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Medical Staff Organization Manual of CentraCare - Monticello

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CentraCare adopts the following Policy/Procedure for:

CentraCare - Monticello

ARTICLE 1

GENERAL

A. **DEFINITIONS**

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

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.

C. **DELEGATION OF FUNCTIONS**

Functions assigned to an identified individual or committee may be delegated to one or more designees.

ARTICLE 2

MEDICAL STAFF COMMITTEES

A. **MEDICAL STAFF COMMITTEE MEMBERS**

1. Except as otherwise provided by the Bylaws or this Medical Staff Organization Manual, the Chief of Staff will appoint the members and the chairperson of each Medical Staff committee, in consultation with the Chief Medical Officer.
2. Chairpersons and members of standing committees will be appointed for a one year term but may be reappointed for additional terms.
3. Chairpersons and members of standing committees may be removed, and vacancies filled at the discretion of the person who initially appointed them.
4. The Chief of Staff will be an *ex officio* member, with vote, on all Medical Staff committees.
5. The President and Chief Medical Officer will be *ex officio* members, without vote, on all Medical Staff committees. If required, the Chief

Medical Officer may be counted as a voting member of any Medical Staff committees (other than the Medical Executive Committee) for purposes of establishing a quorum.

B. DUTIES OF COMMITTEE CHAIRPERSONS

Each committee chairperson is responsible for the following functions, either personally or in collaboration with Hospital personnel:

1. assist appropriate staff member(s) in establishing agenda for meetings;
2. preside over meetings and keep meetings organized and on task;
3. establish a quorum in accordance with Section 5.B.3 of the Medical Staff Bylaws of Centracare – Monticello so members can proceed with the committee's business;
4. encourage discussion and participation from all members;
5. guide discussion and debate toward consensus; and
6. authenticate draft committee minutes and attachments in a timely fashion prior to presentation to Medical Executive Committee.

C. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely report after each meeting to the Medical Executive Committee and to other committees and individuals as may be indicated in this Manual.

D. BLOOD TRANSFUSION COMMITTEE

1. **Composition**:

   The Blood Transfusion Committee shall consist of, at a minimum, the Laboratory Medical Director-Chairperson, the Laboratory Manager, the Acute Care Division Director (or designee), and the Blood Bank Lead Technician. Additional staff shall be requested to attend as needed.

2. **Duties**:

   The Blood Transfusion Committee may:

   a. assist the Medical Staff in the formation and revision of policies regarding blood transfusion and care provided in the Facility;

   b. review and analyze data on Blood Transfusion Reaction, Cross

Match Ratio, Blood Product Utilization, Emergency Transfusion Blood Utilization, Appropriateness of Blood Transfusion, and other related Blood Transfusion audits;

c. implement performance improvement when identified;

d. assign subcommittees or performance improvement teams to improve performance as needed;

e. perform peer review functions as outlined in the System Level Peer Review Policy;

f. discuss patient safety issues and proactively discuss safety goals, implement plans, and monitor success as appropriate to the clinical areas; and

g. develop, review and monitor transfusion process for laboratory service area.

3. **Meetings and Reports**:

The Blood Transfusion Committee shall meet at least quarterly and communicate its recommendations to the Medical Executive Committee.

E. PEER REVIEW AND MEDICAL PRACTICE EVALUATION COMMITTEE

1. **Composition**:

a. The Peer Review and Medical Practice Evaluation Committee will consist of the Chief of Staff, the Vice-Chief of Staff, the Surgery Medical Director, and at least two (2) members of the Active Staff, as recommended by the Medical Executive Committee and appointed by the Chief of Staff. The Chief Medical Officer will serve as ex officio voting member of the committee. The committee may also include non-voting representatives of Administration, Nursing Service, Advanced Professional Practice providers, and Quality as appointed by the President of the Hospital. An attempt will be made to appoint members so that there is diversity in membership and broad representation of the clinical specialties.

b. Committee members may request members of the Medical Staff and the Allied Health Staff or other practitioners with clinical expertise to attend meetings and assist the committee in its discussions and deliberations, as needed. Any such practitioner will attend as a guest, without vote, but will be considered an integral part of the professional evaluation process and will be

bound by the same confidentiality requirements as the standing members of the committee.

2. **Duties**:

The Peer Review and Medical Practice Evaluation Committee will perform the following duties:

a. Provide oversight for the approach to mechanisms for medical care review performed by Medical Directors and Medical Staff committees and provide assistance to Medical Directors and Medical Staff committees in their effort to establish procedures for and evaluate results of medical care review as needed;

b. Coordinate medical care review activities between Medical Directors and Medical Staff committees as appropriate;

c. Monitor and review information in the following key activities:

i. review of hospital deaths and mortality data;

ii. medical record review findings;

iii. other key patient outcomes or data;

d. Evaluate new methods and techniques to review medical care and assist in their implementation when appropriate;

e. Assure compliance with and propose changes in medical care review as required by regulatory bodies and third-party payers, and assist Medical Directors and Medical Staff committees with implementation;

f. Refer concerns regarding the performance of individual physicians to the relevant Medical Director and/or the Medical Executive Committee;

g. Refer policy considerations to the Medical Executive Committee or appropriate Medical Staff committee;

h. Refer recommendations for performance improvement processes to the appropriate Medical Director or Medical Staff committee and monitor for compliance or response to recommendation and performance itself;

i. Be responsible for monitoring the key elements of the medical record or representative sample of records to help ensure safe and effective transitions of care and appropriate documentation;

j. Monitor utilization review activities and provide peer review of

selected utilization review cases and refer key findings to appropriate Medical Director and/or Medical Staff committee;

k. Oversee the implementation of the Professional Practice Evaluation Policy;

l. Review and approve quality data elements for ongoing professional practice evaluation and specialty-specific triggers for professional practice evaluation that are identified by each department;

m. Identify those variances from rules, regulations, policies or protocols which do not require physician review, but for which the Medical Staff Office may send an informational letter to the practitioner involved in the case;

n. Review cases referred to it as outlined in the Professional Practice Evaluation Policy;

o. Develop, when appropriate, performance improvement plans for practitioners;

p. Review the effectiveness of the Professional Practice Evaluation Policy and recommend revisions or modifications as may be necessary; and

q. Oversee the Hospital's compliance with quality measures, clinical protocols or clinical process and outcome measures, or other quality indicators required for compliance with regulatory or accreditation requirements.

3. **Meetings and Reports**:

The Peer Review and Medical Practice Evaluation Committee will meet as needed and will maintain a permanent record of its findings, proceedings, and actions. The committee will submit reports of its actions and recommendations to the Medical Executive Committee on a regular basis.

F. TRAUMA MEDICINE SERVICES COMMITTEE

1. **Composition**:

The Trauma Medicine Services Committee shall consist of emergency department physicians and, if possible, representatives from Surgery, Orthopedics, Nursing Services, Administration, and additional staff as needed. The chair shall be the Trauma Program Medical Director.

2. **Duties**:

The Trauma Medicine Services Committee may:

a. review, design and analyze process improvement initiatives and departmental statistics;

b. discuss patient safety issues and proactively discuss safety goals, implement plans, and monitor success as appropriate to the trauma areas;

c. develop and review quality indicators and conduct peer review of mortality/morbidity related to trauma services; and

d. develop, review, and monitor clinical process for trauma service areas.

3. **Meetings and Reports**:

The Trauma Medicine Services Committee shall meet at least quarterly and communicate its recommendations to the Medical Executive Committee.

ARTICLE 3

Medical Director/Dyad Role

A. **Position Summary**:
The Medical Director is responsible for directing the effective operations of the Department, for overseeing clinical quality of care provided by providers in the Department, and for serving as the primary representative of practice in interactions with CCH-M administration and the medical staff.

The Medical Directors report to President and Chief Medical Officer for all aspects of the practice's operation. The Medical Directors are also accountable to the Medical Executive Committee regarding the clinical quality of care provided in the practice.

B. **Duties and Responsibilities**:

Duties and Responsibilities shall include, but not limited to, the following:

1. Participates with administration and medical staff in identifying performance goals and standards for the Department by measuring and monitoring practice performance, and in taking action to improve performance to meet established goals.

2. Participates in identifying improvements for quality, timeliness, cost,

improving process and performance.

3. Assists in developing and approving Department's policies, order sets, clinical protocols, forms reports, and records required by CC-M (CentraCare – Monticello).
4. Conducts periodic team meetings with physicians, support staff and applicable CC-M personnel, and implements such other communication methods as are necessary to foster effective working relationships among the parties and facilitate resolution of problems.
5. Ensure provider compliance with the policies, practices and directions of CC-M, the Medical Staff bylaws, Credentialing Policy, Organizational Manual and Rules and Regulations.
6. Meets with DYAD partner for the Department to review but not limited to:
    a. Infection Control and Prevention.
    b. Event Review and develop action plans if needed including but not limited to Medication errors.
    c. Review Drug Formulary updates, drug shortages and drug changes.
    d. Participate in Performance Improvement.
    e. Participate in analysis of appropriate analytics for the department including but not limited to: Patient Experience, Physician Patient experience, Finance, Roadmaps, Key performance indicators, department specific metrics and financial review.

ARTICLE 4

AMENDMENTS

The process for amending this Medical Staff Organization Manual is set forth in Article 8 of the Medical Staff Bylaws.

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Operating Committee of the Governing Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

systems are for internal use only. They may not be copied by independent companies or organizations that have access to documents, as CentraCare cannot guarantee the relevance of these documents to external entities.

Approval Signatures

Step Description	Approver	Date
Operating Committee	Karleen Janssen: MONT EXEC ASST TO ADMINISTRATOR EX	03/2023
Medical Executive Committee	Karleen Janssen: MONT EXEC ASST TO ADMINISTRATOR EX	03/2023
	Karleen Janssen: MONT EXEC ASST TO ADMINISTRATOR EX	03/2023