# PROVIDENCE REGIONAL MEDICAL CENTER EVERETT

# 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 Medical Staff Credentials & Procedural Policy.

### 1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Manual is to be carried out by a member of Administrative Leadership, 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. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(2) When an individual assigned a function under this Manual 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.

### 1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Manual, technical or minor deviations from the procedures set forth within this Manual do not invalidate any review or action taken.

## ARTICLE 2

## CLINICAL DIVISIONS

### 2.A. CREATION AND DISSOLUTION OF CLINICAL DIVISIONS

(1) Clinical divisions 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 division 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 division (this number must be sufficiently large to enable the division to accomplish its functions as set forth in this Manual and in the bylaws);

(b) the level of clinical activity that will be affected by the new division is substantial enough to warrant imposing the responsibility to accomplish organizational functions on a routine basis;

(c) a majority of the voting members of the proposed division vote in favor of the creation of a new division;

(d) it has been determined by the MEC and the Hospital CEO that there is a clinical and administrative need for a new division; and

(e) the voting Medical Staff members of the proposed division have offered a reasonable proposal for how the new division 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 division is warranted:

(a) there is no longer an adequate number of members of the Medical Staff in the clinical division to enable it to accomplish the functions set forth in this Manual or in the Bylaws;

(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 division;

(c) the division 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 division; or

(e) a majority of the voting members of the division vote for its dissolution.

## 2.B. LIST OF CLINICAL DIVISIONS

The following clinical Divisions are established:

- Medicine
- Surgery
- Women and Children's Services
- Outpatient and Community Medicine

## 2.C. FUNCTIONS AND RESPONSIBILITIES OF DIVISIONS

The functions and responsibilities of divisions and Division Chiefs are set forth in 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 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 the Medical Staff Bylaws.

(3) This Article details the standing members of each Medical Staff committee. However, other individuals (e.g., other Medical Staff members, Hospital personnel, legal counsel, Employer representatives, etc.) 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. These individuals shall be present only for the relevant agenda item and shall be excused for all others. 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 on 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) 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 after each meeting to the MEC and to other committees and individuals as may be indicated in this Manual.

## 3.D. BYLAWS COMMITTEE

### 3.D.1. Composition:

The Bylaws Committee shall be chaired by the Secretary-Treasurer, who is responsible for appointing the other members of the committee, with approval by the MEC.

### 3.D.2. Duties:

The Bylaws Committee shall:

(a) ensure that the Medical Staff Bylaws and the policies appropriately and accurately reflect current Medical Staff practice, applicable legal requirements, and applicable standards of CMS;

(b) review the Medical Staff Bylaws and the Policies at least every three years and present its report to the MEC; and

(c) make draft amendments to the same.

(d) approve and maintain oversight of the Medical Staff budget

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

Meetings shall occur at the discretion of the chair. The Bylaws Committee will report at least annually to the MEC.

## 3.E. CREDENTIALS COMMITTEE

3.E.1. Composition:

(a) The Credentials Committee shall consist of seven voting members who are members of the Active Hospital-Based Staff or Active Office-Based Staff at the time of election, and one voting lay member appointed from the Board. At least one committee member from the Active Hospital-Based Staff or Active Office-Based Staff will be a non-physician. Annually, the Committee will elect and recommend a chair to the MEC. Elections will occur in accordance with voting policy.

(b) Non-Voting members of the Committee shall include the Medical Staff Officers, the CMO, the chair of MSQRC, Division Chiefs, GME Medical Director, Chief Nursing Officer or designee, Health Committee members as needed, and Medical Staff Office representation. In the event of a tie vote, the Medical Staff President will be permitted to cast the deciding vote.

3.E.2. Duties:

(a) The Credentials Committee is responsible for the evaluation of Applicants for initial appointment and reappointment and clinical privileges. In performing this function, the Credentials Committee will consider information on Practitioner performance supplied by the MSQRC as well as information on the numbers of patients cared for and their clinical type. The Credentials Committee will also review requests for modifications of privileges as described in the Credentials & Procedural Policy. In addition, the Credentials Committee will evaluate evidence of continuing education as appropriate to the Practitioner's clinical practice.

(b) The Credentials Committee's duty shall be the evaluation of competency and qualifications of all Practitioners, including limiting the extent of practice of such Practitioners in the Hospital. The Committee, including its discussions and reports to MEC, shall be afforded the protections and immunities provided by

RCW 4.24.250 and Chapter 300 of the 1986 laws of Washington State as now or hereafter amended.

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

The Credentials Committee shall meet as often as necessary to discharge its responsibilities and maintain a record of its procedures and actions. Recommendations shall be made, as appropriate, to the Board and/or the MEC. The Committee shall report directly to the MEC.

3.F. LEADERSHIP COUNCIL

3.F.1. Composition:

(a) The Leadership Council shall be comprised of the following voting members:

(1) Medical Staff President, who shall serve as Chair;

(2) Medical Staff President-Elect;

(3) Chair, Credentials Committee;

(4) Chair, MSQRC

(5) Division Chiefs

(6) Medical Staff Secretary/Treasurer

(7) CMO

(8) Medical Staff Past President

(b) A Medical Staff Services representative shall serve as a non-voting member to facilitate the Leadership Council's activities and to perform functions on behalf of the Council between meetings.

(c) Other appropriate individuals may be invited to attend a particular Leadership Council meeting (as guests, without vote) 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.

(d) Between meetings of the Leadership Council, the Medical Staff President as Chair,

in conjunction with the CMO or another Leadership Council member, may take steps as necessary to implement and operationalize the decisions of the Leadership Council. By way of example and not limitation, this may include providing clarifications to a Practitioner regarding the Leadership Council's decisions or expectations, reviewing and approving communications with the Practitioner, and similar matters.

3.F.2. Duties:

The Leadership Council is a non-disciplinary, primarily advisory body. The Leadership Council makes recommendations to colleagues when appropriate, but does not have the authority to require any particular action. Only the MEC, acting in accordance with the Medical Staff Bylaws documents, possesses disciplinary authority. The Leadership Council shall perform the following specific functions:

(a) serve as a resource for other Medical Staff Leaders who are working with colleagues to improve clinical or professionalism performance or manage health issues that may impact the safety and quality of care;

(b) meet, as necessary, to consider and address any situation involving a Practitioner that may require immediate action;

(c) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;

(d) identify and nominate a slate of qualified individuals to serve as the Medical Staff Officers to be presented to and elected by the Medical Staff;

(e) 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

(f) perform any additional functions as may be requested by the MEC or the Board.

3.F.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 may serve in an advisory function related to MSQRC and Peer Review. In as far as their meetings occur related to this function, they should be afforded protections associated with any quality committee.

3.G. MEDICAL EDUCATION COMMITTEE

3.G.1. Composition:

The Medical Education Committee shall consist of representatives of the Medical Staff, nursing, the Hospital's Strategic Services, and Medical Education Staff.

3.G.2. Duties:

The Medical Education Committee shall contribute to patient safety and patient outcomes and to support practice improvement by providing CME activities that enhance healthcare providers' ability to deliver quality healthcare services and improve our community's overall health.

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

The Committee will meet quarterly or at the discretion of the Chair.

3.H. MEDICAL EXECUTIVE COMMITTEE

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

3.I. MEDICAL STAFF QUALITY REVIEW COMMITTEE ("MSQRC")

3.I.1. Composition:

(a) The MSQRC shall consist of six voting members who are members of the Active Hospital-Based Staff or Active Office-Based Staff at the time of election, and one voting lay member appointed from the Board. The Chair shall be one of the voting members. At least one committee member from the Active Hospital-Based Staff or Active Office-Based Staff will be a non-physician. Annually, the Committee will elect and recommend a chairperson to the MEC.

(b) Non-voting members shall include the Medical Staff officer(s), the CMO and/or an administrative representative(s), the Chair of the Health Committee as needed, the Division Chiefs, Chief Nursing Officer or designee, and Medical Staff Office representation, and a representative of Risk Management. In the event of a tie vote, the Medical Staff President will be permitted to cast the deciding vote. At the discretion of the current Committee chairperson, emeritus chair(s) may continue to serve as a non-voting member on the Committee for up to one year.

3.I.2. Duties:

The MSQRC is a non-disciplinary body, whose primary charge is to attempt to resolve the clinical and behavioral performance issues referred to it in a constructive and successful manner. The MSQRC makes recommendations to colleagues when appropriate, but does

not have the authority to require any particular action. Only the MEC, acting in accordance with the Medical Staff Bylaws documents, possesses disciplinary authority. The MSQRC will perform the following specific functions:

(a) oversee the implementation of the peer review process in order to help ensure consistency and effectiveness of the process;

(b) review, approve, and periodically update the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;

(c) identify 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;

(d) review cases referred to it and perform such other functions as outlined in the Medical Staff's peer review policy;

(e) monitor and determine that system issues that are identified as part of peer review activities are successfully resolved or referred to the appropriate committees or groups

(f) work with Medical Staff Leaders to disseminate educational lessons learned from the review of cases through the peer review process; and

(g) perform any additional functions as may be set forth in applicable policy or as requested by the MEC or the Board.

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

(a) The MSQRC will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The MSQRC will submit reports of its activities to the MEC and the Board on a regular basis. The MSQRC's reports will provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by division 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 not include the details of any reviews or findings regarding specific practitioners unless the MSQRC determines such information is necessary for the MEC to address a matter.

(b) The MSQRC, including its reports to MEC, shall be afforded the protections and immunities provided by RCW 4.24.250 and Chapter 300 of the 1986 laws of Washington State as now or hereafter amended. The files of the MSQRC shall be retained and destroyed subject to the Hospital's record retention policies and/or as approved by the Board and the MEC.

3.J. PRACTITIONER WELL-BEING COMMITTEE ("PWBC")

3.J.1. Composition:

The committee will consist of a chair who is appointed by the Medical Executive Committee, voting members of the Medical Executive Committee, the CMO, the Director of Medical Staff Services and Regulatory Affairs, Volunteer Members of the Medical Staff, and invited guests. The Medical Staff Past President will serve as the vice chair and will co-direct the meetings and initiatives of the committee

3.J.2. Duties:

(a) Regular assessments of the wellbeing of providers of the Medical Staff, to help ensure their long-term success within the medical community;

(b) Vet and support and promote wellness related activities of Medical Staff members

(c) Elevate Medical Staff concerns to the Medical Executive committee.

(d) The PWBC has no independent authority regarding status or privileges.

3.J.3 Reporting and Accountability

(a) Reports to the Budget and Bylaws Committee as it pertains to use of medical staff funds on an annual basis.

(b) Reports to the Medical Executive Committee on an as needed basis but annually at a minimum.

3.J.4. Meetings, Reports, and Recommendations:

The Committee shall meet at the discretion of the Chair, as appropriate to the Committee's function and responsibilities.

3.K HEALTH COMMITTEE

3.K.1 Membership

(a) This ad hoc Committee will consist of at least three members of the Medical Staff: The Chairperson of credentials and two other members as appointed by the Medical Staff President. Preferably, these members should be medical staff officers, division chiefs, or have formal psychiatric/substance abuse training as relevant, however, membership is not restricted to these criteria.

(b) The Medical Staff president should also select the committee's chair. The chair will be an ad hoc advisor to MSQRC and Credentials committee.

(c) Although the committee will meet ad hoc, its membership would be selected and reviewed annually by the medical staff president.

3.K.2 Meetings:

(a) The Committee shall meet at the discretion of the Chair, as appropriate to the Committee's function and responsibilities.

3.K.3 Duties and Responsibilities:

(a) The committee exists to promote the wellbeing of practitioners within the PRMCE Medical Staff, to help ensure their long-term success within the medical community.

(b) The committee may investigate and evaluate reports regarding members of the medical staff related to impairment, from mental, emotional, behavioral, or physical (including infection with blood-borne pathogen[s]) causes.

(c) Cases can be referred to the committee from any member of the medical staff or a medical staff committee. The committee will recommend and monitor appropriate courses of action but has no independent authority regarding status or privileges. However, the committee can recommend consequences for failure to comply with evaluation and treatment recommendations. The committee may require treatment records and documentation of compliance.

(d) The committee will also have the discretion to discontinue monitoring when the committee feels it is appropriate. All information related to referrals, follow-up, and ongoing monitoring will be maintained in a separate, secure file location from general information on the medical staff member.

3.K.4 Accountability:

(a) When indicated, any reports of this committee will be considered a part of the Medical Staff's Quality Review program, and therefore protected from discovery by RCW 4.24.250 and Chapter 300 of the 1986 Laws of Washington.

(b) The Committee shall keep and maintain separate records, reports, and proceedings, and the right to privacy for every practitioner shall be protected. Reporting requirements established by the National Practitioner Data Bank, the Washington State Disciplinary Board, and other legal entities shall be followed.

3.K.5 Reporting:

(a) The committee will report to credentials without using practitioner specific data except as necessary. The reports will come at the request of the chair of credentials, or when the provider in question is up for reappointment. In the interest of privacy protection, information in any report should be limited to general information such as whether the practitioner is in compliance or if there are concern about qualifications.

## 3.L. TRAUMA COMMITTEE

### 3.L.1. Composition:

(a) The Trauma Committee shall consist of members who represent those specialties and divisions most involved with trauma. The Chair will be appointed by the Medical Staff President for a two-year term.

(b) Hospital representation shall include administration, nursing, and other specialties such as pharmacy, nutrition, clergy and rehabilitation. Representatives from community agencies dealing with trauma (e.g. Emergency Medical Services) may also be included.

### 3.L.2. Duties:

The Trauma Committee shall:

(a) oversee the planning and execution of trauma care at the Hospital, as directed through the standards set by the State of Washington and other regulating entities;

(b) maintain liaison with the appropriate local, state and federal organizations;

(c) work with Administration to maintain a comprehensive community-wide trauma program as outlined by State of Washington Code;

(d) work with the Medical Education Committee to organize and present regular trauma conferences that are multidisciplinary, hospital-wide and case-oriented;

(e) work with the Board Planning Committee to plan and implement the delivery of trauma care within the serviced area; and

(f) work with the MEC to assess the level of trauma and follow-up services which are available in the community, and develop appropriate responses to identified deficiencies.

The Committee may, as necessary, convene a quality improvement sub-committee to review studies of significant processes and outcomes. This sub-committee will report to the Quality Review Committee and be afforded the protections of RCW 4.24.250 and Chapter 300 of the 1986 Laws of Washington. Any issues which concern the quality of care provided by a practitioner shall be referred through the Peer Review process as described in policy.

### 3.L.3. Meetings, Reports, and Recommendations:

The Trauma Committee shall meet at least quarterly, or at the discretion of the Chair, as appropriate to the Committee's function and responsibilities. The Committee shall provide, at a minimum, an annual report to the MEC.

## 3.M. UTILIZATION REVIEW COMMITTEE

### 3.M.1. Composition:

(a) The Utilization Review Committee shall consist of representatives of the Medical Staff, including the Chair, who will be appointed by the Medical Staff President.

(b) Members may also include representatives from the Health Information Management department, Revenue Cycle department, compliance and/or regulatory affairs, CMO, Director Case Management, Physician Advisor(s), Division Chiefs, Coding Leader(s), and patient services.

(c) The Chair shall be appointed by the Medical Staff President for a two-year term.

### 3.M.2. Duties:

The Utilization Review Committee shall approve policies and procedures used by the Hospital to fulfill the Utilization Review function as prescribed by Center for Medicare and Medicaid Services, including review of records for timeliness and adequacy. Any issues which concern the quality of care provided by a member of the Medical Staff shall be referred into the Peer Review process as described in policy

### 3.M.3. Meetings, Reports, and Recommendations:

The Utilization Review Committee shall meet at least quarterly, or at the discretion of the chair, as appropriate to the Committee's function and responsibility. The Committee will report at least annually to the MEC.

## ARTICLE 4

## AMENDMENTS

This Manual may be amended as described in the amendment provisions of the Medical Staff Bylaws.

ARTICLE 5

ADOPTION

This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: ______________________

Approved by the Board: ______________________