**Las Palmas Del Sol Healthcare**

# ORGANIZATION MANUAL

**July 27, 2021**

**ORGANIZATION MANUAL**

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## ARTICLE 1

## GENERAL

### 1.A. DEFINITIONS

The definitions that apply to terms used in the Medical Staff Bylaws, Credentials Policy, and Organization Manual 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 Hospital Administration, 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 one or more designees.

(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.

(3) Other Medical Staff Members or Hospital personnel may be invited to attend a particular meeting (as guests, without vote) in order to assist the Department/Committee in its discussion and deliberations regarding issues on its agenda. These individuals shall be present only for the relevant agenda items and shall be excused for all others. Such individuals are bound by the same confidentiality requirements as the standing members of the Department/Committee.

## ARTICLE 2

## CLINICAL DEPARTMENTS AND SECTIONS

### 2.A. DEPARTMENTS

The Medical Staff shall be organized into the following departments[1]:

Internal Medicine/Family Medicine

Emergency Medicine

Surgery

Anesthesia

OB/GYN

Pediatrics

Cardiovascular Services

### 2.B. SECTIONS

Each department may be divided into the following divisions:[2]

Internal Medicine/Family Medicine

Gastroenterology

Psychiatry & Neurology

Radiology & Nuclear Medicine

Surgery

General Surgery

Ophthalmology

Otolaryngology

Neurological Surgery

Pathology

Pediatric Surgery

Plastic Surgery

Podiatry

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1 MS.01.01.01, LD.04.01.05

2 MS.01.01.01, LD.04.01.05

Trauma

Urology

Cardiovascular Services

Cardiology

Cardiovascular Surgery

Pediatrics

Neonatology

**2.C.**

Service lines may exist to provide fully integrated services which are necessary to manage the health of a defined classification of patients. The classification may be based upon a medical condition, a procedure or clinical service or a patient population. Service lines need not be specifically identified in this Organization Manual or any other Bylaws document or Hospital or Medical Staff policy.

**CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS AND SECTIONS**

(1) Clinical departments and sections shall 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 shall be considered in determining whether a clinical department or section should be created (the existence of each of these factors is not required):

(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 (at least 20 Active Staff Members in the clinically distinct area of practice or with sufficient patient volume to support meaningful ongoing Medical Peer Review activities) or section (at least five Active Medical Staff members in a clinically distinct area of practice with sufficient patient volume to support the occasional need of these specialists to deliberate qualify of care issues unique to their specialty) ;

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

(c) a majority of the voting Members who would be assigned to the proposed department or section vote in favor of the creation of a new department or section;

(d) it has been determined by the Medical Staff Leaders and the Chief Executive Officer that there is a clinical and administrative need for a new department or section; and

(e) the voting Medical Staff Members who are in favor of, and would be assigned to, the proposed department or section have offered a reasonable proposal for how the new department or section will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) In the event that a new department or section is created, the Medical Executive Committee will recommend those Practitioners who shall be assigned to the department or section.

(4) The following factors shall be considered in determining whether the dissolution of a clinical department or section is warranted (the existence of each of these factors is not required):

(a) there is no longer an adequate number of Members of the Medical Staff in the clinical department or section 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 or section;

(c) the department or section 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 section director; or

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

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

Service lines may be created, consolidated, and dissolved jointly by the Medical Executive Committee and Board of Trustees. Service line creation is appropriate when it is determined that quality of care can be provided more efficiently and effectively to a defined classification of patients through a service line. Consolidation is appropriate when it is determined that the service line would function more effectively and efficiently in combination with other service lines. Dissolution is appropriate when there is an insubstantial number of patients or an insignificant amount of clinical activity within the service line or when it is determined that patients could be better served through a different organizational structure (such as departments or divisions).

## ARTICLE 3

## MEDICAL STAFF COMMITTEES

### 3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out Medical Peer Review activities including, but not limited to, 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 chairs and members of the committees are set forth in Article 6 of the Medical Staff Bylaws.

(3) This Article details the standing members of each Medical Staff committee. In addition to the standing members, other Medical Staff Members or Hospital 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. All such individuals are an integral part of the Medical Peer Review process and are bound by the same confidentiality requirements as the standing members of such committees.

(4) A standing committee shall also have the option of calling upon any Member of the Medical Staff or other Practitioner to serve on the committee as a member or agent on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment subject to approval of the President of the Medical Staff. Ad hoc members or agents of a committee shall be bound by the confidentiality requirements of the committee, and shall not have any voting rights.

(5) 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, sections, and committees.

(6) See Medical Staff Bylaws Article 6 for additional provisions.

### 3.B. 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 report after each meeting to the Medical Executive Committee which shall report to the Board, and to other committees and individuals as may be indicated in this Manual. The chairperson of each committee shall be available to meet with the Medical Executive Committee, Board of Trustees, its committees or the Chief Executive Officer on all recommendations that the committee may make.

## 3.C. BYLAWS COMMITTEE

### 3.C.1. Composition:

The Bylaws Committee shall be composed of the Immediate Past Chiefs of Staff who shall co-chair the committee, the Vice-President and at least 20 Active Staff Members representing each department. The *ex officio* members, without vote, shall be: the Chief Executive Officers, the Chief Medical Officers, the Chief Nursing Executive and Chief Nursing Officers, and Medical Staff Services personnel appointed by the Chief Executive Officer.

### 3.C.2. Duties:

The Bylaws Committee shall be responsible for performing the review and revisions of the Bylaws under the oversight and direction of the Medical Executive Committee. The Bylaws Committee shall review the Bylaws, the Credentials Policy, this Organization Manual, the Rules and Regulations and associated Medical Staff policies and recommend any needed additions, revisions, modifications, amendments or deletions. The Bylaws Committee shall also review all department and section rules and regulations.

### 3.C.3. Meetings and Reports:

The Bylaws Committee shall meet at least annually and shall report its recommendations and activities to the Medical Executive Committee.[3]

## 3.D. CREDENTIALS COMMITTEE

### 3.D.1. Composition:

The Credentials Committee shall consist of the Chief of Staff – Elect from each campus, who shall co-chair the committee, and the chairpersons of each department. The *ex officio* members, without vote, shall be: the Co-Chairs of the Professional Practice Evaluation Committee , the Chief Executive Officers, the Chief Medical Officers, the Chief Nursing Executive and Chief Nursing Officers, and a designated representative from the Medical Staff Services department. Advanced Practice Professionals with Clinical Privileges may be invited to attend meetings to assist the Credentials Committee on an ad hoc basis without voting rights.

### 3.D.2. Duties:

The Credentials Committee shall:

(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) review, as may be requested by the Medical Executive Committee or other appropriate committee, all information available regarding the current clinical competence of

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[3] MS.02.01.01

Practitioners and, as a result of such review, make a written report of its findings and recommendations;

(3) recommend the numbers and types of cases to be reviewed as part of the initial focused professional practice evaluation;

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

(5) 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;

(6) evaluate and make recommendations to the Medical Executive Committee and Board of Trustees 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;

(7) develop and recommend delineation of clinical privileges forms and any necessary policies for each type of Advanced Practice Professional permitted by the Board of Trustees 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 delegation, direction and/or supervision requirements, and malpractice insurance requirements; and

(8) review the qualifications of all Advanced Practice Professionals who apply for Clinical Privileges in the Hospital, interview such applicants as may be necessary, and make a written report of its findings and recommendations.

**3.D.3. Meetings and Reports:**

The Credentials Committee shall meet at least monthly and shall report its recommendations and activities to the Medical Executive Committee.[4]

**3.E. LEADERSHIP COUNCIL**

**3.E.1. Composition:**

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

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

(b) Vice President of the Medical Staff;

(c) Chief Elects for Del Sol and Las Palmas

[4] MS.02.01.01

(c) Co-Chairs of the Professional Practice Evaluation Committee ("PPEC"); and

(c) Immediate Past Chiefs of Staff for Del Sol and Las Palmas.

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

(a) The Chief Executive Officers, the Chief Medical Officers, and the Chief Nursing Executive and Chief Nursing Officers; and

(b) Professional Practice Evaluation (PPE) Support Staff representatives (as defined in the PPE Policy).

**3.E.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 issues regarding Practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy;

(3) appoint the members of the Professional Practice Evaluation Committee ("PPEC");

(4) meet, as necessary, to consider and address situations that may require immediate action;

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

(6) perform any additional functions as may be requested by the PPEC , the Medical Executive Committee, or the Board.

3.**E.3. Meetings and Reports:**

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 PPEC, 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. These reports will generally not include the details of any reviews or findings regarding specific practitioners.

**3.F. MEDICAL EDUCATION COMMITTEE**

**3.F.1. Composition:**

The Medical Education Committee shall consist of representatives including, but not limited to, physicians actively practicing at the Medical Center, the CME Coordinator, Manager/Director of Medical Staff Services and Physician Performance Improvement representatives. All members shall be voting members.

**3.F.2. Duties:**

The Medical Education Committee shall plan, implement, coordinate and promote ongoing clinical and scientific education programs for Medical Staff Members and other individuals with Clinical Privileges. In addition, the committee shall perform the following specific duties:

(1) establish liaison with the quality assessment and performance improvement program to identify the need for education based on the findings from the program;[5]

(2) assist in prioritizing plans for Hospital-sponsored education; [6]

(3) ensure the provision of any required Medical Staff education, including:

(a) education about illness, impairment, and health issues specific to physicians and other individuals with Clinical Privileges;[7]

(b) education about safety and quality, including unprofessional or inappropriate conduct and its potential impact on patient safety; [8]

(c) central line-associated bloodstream infections and the importance of prevention; [9]

(d) education regarding anticoagulation therapy safety to those who prescribe;[10]

(e) health care-associated infections, including multidrug-resistant organisms, and prevention strategies; [11]

(f) surgical site infections and the importance of prevention; [12]

(g) education about assessing and managing patients with pain; [13]

(h) education about influenza vaccine, non-vaccine control and prevention measures, and the diagnosis, transmission and impact of influenza; [14]

(i) education about the safety or quality of care provided in the organization as may be reported to the Joint Commission; [15]

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5 MS.12.01.01
6 MS.12.01.01
7 MS.11.01.01
8 LD.03.01.01
9 NPSG.07.04.01
10 NPSG.03.05.01
11 NPSG.07.03.01
12 NPSG.07.05.01
13 MS.03.01.03, MS.05.01.01
14 IC.02.04.01
15 APR.09.02.01

(j) education regarding the Practitioner's role(s) in emergency response and to whom he or she reports during an emergency; [16]

(k) education for Licensed Independent Practitioners who perform waived testing;[17]

(l) education regarding minimizing, eliminating and reporting environmental risks; and[18]

(m) alternative procedures to follow when electronic information systems are unavailable; [19]

(n) select appropriate teaching methods and knowledgeable faculty for each education program;

(o) promote and document attendance at each program and assess the effectiveness of each program;

(p) make recommendations regarding access to electronic medical resources;

(q) make recommendations regarding the financial needs of the continuing education program; and

(r) provide liaison and oversee the affiliation with any graduate medical education programs, including overseeing the safety and quality of care provided by program participants, and related educational and supervisory needs.[20]

**3.F.3. Meetings and Reports:**

The Medical Education Committee shall meet at least tri-annually and shall report its recommendations and activities to the Medical Executive Committee.[21] The Medical Education Committee shall communicate periodically with the Medical Executive Committee and the Board of Trustees about the educational needs and the Mission Statement of the Medical Education Committee.[22]

**3.G. MEDICAL STAFF LEADERSHIP DEVELOPMENT & NOMINATING COMMITTEE**

**3.G.1. Composition:**

The Medical Staff Leadership Development & Nominating Committee shall consist of the President and Vice-President of the Medical Staff, Immediate Past Chiefs of Staff, Secretary/Treasurers, Chiefs of Staff – Elect, and one Active Staff Member from each

16 EM.02.02.07
17 WT.03.01.01
18 EC.03.01.01
19 IM.01.01.03
20 MS.04.01.01
21 MS.02.01.01
22 MS.04.01.01, LD.01.03.01

department. The Chief Executive Officers, the Chief Medical Officers, and the Chief Nursing Executive and Chief Nursing Officers shall serve as *ex officio* members without vote. The President and Vice President shall serve as co-chairs. No candidate for election may serve as a member of the Medical Staff Leadership Development & Nominating Committee.

**3.G.2. Duties:**

The Medical Staff Leadership Development & Nominating Committee shall define desired leadership characteristics, identify and recruit future potential Medical Staff leaders from among the Active Medical Staff Members of the Medical Staff, and advise the Chief Executive Officer, the Chief Medical Officer and the Medical Executive Committee of the education and development needs of potential Medical Staff leaders so as to be successful in future roles. The committee shall solicit and accept nominations for elected Medical Staff officer and Medical Executive Committee positions, consult with the nominees concerning their qualifications and willingness to serve, prepare ballots, and supervise the election process.

**3.G.3. Meetings and Reports:**

The Medical Staff Leadership Development & Nominating Committee shall meet at least every two years and shall report its recommendations and activities to the Medical Executive Committee.[23]

**3.H. PROFESSIONAL PRACTICE EVALUATION COMMITTEE ("PPEC")**

**3.H.1. Composition:**

(1) The Professional Practice Evaluation Committee ("PPEC") shall consist of the following voting members:

(a) At least one Active Staff member whose primary practice campus is Del Sol and one Active Staff member whose primary practice campus is Las Palmas, who shall serve as Co-Chairs;

(b) The Immediate Past Presidents of the Medical Staff; and

(c) Additional Medical Staff Members appointed by the Leadership Council who are:

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

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

(iii) supportive of evidence-based medicine protocols.

(2) In addition to the Chief Executive Officers, the Chief Medical Officers, and the Chief Nursing Executive and Chief Nursing Officers, the Professional Practice Evaluation (PPE)

[23] MS.02.01.01

Support Staff representatives shall serve as *ex officio* members, without vote, to facilitate the PPEC's activities.

(3) Before any PPEC Member 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 PPEC.

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

**3.H.2. Duties:**

The PPEC 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, assist in the development of, and recommend to the Medical Executive Committee patient care protocols from departments, sections or others;

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

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

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

(10) 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

(11) 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.H.3. Meetings and Reports:**

The PPEC shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The PPEC shall submit reports of its activities to the MEC and the Board on a regular basis. The PPEC'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.I. INFECTION CONTROL COMMITTEE

### 3.I.1. Composition:

The Infection Control Committee of the Medical Staff shall consist of at least 2 members of the Staff from each campus, with Co-Chairs from each campus to assure representation. Hospital Administration, Nursing, Quality Assurance, Social Services and Case Management will be represented. The Chief Executive Officers, the Chief Medical Officers, and the Chief Nursing Executive and Chief Nursing Officers shall serve as *ex officio* members without vote.

### 3.I.2. Duties:

The duties of the Infection Control Committee are to:

(1) assess infection control activities such as surveillance of nosocomial infections;

(2) identify risks and trends relating to infection control; and

(3) provide direction to these activities and works on decreasing the Hospital's overall incidence of infection.

### 3.I.3. Meetings and Reports:

The Infection Control Committee shall meet at least quarterly and shall report their recommendations and activities to the Medical Executive Committee.

## 3.J. QUALITY COUNCIL

### 3.J.1. Composition:

The Quality Council will consist of at least 2 (two) members of the Staff appointed to assure representation of each department and the Medical Staff at large. The purpose of the Quality Council is to assume a leadership role in performance improvement through the monitoring and evaluation of hospital-wide functions. This is accomplished through the council's active role in improving organizational performance, organizational planning, integration of services, directing departments and through their role in quality review sessions.

### 3.J.2. Duties:

The duties of the Quality Council include the following:

(1) assume an active role in improving organization performance, organizational planning, integration of services, and directing of departments;

(2) make referrals to an individual, department, service, or committee in order to implement improvement activities, perform further evaluation, make recommendations and refer for corrective action(s), and/or request evidence of effectiveness of action(s) taken;

(3) review quarterly reports on Performance Improvement, as well as the Annual Evaluation, and make recommendations as necessary;

(4) review Peer/Case Review activity reports, and evaluate, recommend, or advise as appropriate;

(5) review Performance Improvement and other Medical Peer Review activities for the purpose of assessing the effectiveness of quality improvement activities to improve patient care outcomes and processes;

(6) oversee the Continuous Quality Improvement (CQI) efforts throughout the Hospital, which shall include, but is not limited to:

(a) implementing the CQI process,

(b) providing oversight to guide, facilitate, and charter Performance Improvement/CQI Teams,

(c) receiving recommendations from various sources regarding Quality Improvement efforts, and

(d) acting on reports from Performance Improvement Team activities; and

(7) overseeing education of Staff and facilitating communication of team progress and improvement throughout the organization.

**3.J.3. Meetings and Reports:**

The Quality Council will meet monthly at least eight times a year. The Leadership Session will be held quarterly or at least three times a year. The Council will maintain a permanent record of its proceedings and actions.

**3.K. PHARMACY AND THERAPEUTICS COMMITTEE**

**3.K.1. Composition:**

The Pharmacy and Therapeutics Committee of the Medical Staff shall consist of at least 2 (two)_ members of the Staff from each campus, including co-chairs from each campus, to assure representation. Hospital Administration, Nursing, Social Services, Risk Management, Quality/Performance Improvement, Pharmacy and Case Management will be represented. The Chief Executive Officers, the Chief Medical Officers, and the Chief Nursing Executive and Chief Nursing Officers shall serve as *ex officio* members without vote.

**3.K.2. Duties:**

The duties of the Pharmacy and Therapeutics Committee include the following:

(1) pursue an environment through the organization by which all medications are utilized in an appropriate and safe manner;

(2) formulate policies regarding evaluation, selection, and therapeutic use of drugs;

(3) work toward a proactive prevention of medication errors; and

(4) provide oversight and guidance for the pharmacy and therapeutic practices throughout the organization.

**3.K.3. Meetings and Reports:** The Pharmacy and Therapeutics Committee shall meet at least quarterly and shall report their recommendations and activities to the Medical Executive Committee.

## ARTICLE 4

## MEDICO-ADMINISTRATIVE OFFICERS

### 4.A. MEDICO-ADMINISTRATIVE OFFICERS

#### 4.A.1. Defined

A medico-administrative officer is a Practitioner who is employed by or contracts with the Hospital, or otherwise serves pursuant to a contract in a capacity that includes administrative responsibilities, and may also include clinical responsibilities.

#### 4.A.2. Medical Staff Appointment, Clinical Privileges and Obligations

All individuals in administrative positions who desire Medical Staff membership or clinical privileges shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Medical Staff membership or clinical privileges, as outlined in these Bylaws.[24] Additional requirements for employment or a contractual agreement may be imposed. The Medical Staff, as in the case of other Practitioners, shall delineate the clinical privileges of medico-administrative officers who request to admit and/or treat patients.

#### 4.A.3 Removal from Office or Adverse Change in Membership Status or Clinical Privileges

(1) In the event a Practitioner is employed by or under contract with the Hospital, or otherwise serving in a medico-administrative position pursuant to a contract which includes a provision removing the Practitioner from office through the termination or expiration of employment or of the contract, and the contract includes a provision terminating Medical Staff membership or clinical privileges upon expiration or termination of the contract, full effect shall be given to the specific provisions in the contract regarding the consequence such termination or expiration of the contract has on the Medical Staff membership and clinical privileges of the Practitioner. Termination of Medical Staff membership or clinical privileges upon expiration of or termination of the contract shall not entitle the Practitioner to the hearing and appeal procedures of Article Six of these Bylaws. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

(2) A medico-administrative Practitioner subject to an action in Article Six which would entitle a Practitioner to the hearing and appeal procedures in that Article is equally entitled to those procedures. Pursuant to any specific provisions of the contract, such adverse change in membership status or clinical privileges may result in termination of the contract. In the event there is a conflict between the terms of the contract and these Bylaws, the terms of the contract shall control.

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24 MS.03.01.01, MS.03.01.03

## 4.B. CHIEF MEDICAL OFFICER

### 4.B.1. General

There shall be a Chief Medical Officer for the Hospital and a Chief Medical Officer for each campus. The Hospital Chief Medical Officer also may serve as a Campus Chief Medical Officer. The Chief Medical Officers are not elected by the Medical Staff and are not officers of the Medical Staff organization. The Chief Medical Officers are Medico-Administrative Officers, and as such, the provisions of Section 4.A. above apply.

### 4.B.2. Qualifications

Each Chief Medical Officer shall be a Physician who is employed or under contract with the Hospital to perform administrative duties related to the Medical Staff affairs of the Hospital. A Chief Medical Officer is not required to be a Member of the Medical Staff or hold Clinical Privileges. If a Chief Medical Officer wishes to provide patient care services in the Hospital, the Chief Medical Officer must meet all of the qualifications for Medical Staff membership and the requested Clinical Privileges in accordance with the procedures in the Medical Staff Bylaws and the Medical Staff Credentials Policy.

### 4.B.3. Responsibilities and Authority

The Chief Medical Officers shall serve as advisors to the officers of the Medical Staff and as a liaison between the Medical Staff and Hospital Administration. The authority of the Chief Medical Officers shall be that of an administrator of the Hospital, as assigned by the Chief Executive Officer. Specific responsibilities include, but are not limited to:

(1) Administratively oversee the Medical Staff Services in performance of the credentialing function;

(2) Serve as a designee of the Chief Executive Officer in reviewing and approving applications for temporary privileges;

(3) Serve as an *ex-officio* Member of all Medical Staff committees, without vote, including the Medical Executive Committee; and

(4) Advise and assist the officers of the Medical Staff, department and section chairs and Medical Staff committees in the performance of their duties, including providing orientation and education to Medical Staff Leaders with regard to their leadership roles.

### 4.B.4. Appointment

After having received input from the Medical Executive Committee, the Hospital Chief Medical Officer, the Chief Medical Officer – Las Palmas and the Chief Medical Officer – Del Sol shall be appointed by the Chief Executive Officer of the Hospital and approved by the Board of Trustees.

### 4.B.5. Vacancy

In the event of a vacancy in the position of the Hospital Chief Medical Officer, the Hospital Chief Executive Officer shall ensure that any assigned Medical Staff functions are performed. In the event of a vacancy in the position of the Chief Medical Officer – Las Palmas or Chief Medical Officer – Del Sol, the Chief of Staff-Las Palmas and the Chief

of Staff-Del Sol, respectively, shall ensure that any Medical Staff functions associated with such positions are performed.

## ARTICLE 5

## ADOPTION AND AMENDMENTS

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.

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

Adopted by the Medical Staff: **October 16, 2019**

Approved by the Board of Trustees: **October 29, 2019**

## 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 Trustees[1]; 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.[2]

**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;[3]

(2) planning and prioritizing performance improvement activities;[4]

(3) budgeting;[5]

(4) providing for uniform performance of patient care processes;[6]

(5) recruitment, retention, development and continuing education of all staff;[7]

(6) consideration and implementation of clinical practice guidelines as appropriate to the patient population;[8]

(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;[9] and

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1 MS.01.01.01, MS.03.01.01, MS.05.01.01

2 MS.03.01.03, LD.03.04.01

3 LD.02.01.01

4 LD.03.03.01, LD.03.05.01, LD.04.04.01, PI.03.01.01

5 LD.04.01.03

6 LD.02.01.01, MS.01.01.01, LD.01.05.01

7 LD.02.01.01, LD.03.06.01

8 LD.04.04.07

9 MS.03.01.01

(9) securing autopsies in all cases of unusual deaths and of medical, legal and educational interest.[10]

**Appendix A.3 – Medical Peer Review - Credentialing and Privileging:**

The Medical Staff is responsible to the Board of Trustees for the credentialing and privileging 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 and privileging 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;[11]

(2) establishing professional criteria for Membership and for Clinical Privileges;[12]

(3) conducting an evaluation of the qualifications and competence of individuals applying for Medical Staff Membership or Clinical Privileges;[13]

(4) submitting recommendations to the Board of Trustees regarding the qualifications of an applicant for Membership or Clinical Privileges;[14]

(5) establishing a mechanism for fair hearing and appellate review;[15] and

(6) establishing a mechanism to ensure that the scope of practice of individuals with Clinical Privileges is limited to the Clinical Privileges granted.[16]

**Appendix A.4 – Medical Peer Review - Quality Assessment/Performance Improvement/Patient Safety/OPPE/FPPE:**

The Medical Staff is accountable to the Board of Trustees for the quality of care provided to patients.[17] 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.[18] All organized services related to patient care will be evaluated.[19] 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

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10 MS.05.01.01

11 MS.01.01.01.

12 MS.02.01.01, MS.06.01.03, MS.06.01.07, MS.08.01.03

13 MS.06.01.07

14 MS.01.01.01, MS.06.01.03, MS.06.01.07

15 MS.10.01.01

16 MS.08.01.03, MS.03.01.01, MS.06.01.05

17 42 C.F.R. §482.12(a)(5)

18 MS.01.01.01, MS.05.01.01, MS.06.01.07, MS.08.01.03, 42 C.F.R. §482.22(a)(1)

19 42 C.F.R. §482.21(a)(1)

forth in Medical Staff policies.[20] 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 Trustees.[21]

The Medical Staff shall participate with the Board of Trustees 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.[22]

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;[23]

(2) root cause analysis, investigation and response to any unanticipated adverse events;[24]

(3) medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;[25]

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20 42 C.F.R. §482.21

21 MS.05.01.03

22 MS.05.01.01

23 LD.04.04.05, MS.05.01.01

24 LD.04.04.05, MS.05.01.01

25 MS.05.01.01, 42 C.F.R. §482.21(a)(2)

(4) performance based on the results of core measures and other publicly reported performance information;[26]

(5) use of information about adverse privileging decisions for any Practitioner privileged through the Medical Staff process;[27]

(6) use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;[28]

(7) use of blood and blood components, including the review of any significant transfusion reactions;[29]

(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;[30]

(9) appropriateness, medical necessity, and efficiency of clinical practice patterns, including the review of surgical appropriateness, readmissions, appropriateness of discharge and resource/utilization review;[31]

(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;[32] and

(11) use of developed criteria for autopsies.[33]

**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.[34] Such activities shall include, but are not limited to, the following:

(1) analyzing and improving patient satisfaction;[35]

(2) education of patients and families;[36]

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26 Hospital Quality Alliance and public reporting initiatives

27 MS.05.01.01

28 MS.05.01.01, 42 C.F.R. §482.21, 42 C.F.R. §482.23(c)(4)-(5), 42 C.F.R. §482.25(b)(6)

29 MS.05.01.01, 42 C.F.R. §482.21, 42 C.F.R. §482.23(c)(4)-(5)

30 MS.05.01.01, 42 C.F.R. §482.21

31 MS.05.01.01, 42 C.F.R. §482.21, 42 C.F.R. §482.30

32 MS.05.01.01

33 MS.05.01.01

34 MS.05.01.03

35 MS.03.01.01

36 MS.05.01.03

(3) coordination of care with other Practitioners and Hospital personnel, as relevant to the care of an individual patient;[37]

(4) accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates;[38]

(5) the quality of history and physical exams;[39] and

(6) surveillance of nosocomial infections.[40]

**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.[41] 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.[42]

**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.[43] 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;[44] and

(2) the findings of performance improvement activities.[45]

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

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37 MS.05.01.03

38 MS.05.01.03, RC.01.03.01, 42 C.F.R. §482.21

39 MS.03.01.01

40 IC.01.03.01, 42 C.F.R. §482.21(a)(2), 42 C.F.R. §482.42(b)

41 MS.05.01.03

42 MS.05.01.03, 42 C.F.R. §482.22(a)(1)

43 MS.12.01.01, Ethics and Compliance Policy LL.010

44 MS.12.01.01

45 MS.12.01.01

participants in an affiliated professional graduate education program by Members of the Medical Staff in carrying out their patient care responsibilities.[46]

**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 Trustees;[47]

(2) remain in compliance with all applicable federal and state laws and regulations, and applicable accreditation standards;[48]

(3) remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities;[49] and

(4) remain consistent with Hospital policies.[50]

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46 MS.04.01.01

47 MS.01.01.01

48 LD.04.01.01

49 MS.01.01.01, LD.01.05.01

50 LD.01.03.01