

MERCYONE DES MOINES MEDICAL CENTER

MEDICAL STAFF ORGANIZATION MANUAL

**MercyOne Medical Staff
MercyOne Des Moines
MercyOne West Des Moines**

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

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

1.B. TIME LIMITS

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

1.C. DELEGATION OF FUNCTIONS

- (1) When a function is to be carried out by a member of Medical Center Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees.
- (2) When a Medical Staff or Allied Health Staff member is unavailable or unable to perform an assigned 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. DEPARTMENTS

The Medical Staff will be organized into the following clinical departments:

- Department of Anesthesiology
- Department of Cardiology
- Department of Critical Care
- Department Medicine
- Department of Neuroscience
- Department of Obstetrics and Gynecology
- Department of Orthopedics
- Department of Pediatrics
- Department of Radiology
- Department of Surgery

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

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

2.C. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS

- (1) Clinical departments will be created and may be consolidated or dissolved by the Medical Executive Committee upon approval by the Board as set forth below.
- (2) The following factors will 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 Chief Medical Officer and by the rest of the Medical Staff leadership 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 the designated responsibilities and functions, including, where applicable, meeting requirements.
- (3) The following factors will 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 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.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

- (1) This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.
- (2) Procedures for the appointment of committee chairpersons and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.
- (3) In addition to the stated composition of any committee, the President of the Medical Staff may appoint one or more members of the Allied Health Staff to serve as a member of a given committee.
- (4) This Article details the standing members of each Medical Staff committee. In addition to the standing members, other Medical Staff members or Medical Center personnel may be invited to attend a particular Medical Staff committee meeting (as guests, without vote) in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. 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.
- (5) In accordance with Article 5 of the Medical Staff Bylaws, the Medical Executive Committee may establish additional committees or special task forces.

3.B. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual will meet as necessary to accomplish its duties and will maintain a permanent record of its findings, proceedings, and actions. Each committee will 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.C. CREDENTIALS COMMITTEE

3.C.1. Composition:

- (a) Chair, is appointed by Medical Executive Committee and President of the Medical Staff.

- (b) A minimum of six (6), to a maximum of nine (9) physicians are appointed to the Credentials Committee by the President of the medical staff. Interested members of the medical staff may indicate a willingness to serve, themselves, or be nominated by others on the medical staff. Physicians should represent a number of the clinical departments, both medical and surgical. All appointed physician members have voting status.
- (c) Members will serve three years terms, and it is recommended that terms are staggered. The committee member may serve up to two recurrent terms. Thus, two or three members will be appointed each year.
- (d) Non-voting committee members include medical staff and credentialing specialists, and the chief medical officer (CMO).
- (e) The Committee may consult with additional medical staff members, or allied health staff, when considering the work assigned to the committee.
- (f) Committee will meet on as frequent a basis as is necessary to complete its work in a timely manner. Some meetings may be completed virtually / electronically.

3.C.2. Duties:

The Credentials Committee will perform the following duties:

- (a) review the credentials of all applicants for 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) review, as may be requested by the Medical Executive Committee or the Professional Practice Evaluation Committee, all information available regarding the current clinical competence of individuals currently appointed to the Active Staff or Allied Health Staff and, as a result of such review, make a written report of its findings and recommendations;
- (c) recommend the numbers and types of cases to be reviewed as part of the initial focused professional practice evaluation;
- (d) review and approve specialty-specific criteria for ongoing professional practice evaluation and specialty-specific triggers that are identified by each department; and
- (e) recommend appropriate threshold eligibility criteria for clinical privileges, including clinical privileges for new procedures and clinical privileges that cross specialty lines.

3.C.3. Meetings and Reports:

The Credentials Committee will meet as often as necessary to accomplish its duties and will report its recommendations to the Medical Executive Committee, the President of MMC-DM, and the Board. Fifty percent of the committee membership will constitute a quorum.

3.D. LEADERSHIP COUNCIL

3.D.1. Composition:

- (a) The Leadership Council will consist of the following:
 - (1) the President of the Medical Staff;
 - (2) the President-Elect of the Medical Staff;
 - (3) Chair of Credentials
 - (4) Past-President
 - (5) the Chief Medical Officer.
- (b) At the discretion of the President of the Medical Staff and the Chief Medical Officer, the duties of the Leadership Council may be carried out by any complement of Leadership Council members, who will report back to the full Leadership Council at its next meeting.
- (c) Other Medical Staff members or Medical Center personnel may be invited to attend a particular Leadership Council meeting to assist the Leadership Council in its discussions and deliberations. Any such individual will attend as a guest, without vote, but will be considered an integral part of the peer review process and will be bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.D.2. Duties:

The Leadership Council may perform the following functions:

- (a) review and address issues regarding the clinical practice of members as part of the peer review process and as set forth in the peer review policy;

- (b) serve as the primary body responsible for addressing concerns about the professional conduct of members by engaging in collegial intervention and other progressive steps as set forth in the Code of Conduct Policy;
- (c) review cases referred to it as outlined in the PPE Policy;
- (d) develop, when appropriate, performance improvement plans for practitioners, as described in the PPE Policy;
- (e) meet, as necessary, to consider and address any situation that may require immediate action involving a member of the Medical Staff or Allied Health Staff; and
- (f) perform any additional functions as may be requested by the Medical Executive Committee and the Board.

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

The Leadership Council will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The Leadership Council will report to the Medical Executive Committee.

3.E. PRACTITIONER HEALTH COMMITTEE

3.E.1. Composition:

- (a) The Practitioner Health Committee will consist of the immediate past President of the Medical Staff, the Medical Staff President, the Chief Medical Officer, and other members of the Medical Staff appointed for their experience in addressing health issues.
- (b) Whenever the health of a member of the Medical Staff or Allied Health Staff is under review, the chairperson of his or her department will also join the committee on an *ad hoc* basis. The Immediate Past President of the Medical Staff will serve as the chairperson of the Practitioner Health Committee.

3.E.2. Duties:

The Practitioner Health Committee will perform the following duties:

- (a) assume responsibility for the supervision and management of practitioner health issues, as requested;

- (b) review the performance of any individual who is referred to the committee and assess whether the individual would benefit from or require treatment, rehabilitation, or other assistance;
- (c) assist in the diagnosis, treatment, and rehabilitation of practitioners who may be impaired;
- (d) develop a process for referrals to the committee (including a self-referral process);
- (e) maintain confidentiality of practitioners reviewed by the committee, unless limited by law, ethical considerations, or concerns about patient safety; and
- (f) arrange educational programs for the Medical Staff and the Allied Health Staff on practitioner health issues, including preventive measures designed to promote well-being.

3.E.3. Meetings and Reports:

The Practitioner Health Committee will meet as necessary to perform its duties. At its discretion, it may report to the Medical Executive Committee if it determines that, despite the committee's efforts, a practitioner is potentially unable to safely perform his or her privileges.

3.JF PROFESSIONAL PRACTICE EVALUATION COMMITTEE

3.F.1. Composition:

- (a) The Professional Practice Evaluation Committee will consist of the following:
 - (1) Vice-Chairs of the Clinical Departments and Medical Director of Trauma Services
 - (2) the Chief Medical Officer.
- (b) The Chief Medical Officer may appoint administrative staff as needed who will serve *ex officio*, without vote.
- (c) The chairperson of the Professional Practice Evaluation Committee will be appointed by the President of the Medical Staff and must be approved by the Medical Executive Committee.
- (d) Before any Professional Practice Evaluation Committee member begins serving, the member must understand the expectations and requirements of the position and affirmatively accept them. Members will participate, as required, in periodic training on professional practice evaluation, with the nature of the training to be

identified by the Leadership Council or the Professional Practice Evaluation Committee.

- (e) If additional expertise is required, the Professional Practice Evaluation Committee may request that a practitioner with the necessary expertise attend Professional Practice Evaluation Committee meetings while the matter is under consideration. The practitioner may assist the Professional Practice Evaluation Committee in its deliberations and the appropriate interventions. The practitioner will be present only for the relevant agenda items. Any such practitioner will attend as a guest, without vote, but will be an integral part of the professional practice evaluation process and will be bound by the same confidentiality requirements as the standing members of the committee.

3.F.2. Duties:

The Professional Practice Evaluation Committee will perform the following duties:

- (a) oversee the implementation of the Professional Practice Evaluation Policy (“PPE Policy”), providing training and support to the various components of the process;
- (b) review and approve ongoing professional practice evaluation quality data elements that are identified by specialties;
- (c) review and approve the specialty-specific quality indicators identified by the specialties that will trigger the professional practice evaluation/peer review process;
- (d) review, approve, and assist in the development of patient care protocols and guidelines that are recommended by specialties or others;
- (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;
- (h) monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;
- (i) periodically review the effectiveness of the PPE Policy and recommend revisions as may be necessary;
- (k) perform any additional functions as may be requested by the Leadership Council, the Medical Executive Committee, or the Board.

3.F.3. Meetings and Reports:

The Professional Practice Evaluation Committee will meet as often as necessary to accomplish its duties and will promptly report its findings to the Medical Executive Committee.

ARTICLE 4

AMENDMENTS AND ADOPTION

- (a) The amendment process for this Manual is set forth in the Medical Staff Bylaws.
- (b) This Manual is adopted and made effective upon approval of the Board, superseding and replacing any other Bylaws, Medical Staff Rules and Regulations, and Medical Center or Medical Staff policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____ 2/20/2020

Approved by the Board: _____ 4/22/2020