THE
MEDICAL STAFF
ORGANIZATION MANUAL

Part of the Yakima Valley Memorial

Medical Staff Bylaws, Policies, & Rules & Regulations

Board Approved 3/21/2022

ORGANIZATION MANUAL

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to the capitalized terms used in the Medical Staff Bylaws, the Credentials Policy, and the Organization Manual are set forth in the Credentials Policy.

1.B. DELEGATION OF FUNCTIONS

Medical Staff functions and duties set forth in these Bylaws may be delegated to qualified Practitioners and Hospital employees as set forth in the Delegation of Functions provisions of Article 1 of the Medical Staff Credentials Policy.

ARTICLE 2

CLINICAL DEPARTMENTS

2.A. EXISTING DEPARTMENTS

The Medical Staff is organized into the following departments:

1. Anesthesia
2. Cardiology
3. Pulmonary & Critical Care
4. Emergency Medicine
5. Family Medicine
6. Head & Neck Sub-Specialty
7. Medicine (including but not limited to Practitioners practicing within the specialties of neurology, infectious disease, endocrinology, nephrology, rheumatology, psychiatry, gastroenterology, sleep medicine and dermatology)
8. Obstetrics/Gynecology
9. Orthopedics
10. Pediatrics & Neonatology
11. Radiation Oncology, Hematology, and Oncology
12. Radiology
13. Surgery
14. Urology

2.B. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

(1) Clinical departments may be created, consolidated, subdivided, or dissolved by the Medical Executive Committee, 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 who would be assigned to 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 Chief Executive Officer that there is a clinical and administrative need for a new department (e.g., the accomplishment of functions by the relevant, existing departments has become unwieldy due to the substantial number of individuals assigned to the department or the number and dissimilarity of specialties assigned to the department); and

(e) the voting Medical Staff Members who are in favor of, and would be assigned to, 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) In the event that a new department is created, the Medical Executive Committee will recommend to the Board those Practitioners who shall be assigned to the department.

(4) 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 of 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 department chairperson; or

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

(5) In the event that a department is dissolved, the Medical Executive Committee will recommend the new department assignment for those Practitioners whose department was dissolved.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in Articles 3 and 4 of this Manual will 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 report after each meeting to the Medical Executive Committee and to other committees and individuals as may be indicated in this Manual.

3.B. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out credentialing, ongoing and focused professional practice evaluation, and other quality and 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 members of each standing Medical Staff committee. In addition to the existing members of a committee, other Medical Staff Members or Board members, and Hospital personnel may be invited, either by the chair of the committee or by the committee itself, to attend particular Medical Staff committee meetings (as guests, without vote) in order to assist the committee in its discussions and deliberations regarding the issues on its agenda and such individuals may be appointed to sit on subcommittees or ad hoc committees that are delegated functions by a committee (for example, performing research and reporting back to the committee on a particular matter or performing a collegial intervention on behalf of the committee). All such individuals are an integral part of the credentialing, quality assurance, and peer review process and are bound by the same confidentiality requirements as the standing members of such committees.

(4) Individual Members of the Medical Staff and other Practitioners with Clinical Privileges care for patients within an organizational context. Within this context, members of the Medical Staff and other Practitioners with Clinical Privileges participate in the important Medical Staff activities summarized in Appendix A through departments and committees.

3.C. ADVANCED PRACTICE PROFESSIONALS REVIEW COMMITTEE

3.C.1. Composition:

The Advanced Practice Professionals Review Committee shall consist of the following individuals who shall serve *ex officio*, with vote: the Chief Medical Officer, the Chief Nursing Officer, the President of the Medical Staff and the Medical Staff Services Director. The Advanced Practice Professionals Review Committee shall also include the following as members, each of whom shall be appointed by the President of the Medical Staff: one nurse practitioner, one physician assistant, and three members of the Medical Staff who shall be selected so that the Committee has adequate clinical expertise to perform its functions. Other Medical Staff Members or Hospital personnel (including relevant department chairperson(s), other individual(s) in the Medical Staff department, or service line with relevant clinical expertise, and head(s) and/or nurse manager(s) of the Hospital departments in which the Advanced Practice Professional would work, may be invited to attend meetings in order to assist the Advanced Practice Professionals Review Committee in its discussions and deliberations regarding issues on its agenda.

3.C.2. Duties:

The Advanced Practice Professionals Review Committee shall:

(1) evaluate and make recommendations to the Credentials Committee, Medical Executive Committee, and Board of Directors regarding the need for the services that could be provided by the types of Advanced Practice Professionals that are not currently permitted to practice in the Hospital; and

(2) develop and recommend policies for each type of Advanced Practice Professional permitted by the Board of Directors to practice in the Hospital, which shall specify training, education, and experience requirements for Applicants, the scope of practice or Clinical Privileges to be granted, any conditions that apply to the Advanced Practice Professionals functioning within the Hospital, any ongoing supervision requirements, and malpractice insurance requirements.

3.C.3. Meetings and Reports:

The Advanced Practice Professionals Review Committee shall make a report of its recommendations after each meeting to the Credentials Committee, and, where appropriate, to the Medical Executive Committee and the Board of Directors. The chairperson of the committee shall be available to meet with the Credentials Committee, Medical Executive Committee, or Board on all recommendations that the Advanced Practice Professionals Review Committee makes.

3.D. COMMITTEE ON PROFESSIONAL ENHANCEMENT ("CPE")

3.D.1. Composition:

(1) The Committee on Professional Enhancement ("CPE") shall consist of the following voting members:

(a) The Medical Director of Quality and Safety, who shall be a voting member of the Committee and serve as the Chair, provided he or she is a Member of the Medical Staff;

(b) Six other Members of the Medical Staff, appointed by the Leadership Council, with a preference given to:

(i) A Past President of the Medical Staff or, if none is available and willing to serve, another experienced leader; and

(ii) Five additional Medical Staff Members who are:

(A) broadly representative of the clinical specialties on the Medical Staff,

(B) experienced and/or interested in credentialing, privileging, professional practice evaluation/peer review, or other Medical Staff affairs; and

(C) supportive of evidence-based medicine protocols.

(2) The following individuals shall serve as *ex officio* members, without vote, to facilitate the CPE's activities:

(a) Chief Medical Officer;

(b) The Associate Chief Medical Officer; and

(b) Professional Practice Evaluation (PPE) Support Staff representatives.

(3) Before any member of the Committee on Professional Enhancement begins serving, the member must understand 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 the Committee on Professional Enhancement.

(4) To the fullest extent possible, CPE members shall serve staggered, multiple-year terms, so that the Committee always includes experienced members. Appointed members may be reappointed for additional terms.

3.D.2. Duties:

The Committee on Professional Enhancement shall perform the following functions:

(1) oversee the implementation of the Professional Practice Evaluation Policy and ensure that all components of the process receive appropriate training and support;

(2) review reports showing the number of cases being reviewed through the Professional Practice Evaluation Policy, by department or specialty, and the dispositions of those cases, in order to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;

(3) approve Ongoing Professional Practice Evaluation (OPPE) data elements that are identified by individual departments, and adopt Medical Staff-wide OPPE data elements;

(4) approve the specialty-specific quality indicators identified by the departments that will trigger the professional practice evaluation/peer review process;

(5) identify variances from rules, regulations, policies, or protocols for which an informational letter may be sent to the Practitioner involved in the case;

(6) review cases referred to it as outlined in the Professional Practice Evaluation Policy;

(7) develop, when appropriate, performance improvement plans for Practitioners, as described in the Professional Practice Evaluation Policy;

(8) monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;

(9) work with department chairs to disseminate educational lessons learned from the review of cases pursuant to the Professional Practice Evaluation Policy, either through education sessions in the department or through some other mechanism; and

(10) 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.D.3. Meetings:

The Committee on Professional Enhancement 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 to provide for appropriate oversight of PPE activities by the MEC and Board (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).

3.E. CREDENTIALS COMMITTEE

3.E.1. Composition:

The Credentials Committee shall consist of seven Members of the Medical Staff who are appointed based on their interest and experience in credentialing matters, one of whom shall be appointed to serve as Chair, and the Chairperson of the Committee on Professional Enhancement. The *ex officio* members, without vote, shall be: the Chief Executive Officer, the Chief Medical Officer, the Chairperson of the Advanced Practice Professionals Review Committee, and a designated representative from the Medical Staff Services department.

3.E.2. Duties:

The Credentials Committee delegates some of its duties for Application verification, information gathering, and initial reviews of Applications to the Medical Staff Office, CMO, and Hospital, as set forth in the Medical Staff Credentials Policy and other Hospital and Medical Staff Bylaws, Rules and Regulations and policies. All activities undertaken to receive, verify, and process an Application for initial and/or renewed Membership or Clinical Privileges are part of the quality improvement and peer review processes of the Hospital and its Medical Staff and are protected as such, even if such activities occur prior to any action by the Credentials Committee with respect to the Application. The Credentials Committee shall perform the following duties:

(1) in accordance with the Credentials Policy, review the credentials of all Applicants for initial and renewed Medical Staff Membership 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;

(2) upon request of the Medical Executive Committee, Bylaws Committee, or any other relevant committee, review those portions of the Medical Staff Bylaws, Rules and Regulations, and policies that address qualifications for Membership and Clinical Privileges, Medical Staff categories, and the credentialing process, and make recommendations to the Medical Executive Committee regarding the same;

(3) upon request of the Medical Executive Committee, Bylaws Committee, or any other relevant committee, review Application forms used for requesting consideration for

Medical Staff Membership or Clinical Privileges, and make recommendations to the Medical Executive Committee regarding the same;

(4) recommend the numbers and types of cases to be reviewed as part of the focused professional practice evaluation applicable to all initial grants of Clinical Privileges;

(5) review and approve the specialty-specific criteria for ongoing professional practice evaluation and specialty-specific triggers for focused professional practice evaluation that are identified by each department;

(6) recommend to the Medical Executive Committee the need for new treatments and procedures when Clinical Privileges for such are requested by an individual;

(7) recommend to the Medical Executive Committee appropriate threshold eligibility criteria for Clinical Privileges, including Clinical Privileges for new procedures and Clinical Privileges that cross specialty lines; and

(8) collaborate with the Advanced Practice Professionals Review Committee regarding questions about scope of licensure, the relationships between Advanced Practice Professionals and Supervising/Collaborating Practitioners, and, as applicable, the level of supervision required for Advanced Practice Professionals.

3.E.3. Meetings:

The Credentials Committee shall meet at least monthly and shall report its recommendations and activities to the Medical Executive Committee.

3.F. LEADERSHIP COUNCIL

3.F.1. Composition:

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

(a) President of the Medical Staff, who shall serve as Chair;

(b) the Vice President of the Medical Staff; and

(c) the Chief Medical Officer.

(2) The following individuals shall serve as *ex officio* members, without vote, to facilitate the Leadership Council's activities:

(a) the Chair of the Committee on Professional Enhancement (CPE);

(b) The Associate Chief Medical Officer; and

(c) Medical Staff Services representatives and/or Professional Practice Evaluation (PPE) specialists.

3.F.2. Duties:

The Leadership Council shall perform the following functions:

(1) review and address concerns about Practitioners' professional conduct as outlined in the Medical Staff policy on professionalism;

(2) review and address concerns about Practitioners' health status and the ability to provide safe and competent care as outlined in the policy on Practitioner health;

(3) review and address issues regarding Practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy;

(4) appoint the members of the Committee on Professional Enhancement ("CPE");

(5) appoint pre-determined reviewers to function in accordance with the Professional Practice Evaluation Policy;

(6) meet, as necessary, to consider and address any situation that may require immediate action;

(7) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any department or unit within the Hospital; and

(8) perform any additional functions as outlined in the Professional Practice Evaluation Policy or as may be requested by the CPE, the Medical Executive Committee, or the Board.

3.F.3. Meetings:

The Leadership Council shall report to the CPE, the MEC, and any others described in the Professional Practice Evaluation Policy. The Leadership Council's reports to the MEC will provide summary and aggregate information regarding the committee's activities.

3.G. SPECIALTY-SPECIFIC QUALITY COMMITTEES

There may be specialty-specific quality committees to conduct performance improvement and patient safety analyses that are not focused on Practitioner-specific opportunities for improvement (as those matters would be managed through the Professional Practice Evaluation process), but are integral to the delivery of quality care. Such committees may be created, dissolved, and reorganized by approval of both the Medical Executive Committee and Board. These committees can recommend and/or conduct education, make

recommendations for system changes, and make policy recommendations, amongst other things. All activities of the specialty-specific quality committees will be reported to the Committee on Professional Enhancement and Medical Executive Committee.

3.H. TRAUMA COMMITTEE

3.H.1. Composition:

As listed in trauma Committee Policy.

3.H.2. Duties:

The Trauma Committee performs the functions outlined in the Trauma Policies, including reviewing and discussing policies and procedures related to trauma care, recommending standards and protocols and guidelines related to trauma care, coordinating trauma services with sub-specialty trauma support groups, monitoring the quality of trauma care and developing plans of action when appropriate, recommending trauma education with emphasis on trauma care personnel and community needs, and providing guidance, education, and other information regarding optimal trauma care to Practitioners and personnel who provide trauma care.

3.H.3. Meetings:

The Trauma Committee will need as often as necessary to perform its functions and will report its activities to the Medical Executive Committee.

ARTICLE 4

ADOPTION AND AMENDMENTS

(1) This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other conflicting policies and rules and regulations of the Medical Staff or Hospital pertaining to the subject matter thereof.

(2) The amendment process for this Manual is set forth in the Bylaws.

Adopted by the Medical Staff: **3/15/2022**

Approved by the Board of Directors: **3/21/2022**

Previous Board Approval:
1/28/2020; 6/22/2020; 8/24/2020; 4/26/2021 (revision of CPE membership); 11/2021 (added Medical Director of Quality & Safety to chair CPE); 2/2022 (added ACMO to Leadership Council and CPE as ex-officio member); 3/2022 (removed Cancer Committee, Clinical Ethics Advisory Committee, Infection Control Committee, Pharmacy and Therapeutics Committee, Radiation Safety Committee, Utilization Review Committee).

APPENDIX A

SUMMARY OF MEDICAL STAFF ACTIVITIES

Appendix A.1 - Governance:

The Medical Staff is not a separate legal entity, but is an integral part of the Hospital, which shall:

(1) establish a framework for self-governance of Medical Staff activities and accountability to the Board of Directors; and

(2) establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in the Hospital.

Appendix A.2 - Planning:

The Medical Staff leaders shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

(1) planning patient care services;

(2) planning and prioritizing performance improvement activities;

(3) budgeting;

(4) providing for uniform performance of patient care processes;

(5) recruitment, retention, development and continuing education of all staff;

(6) consideration and implementation of clinical practice guidelines as appropriate to the patient population;

(7) establishing and maintaining responsibility for written policy and procedures governing medical care provided in the emergency service or department;

(8) establishing, if emergency services are not provided at the Hospital, policies and procedures for appraisal of emergencies, initial treatment and referral of patients when needed; and

(9) securing autopsies in all cases of unusual deaths and of medical, legal and educational interest.

Appendix A.3 - Credentialing and Privileging:

The Medical Staff is responsible to the Board of Directors for the credentialing process, which includes a series of activities designed to collect relevant data that will serve as a basis for decisions regarding the initial and renewed grant of Medical Staff Membership and/or Clinical Privileges. The Medical Staff shall perform the following functions to ensure an effective credentialing process:

(1) establishing specifically defined mechanisms for the process of granting Membership to the Medical Staff, and for the granting of delineated Clinical Privileges to qualified Applicants;

(2) establishing professional criteria for Membership and for Clinical Privileges;

(3) conducting an evaluation of the qualifications and competence of individuals applying for Medical Staff Membership or Clinical Privileges;

(4) submitting recommendations to the Board of Directors regarding the qualifications of an Applicant for Membership or Clinical Privileges;

(5) establishing a mechanism for fair hearing and appellate review; and

(6) establishing a mechanism to ensure that the scope of practice of individuals with Clinical Privileges is limited to the Clinical Privileges granted.

Appendix A.4 - Quality Assessment/Performance Improvement/Patient Safety/OPPE/FPPE:

The Medical Staff is accountable to the Board of Directors for the quality of care provided to patients. All Medical Staff Members and all others with delineated Clinical Privileges will be subject to periodic review and appraisal as part of the Hospital's quality assessment, peer review and performance improvement activities. All organized services related to patient care will be evaluated. The Medical Staff shall perform the roles in quality assessment, peer review and performance improvement that are listed below as well as additional rules that may be set forth in Medical Staff policies. The Medical Staff will be responsible for communicating the findings, conclusions, recommendations, and actions taken to improve organization performance to appropriate Medical Staff Members and the Board of Directors.

The Medical Staff shall participate with the Board of Directors and administration in the performance of executive responsibilities related to the Hospital quality assessment, peer review and performance improvement program which address the following:

(1) an ongoing program for quality improvement and patient safety, including the reduction of medical errors;

(2) Hospital-wide quality assessment and performance improvement efforts that address priorities for improved quality of care and patient safety and the evaluation of those actions;

(3) the results of Hospital-wide quality assessment and performance improvement being utilized for ongoing professional practice evaluation ("OPPE") and focused professional practice evaluation ("FPPE"), and peer review activities;

(4) the establishment of clear expectations for safety; and

(5) the number of improvement projects that will be conducted annually.

Appendix A.5.1 - Leadership Role in Performance Improvement:

The Medical Staff shall perform a leadership role in the Hospital's quality assessment, peer review, performance improvement, and patient safety activities when the performance of a process is dependent primarily on the activities of one or more individuals with Clinical Privileges.

Such activities shall include, but not be limited to, a review of the following:

(1) use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;

(2) root cause analysis, investigation and response to any unanticipated adverse events;

(3) medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;

(4) performance based on the results of core measures and other publicly reported performance information;

(5) use of information about adverse privileging decisions for any Practitioner privileged through the Medical Staff process;

(6) use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;

(7) use of blood and blood components, including the review of any significant transfusion reactions;

(8) use of operative and other procedures, including tissue review and the review of any major discrepancy between pre-operative and post-operative (including pathological) diagnoses;

(9) appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge and resource/utilization review;

(10) significant departures from established patterns of clinical practice, including review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff; and

(11) use of developed criteria for autopsies.

Appendix A.5.2 - Participant Role in Performance Improvement:

The Medical Staff shall participate in the measurement, assessment and improvement of other patient care processes. Such activities shall include, but are not limited to, the following:

(1) analyzing and improving patient satisfaction;

(2) education of patients and families;

(3) coordination of care with other Practitioners and Hospital personnel, as relevant to the care of an individual patient;

(4) accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates;

(5) the quality of history and physical exams; and

(6) surveillance of nosocomial infections.

Appendix A.5.3 - OPPE, FPPE and Peer Review:

Findings relevant to a Practitioner are used in OPPE to verify continued competence for the Clinical Privileges granted and FPPE for both the initial appraisal of the Practitioner's competence and when indicated for cause. When the findings of quality assessment or performance improvement activities are relevant to a Practitioner's performance and the Practitioner has Clinical Privileges, the Medical Staff is responsible for determining the use of the findings in FPPE, OPPE or peer review. In accordance with the Credentials Policy, Clinical Privileges are renewed or revised appropriately as determined by the Medical Staff or Board based on OPPE or FPPE findings.

Appendix A.6 - Continuing and Graduate Medical Education:

The Hospital and Medical Staff shall sponsor educational activities that are consistent with the Hospital's mission, the patient population served, and the patient care services

provided, within the limitations of applicable federal laws and Hospital policy. The Medical Staff shall develop education programs for Medical Staff Members and others with Clinical Privileges related at least in part to:

(1) the type and nature of care offered by the Hospital; and

(2) the findings of performance improvement activities.

The Medical Staff shall also support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies to provide for supervision of participants in an affiliated professional graduate education program by Members of the Medical Staff in carrying out their patient care responsibilities.

Appendix A.7 - Bylaws Review and Revision:

The Medical Staff shall provide a mechanism for adopting and amending the Medical Staff Bylaws, Rules and Regulations, and policies and for reviewing and revising the Medical Staff Bylaws, Rules and Regulations, and policies as necessary to:

(1) remain consistent with the Bylaws of the Board of Directors;

(2) remain in compliance with all applicable federal and state laws and regulations, and applicable accreditation standards;

(3) remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities; and

(4) remain consistent with Hospital policies.