



PeaceHealth
Southwest Medical Center

PeaceHealth Southwest Medical Center MEDICAL STAFF ORGANIZATION MANUAL

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MEDICAL STAFF ORGANIZATION MANUAL

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

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

1.B. DELEGATION OF FUNCTIONS

- (1) When a function under this Manual 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 chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. In addition, if the designee is performing ongoing functions, the delegation is subject to the review of the MEC.
- (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

The following clinical departments are established:

Anesthesia
Behavioral Health
Cardiology
Emergency Medicine
Family Medicine
Medicine
Obstetrics and Gynecology
Pediatrics
Radiology
Surgery

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS

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

2.C. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

- (1) Clinical departments shall be created and may be consolidated or dissolved by the MEC upon approval by the Board as set forth below.
- (2) The following factors shall be considered in determining whether a clinical department should be created:
 - (a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in the Bylaws);
 - (b) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;
 - (c) a majority of the voting members of the proposed department vote in favor of the creation of a new department;
 - (d) it has been determined by the Medical Staff leadership and the CAO that there is a clinical and administrative need for a new department; and
 - (e) the voting Medical Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

- (3) The following factors shall be considered in determining whether the dissolution of a clinical department is warranted:
 - (a) there is no longer an adequate number of members of the Medical Staff in the clinical department to enable it to accomplish the functions set forth in the Bylaws and related policies;
 - (b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;
 - (c) the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;
 - (d) no qualified individual is willing to serve as chair of the department; or
 - (e) a majority of the voting members of the department vote for its dissolution.

2.D. DEPARTMENT MEETINGS

- (1) Departments shall meet as often as necessary to accomplish their functions, at times set by the relevant department chair.
- (2) Department meetings shall be accomplished in accordance with the provisions common to all meetings as set forth in Article 6 of the Medical Staff Bylaws.
- (3) The relevant department chair shall serve as the presiding officer for all meetings.
- (4) In addition to members of a relevant clinical department, other Medical Staff members or Hospital personnel may be invited to attend a particular department meeting in order to assist that department in its discussions and deliberations regarding the issues on its agenda. All such individuals are an integral part of the credentialing, quality assurance, and professional practice evaluation process and are bound by the same confidentiality requirements as the members of the relevant clinical department.

2.E. DEPARTMENT SECTIONS

- (1) Leadership Council may create and dissolve Department Sections in consultation with the department chair.
- (2) Section chairs are appointed and removed by the Chief of Staff upon recommendation of the Leadership Council, Department Chair and Section members.
 - (a) Section chairs shall serve a term of two years.
 - (b) Section chairs shall work in collaboration with the department chair, Medical Staff leaders and other Hospital personnel on the following, as may be requested:
 - (i) providing guidance, and making recommendations and suggestions regarding patient care within their section;
 - (ii) participating in performance improvement functions within their section; and
 - (iii) participating in the development of criteria for clinical privileges or providing specialty expertise review of clinical privilege requests within their section.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

- (1) This Article outlines the Medical Staff committees of the Hospital that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.
- (2) Procedures for the appointment of committee chairs and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.
- (3) This Article details the standing members of each Medical Staff committee. However, other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Staff committee meeting in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. All such individuals are an integral part of the credentialing, quality assurance, and professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of such committees.

3.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical Staff committee, members must acknowledge and agree to the following:

- (1) have the willingness and ability to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent upon the full participation of its members;
- (2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;
- (3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee’s functions may be performed in an informed, efficient, and effective manner;
- (4) attend meetings on a regular basis to promote consistency and good group dynamics;
- (5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid off-topic or sidebar conversations;
- (6) voice disagreement in a respectful manner that encourages consensus-building;
- (7) understand and strive for “consensus” decision-making, thereby avoiding the majority vote whenever possible;
- (8) speak with one voice as a committee and support the actions and decisions made (even if they were not the individual’s first choice);
- (9) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

- (10) bring any conflicts of interest to the attention of the committee chair, in advance of the committee meeting, when possible;
- (11) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the committee chair outside of committee meetings;
- (12) participate in the development of an annual committee work plan and ensure that committee plans are in alignment with the strategic goals of the Hospital and Medical Staff; and
- (13) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

3.C. 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 as applicable to the MEC and to other committees and individuals as may be indicated in this Manual.

3.D. CME COMMITTEE

3.D.1. Composition:

- (a) The voting members of the CME Committee shall consist of Medical Staff members who are:
 - (1) broadly representative of the clinical specialties on the Medical Staff;
 - (2) interested or experienced in continuing medical education;
 - (3) appointed by the Leadership Council.
- (b) The following individuals shall serve as non-voting members to facilitate the committee's activities:
 - (1) CMO; and
 - (2) Representatives from Quality and Patient Safety, Family Medicine of Southwest, Pharmacy and Nursing as appointed by the Leadership Council.

3.D.2. Duties:

- (a) Support the CME Program's Mission to offer a variety of innovative and timely educational opportunities for members of the PHSW medical staff to enhance their ability to provide quality medical care and improve the health of the community.
- (b) Promote education that will positively impact the quality of patient care and satisfaction.
- (c) Develop long-range institutional educational goals and plans, both clinical and professional.
- (d) Use the ACCME Essentials and Standards in determining program compliance.
- (e) Develop and enforce policies germane to CME, such as Commercial Support Guidelines, Honoraria policy, etc. which are consistent with accreditation guidelines.

- (f) Assist in the needs assessment process for department education and general programs.
- (g) Approve programs for Category I CME credit.
- (h) Review evaluations of individual programs and use in future program planning.
- (i) Conduct annual evaluation of CME program, including review and possible revision of Mission Statement, updating policies, etc.
- (j) Review peer review quality indicator trends and statistics and accept referrals from the Committee for Professional Enhancement for educational purposes. All quality data will be protected from disclosure.

3.E. COMMITTEE FOR PROFESSIONAL ENHANCEMENT ("CPE")

3.E.1. Composition:

- (a) The voting members of the CPE shall consist of Medical Staff members who are:
 - (1) broadly representative of the clinical specialties on the Medical Staff;
 - (2) interested or experienced in credentialing, privileging, PPE/peer review, or other Medical Staff affairs and/or who have had previous Medical Staff leadership experience;
 - (3) supportive of evidence-based medicine protocols; and
 - (4) appointed by the Leadership Council.
- (b) The following individuals shall serve as non-voting members to facilitate the CPE's activities:
 - (1) CMO; and
 - (2) PPE Support Staff representative(s).
- (c) The Vice Chief of Staff shall serve as Chair and voting member. If the Vice Chief of Staff is unwilling or unable to serve, the Leadership Council shall appoint another physician leader (e.g., Medical Staff Officer, department chair, or committee chair) who is experienced in credentialing, privileging, PPE/peer review, or Medical Staff matters.
- (d) To the fullest extent possible, CPE members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.
- (e) Before any CPE member begins serving, the member must review the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on professional practice evaluation, with the nature of the training to be identified by the Leadership Council or CPE.
- (f) Other Medical Staff members or Hospital personnel may be invited to attend a particular CPE meeting (as guests, without vote) in order to assist the CPE in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the professional

practice evaluation process and are bound by the same confidentiality requirements as the standing members of the CPE.

3.E.2. Duties:

The CPE shall perform the following functions:

- (a) oversee the implementation of the Professional Practice Evaluation Policy (Peer Review) (“PPE Policy”) and ensure that all components of the process receive appropriate training and support;
- (b) review reports showing the number of cases being reviewed through the PPE Policy, by department or specialty, in order to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;
- (c) review, approve, and periodically update Ongoing Professional Practice Evaluation (“OPPE”) data elements that are identified by individual departments and sections, and adopt Medical Staff-wide data elements;
- (d) review, approve, and periodically update the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;
- (e) identify those variances from rules, regulations, policies, or protocols which do not require physician review, but for which an Informational Letter may be sent to the practitioner involved in the case;
- (f) review cases referred to it as outlined in the PPE Policy;
- (g) develop, when appropriate, Performance Improvement Plans for practitioners, as described in the PPE Policy;
- (h) monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;
- (i) work with department chairs to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through educational sessions in the department or through some other mechanism; and
- (j) perform any additional functions as may be set forth in applicable policy or as requested by the Leadership Council, the MEC, or the Board.

3.E.3. Meetings, Reports, and Recommendations:

The CPE shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The CPE shall submit reports of its activities to the MEC and the Board on a regular basis. The CPE’s reports will provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty; types and numbers of dispositions for the cases; listing of education initiatives based on reviews; listing of system issues identified). These reports will generally not include the details of any reviews or findings regarding specific practitioners.

3.F. CREDENTIALS COMMITTEE

3.F.1. Composition:

- (a) The Credentials Committee shall consist of at least five members of the Medical Staff with preference given to individuals who have served in Medical Staff leadership positions and/or who have a particular interest in the credentialing functions.
- (b) To the fullest extent possible, Credentials Committee members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.
- (c) The CMO and Medical Staff Support Staff representatives shall serve as ex officio members, without vote, to facilitate the Credentials Committee's activities.

3.F.2. Duties:

The Credentials Committee 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 written reports of its findings and recommendations;
- (b) in accordance with the Policy on Advance Practice Professionals, review the credentials of all applicants seeking to practice as Category I and Category II practitioners, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;
- (c) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Advance Practice Professionals and, as a result of such review, make a written report of its findings and recommendations;
- (d) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.2 pertaining to the development and ongoing review of privilege delineations, Section 4.A.3 ("Clinical Privileges for New Procedures"), and Section 4.A.4 ("Clinical Privileges That Cross Specialty Lines") of the Credentials Policy.

3.G. LEADERSHIP COUNCIL

3.G.1. Composition:

- (a) The Leadership Council shall be comprised of the following voting members:
 - (1) Chief of Staff, who shall serve as Chair;
 - (2) Vice Chief of Staff;
 - (3) Chair, CPE;

- (4) Immediate Past Chief of Staff; and
 - (5) Chair, Credentials Committee.
- (b) The following individuals shall serve as non-voting members to facilitate the Leadership Council's activities:
- (1) CMO; and
 - (2) PPE Support Staff representative(s).
- (c) Other Medical Staff members or Hospital personnel may be invited to attend a particular Leadership Council meeting (as guests, without vote) in order to assist the Leadership Council in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the Leadership Council review process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.G.2. Duties:

The Leadership Council shall perform the following functions:

- (a) review and address concerns about practitioners' professional conduct as outlined in the Medical Staff Professionalism Policy;
- (b) review and address possible health issues that may affect a practitioner's ability to practice safely as outlined in the Practitioner Health Policy;
- (c) review and address issues regarding practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy (Peer Review);
- (d) meet, as necessary, to consider and address any situation involving a practitioner that may require immediate action;
- (e) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;
- (f) identify and nominate a slate of qualified individuals to serve as the Medical Staff Officers and any at-large members of the MEC, to be presented to and elected by the Medical Staff;
- (g) appoint the chairs and members of all Medical Staff committees, except for the MEC;
- (h) cultivate a physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future; and
- (i) perform any additional functions as may be requested by the CPE, the MEC, or the Board.

3.G.3. Meetings, Reports, and Recommendations:

The Leadership Council shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The Leadership Council shall report to the CPE, the MEC, and others as described in the Policies noted above. The Leadership Council's reports will

provide summary and aggregate information regarding the committee's activities. These reports will generally not include the details of any reviews or findings regarding specific practitioners.

3.H. MEDICAL EXECUTIVE COMMITTEE

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

3.I. PRACTITIONER HEALTH AND WELL-BEING COMMITTEE

3.I.1. Composition:

The Practitioner Health and Well-Being Committee will include at least five members of the Medical Staff. The Chief of Staff will make appointments to the Committee as vacancies occur as a result of the expiration of terms, resignations, etc. and may also remove members from the Committee. To the extent possible, the Committee shall include specialties representative of the Medical Staff, including an anesthesiologist, an internist, a family physician, a surgeon, and a psychiatrist (preferably with experience or a special interest in a psychological sense of community vital to personal well-being). The Committee should also include a chaplain and the CMO as an ex officio member.

3.I.2. Duties:

The purpose of the Practitioner Health and Well-Being Committee is to promote the physical, psychological, social and professional well-being of all physicians and other credentialed providers. The Hospital is committed to creating a work environment that provides physicians with the tools and resources necessary to perform quality patient care and promotes appreciation for personalized provider well-being and respect for their dignity, time and privacy. The Committee has adopted the following guiding beliefs as a foundation for development and preservation of this program:

- (a) taking steps to create a welcoming, safe environment for practitioners to seek assistance;
- (b) promoting collegiality through social and professional activities;
- (c) actively demonstrating support and recognition during notable events;
- (d) consulting policy changes that impact the Medical Staff;
- (e) ensuring that practitioners are aware that the Employee Assistance Program ("EAP") is available as a resource option, whenever possible;
- (f) encouraging self-referral to community care and outreach centers;
- (g) providing educational resources; and
- (h) promoting the maintenance of confidentiality.

3.J. TRAUMA COMMITTEE

3.J.1. Composition:

The Trauma Committee shall consist of at least five members of the Medical Staff with representation from general surgery, pediatrics, surgical sub-specialties, anesthesiology, emergency medicine, family practice, and radiology, when possible. The committee shall also include medical program directors of local EMS programs, and representatives from nursing and ancillary services related to critical trauma

care as well as administration, as necessary. For those hospitals that are designated trauma centers, the chair of the Trauma Committee will be the Trauma Medical Director. In addition, one of the standing members of the committee will be the Trauma Program Director or Trauma Program Manager.

3.J.2. Duties:

The Trauma Committee shall:

- (a) formulate and establish appropriate trauma care protocols, subject to the approval of the Medical Staff (such protocols will be compiled in a manual or electronic data base and shall be included in the proposal for Oregon and Washington State Trauma System participation);
- (b) engage in a program of patient-care appraisal by making a systematic review of current hospital cases, functioning in conjunction with the CPE;
- (c) make recommendations to the CPE regarding criteria and procedures for evaluating the quality of trauma care;
- (d) systematically review the record of discharged trauma patients with special attention to all trauma deaths, forwarding practitioner-specific matters to the CPE as may be necessary;
- (e) review results of trauma data collected and make recommendations for continuing education based on the needs defined by the data review;
- (f) review and recommend public education programs in trauma prevention;
- (g) assist the nursing services in the development of policies relating to nursing care; and
- (h) report to the CPE and the MEC.

ARTICLE 4

AMENDMENTS

- (A) This Manual may be amended by a majority vote of the members of the MEC, which may consult with any other Medical Staff leader or leadership body as may be necessary.
- (B) Prior to initiating the formal notice process below, the MEC shall submit all proposed amendments to the PeaceHealth Legal Department for review and comment. Proposed amendments that are determined to be relevant to other PeaceHealth hospitals will be forwarded by the PeaceHealth Legal Department Committee to those hospitals for consideration by their respective MECs.
- (C) Notice of all proposed amendments shall be provided to each voting member of the Medical Staff at least seven days prior to the MEC meeting. Any voting member of the Medical Staff may submit written comments to the MEC.
- (D) 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 Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein, and henceforth all department and committee activities of the Medical Staff and of each individual serving as a member of a department or staff committee shall be undertaken pursuant to the requirements of this Manual.

Adopted by the Medical Staff: 8/2/2018

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