations for medical records; and

(b) conduct periodic reviews of a representative sample of records to assess the quality of the documentation; and

(c) conduct periodic reviews of summary information regarding the timely completion of all medical records and make recommendations concerning the same as appropriate; and

(d) reviews and approves changes to the hospital medical records regulations.

Utilization Management Committee-EWD Functions:

The Utilization Management Committee-EWD shall:

(a) monitor utilization to evaluate the appropriateness of hospital admissions, length of stays, discharge practices, use of medical and hospital services and resources, and other factors related to utilization of hospital and physician services;

(b) formulate a written utilization management plan for the Hospital(s), to be approved by the Executive Committee, the CEO/COO, and the Board, in accordance with all applicable accreditation, third-party payor, and regulatory requirements which shall be in effect at all times;

(c) evaluate the medical necessity for initiation of and continued hospital services or level of care for particular patients and make recommendations on the same to the attending physician, the Executive Committee, and the CEO/COO. No physician shall have review responsibility for any extended stay cases in which that physician has been professionally involved; and

(d) Physicians assigned to the Committee serve as Physician Advisors for the medial Staff and Care Managers.

ARTICLE 4

AMENDMENTS

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. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Executive Committee meeting, and any member of the Medical Staff may submit written comments on the amendments to the Executive Committee. No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Medical Staff and the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Originally adopted by the Medical Staff:	July 25, 2006
Originally approved by the Board:	July 26, 2006
Revisions adopted by the Medical Staff:	February 24, 2009, December 21, 2010, July 23, 2013, July 28, 2015, October 27, 2015, October 23, 2018, November 26, 2019, September 22, 2020
Revisions approved by the Board:	March 18, 2009, January 19, 2011, September 16, 2015, November 18, 2015, November 14, 2018, January 15, 2020, November 18, 2020