SECTION 3
ORGANIZATIONAL MANUAL

INITIAL ADOPTION AND APPROVAL:
Medical Staff – May 9, 1997
Medical Executive Committee – June 12, 1997

ANNUAL REVIEW

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**Appendix A:** Medical Staff Organizational Chart

**Appendix B:** Quality Program Table of Organization
DEFINITIONS

The definitions referenced in the Medical Staff Bylaws also apply in the Organizational Manual.

CONFIDENTIALITY OF INFORMATION AND IMMUNITY FROM LIABILITY

The protection identified in Article X of the Medical Staff Bylaws shall apply to the Organizational Manual of the Medical Staff Bylaws.

ARTICLE I. MEDICAL STAFF LEADERSHIP STRUCTURE

A. Medical Executive Committee

The selection, composition, and function of the Medical Executive Committee is defined in the main body of these Medical Staff Bylaws.

B. Campus Medical Staff Operating Committee

The selection, composition, and function of the Campus Medical Staff Operating Committee is defined in the main body of these Medical Staff Bylaws.

ARTICLE II. CLINICAL SECTIONS OF THE MEDICAL STAFF

A. The Medical Staff recognizes specialty focused clinical sections as follows:

1. Medicine (representing physiatry)
2. Surgery (representing podiatry, dentistry, pathology)
3. Obstetrics and Gynecology
4. Mental Health
5. Family Practice
6. Diagnostic Imaging
7. Pediatrics
8. Anesthesiology
9. Emergency Medicine
B. Medical staff members and Allied Health Professionals are assigned to the appropriate clinical section upon appointment to the medical staff. Each clinical section will be comprised of all medical staff members or Allied Health Professionals who practice in that specialty area.

C. Each clinical section at each Campus will have a section chief.

1. See Medical Staff Bylaws Article III, Section 8 for the clinical section chief duties.

2. The authority and responsibility of the clinical section chiefs may also include:
   a) To represent or designate representation for that specialty on appropriate IDT Leadership Teams
   b) When requested by a IDT Leadership Team, to provide or designate provision of appropriate staff for peer review activities, including support of Credentials Committee;
   c) To ensure that specialty groups have an opportunity to meet on issues of interest;
   d) To be the responsible representative of that specialty at each Campus to provide real time response to medical staff issues brought by the hospital or the medical staff;
   e) Others as are assigned by the Medical Executive Committee or the Campus Operating Committee.

3. The selection of clinical section chiefs will be by vote of the members of the section at each Campus.
   a) Nominations may be made by any member of the section
   b) Selection will be conducted in conjunction with the selection of the Medical Executive Committee
   c) Write in ballots will be accepted
   d) The clinical section chief will be the nominee receiving the largest number of votes.
   e) There are no term limits for clinical section chiefs.

D. Clinical sections chiefs may select a member to serve in the capacity of assistant chief. In the absence of the Section Chief, an Assistant Section Chief shall assume all the duties and have the authority of the Section Chief.

E. Clinical section functions and meeting options are as described in the main body of the Bylaws.
ARTICLE III. FRANCISCAN QUALITY COUNCIL, INTERDISCIPLINARY TEAMS AND LEADERSHIP TEAMS

SECTION 1. FRANCISCAN QUALITY COUNCIL (FQC)

A. FQC is the regional quality council for CHI-FH. The FQC consists of representative members of the medical staff, nursing staff, ancillary staff and administrative staff. It is jointly co-chaired by an appointed member of the CHI-FH medical staff, approved by the Medical Executive committee, and by the Chief Nursing Officer (CNO).

B. The group meets at least quarterly and receives reports from all service line Leadership Teams on a rotating schedule. All major service lines make quality reports on a periodic basis, and this is usually done by the regional director and the medical director of that service line.

C. Service line FQC reports follow a standard format to cover relevant data, data analysis, process improvement projects, safety and regulatory concerns, and patient/customer satisfaction.

D. Members the CHI-FH Quality divisions such as Risk Management, Safety, Regulatory, and Infection Prevention & Control report directly to the Safety IDT along with other regional non-service line departments. The Safety IDT does not report to FQC. The Safety IDT presents their report summaries bi-annually directly to the Quality and Value Committee, Medical Executive Committee and then the Board.

SECTION 2. INTERDISCIPLINARY TEAMS (IDTS)

A. Interdisciplinary Teams (IDTs) provide the organizational structure for medical staff, nursing, ancillary and administrative staff to carry out the essential functions of the medical staff focusing on a specific segment of patient care. There are five IDTs.

   1. Women’s & Children’s
   2. Special Services
   3. Medicine
   4. Surgery/Anesthesia
   5. Safety

B. Each IDT represents a grouping of clinically related Leadership Teams (LTs). See below, Organization Charts and Quality and Safety Plan, Policy 395.

C. Specific functions of the IDTs include:

   1. Serve as a reference to ensure that all stakeholders are accounted for in communications about policies, order sets, and procedures.
2. Identify who should attend the Franciscan Quality Council meetings. Members of an IDT attend when other members of the IDT are presenting at Franciscan Quality Council.

SECTION 3. LEADERSHIP TEAMS (LTS)

A. The LT usually represents one particular service line offered (e.g., cardiology, critical care, and oncology). LTs generally meet on a monthly basis, and their meeting agenda follows a fairly strict and straightforward template similar to that presented above for IDTs. LTs representing similar service lines at the different hospitals have the choice of meeting together (as a regional LT), or separately (a local LT).

B. Members of a LT consist of medical, nursing, technical, ancillary, and clerical staff involved with the daily care provided within that service line. If there is a paid medical director for the particular service line, then s/he will usually chair the meetings. Section chiefs (from the medical staff structure) for the particular service line are encouraged to attend.

C. LTs are required to develop a report card of essential metrics based on:
   1. Clinical process and outcome data
   2. High Risk Safety and Required Regulatory Practices
   3. Current patient satisfaction scores

D. New Performance Improvement projects are proposed, based on the current data analysis.

E. New draft policy, procedure, pathway, or order set proposals are discussed and amended. Recommendations for implementation and sustainability of new policy and procedures, as well as operational issues related to care delivery are discussed.

F. New policy, protocol, order set, or pathway that only effects the single service line may be approved at the LT level and reported (for courtesy) to the parent IDT. Those that cross service lines need approval at the IDT linking those service lines (see Organizational Chart).

ARTICLE IV. SHARED HOSPITAL SERVICES - MEDICAL STAFF FUNCTIONS

A. Certain required activities require medical staff and hospital operations participation. These include, but are not limited to:
   1. Medical records review
   2. Infection control
3. Blood utilization review
4. Pharmacy, Therapeutics and Technology
5. Medical Research Evaluation Committee
6. Cancer Committee/Tumor Board (as defined in the Oncology Services Structure Standards).

B. These activities, whenever possible, will be incorporated into the performance improvement process through the IDTs and LTs.

C. Appropriate medical staff participation will be assured by the Medical Executive Committee

D. Reports on these activities will be provided to the Medical Executive Committee and the Franciscan Quality Council as appropriate for dissemination to the medical staff and hospital operations.

ARTICLE V. AMENDMENTS

An amendment to these Rules and Regulations may be made under provisions of Article XII, Section 2, of the Medical Staff Bylaws.

ARTICLE VI. ADOPTION

After adoption by the Medical Staff as an amendment to the Bylaws, this Organization Manual, together with the appended Bylaws, Rules and Regulations, Credentialing Manual, and Allied Health Professionals Manual shall replace any previous Bylaws and Rules and Regulations and shall become effective when approved by the Board.

ADOPTED by the Active Medical Staff on May 9, 1997.

APPROVED by the CHI-FH Board of Directors on July 25, 1997.