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CentraCare

RICE MEMORIAL HOSPITAL

301 BECKER AVENUE SW
WILLMAR, MINNESOTA

MEDICAL STAFF BYLAWS,
RULES AND REGULATIONS,
AND POLICIES

MEDICAL STAFF ORGANIZATION AND FUNCTIONS MANUAL

AMENDED 11/10/2021

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ARTICLE 1 - GENERAL

1.1 Definitions

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

1.2 Time Limits

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated.

1.3 Delegation of Functions

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

ARTICLE 2 - CLINICAL DEPARTMENTS AND SECTIONS

2.1 Departments

The Medical Staff will be organized into the following departments:
Amended 08/04/2020 – Division of Internal Medicine Department: creation of Hospital Medicine Department, addition of Internal Medicine to the Family Medicine Department

Anesthesia

Emergency Medicine

Family Medicine/Internal Medicine

Hospital Medicine

Obstetrics-Gynecology

Pathology

Pediatrics

Psychiatry

Radiology

Surgery

2.2 Functions and Responsibilities of Departments

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

ARTICLE 3 - MEDICAL STAFF COMMITTEES

3.1 Medical Staff Committees and Functions

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.

Procedures for the appointment of committee chairpersons and members of the committees are set forth in Article XII of the Medical Staff Bylaws.

3.2 Duties, Meetings, Reports and Recommendations

At a minimum, each committee will perform the duties set forth below and any additional duties which may be assigned by the Medical Executive Committee.

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

3.3 Bylaws Committee

3.3-1 Composition:

The Bylaws Committee will consist of at least three (3) members of the Medical Staff.

3.3-2 Duties:

The Bylaws Committee will perform the following duties:

A. review the Medical Staff Bylaws and associated documents, including the Medical Staff Rules and Regulations, at least every three years and recommend amendments to the Medical Executive Committee; and

B. receive and consider all recommendations for changes to the Medical Staff Bylaws and associated documents by the Board, any committee or department of the Medical Staff, the President of the Hospital, and any Medical Staff member.

3.3-3 Meetings and Reports:

The Bylaws Committee will meet as often as necessary to fulfill its duties, but at least triennially, and will report its recommendations to the Medical Executive Committee and the President of the Hospital.

3.4 Cancer Committee

3.4-1 Composition:

The Cancer Committee shall consist of at least five members of the Medical Staff. These members must meet the qualifications as outlined in the Cancer Center Policy and must include representation from Medical Oncology, Surgery, Radiation Oncology, Diagnostic Radiology, and Pathology. Other Medical Staff representation may include Family Medicine, Urology, Otolaryngology, and others as deemed necessary by the committee. Non-Medical Staff representation includes membership from cancer program administrator, oncology nursing leadership, social worker/case manager, cancer registry team, palliative care services, genetics professional and clinical research nurse. Membership to the committee follows guidelines defined by the American College of Surgeons Commission on Cancer. Both physicians and non-physicians may be voting members of this committee. Meeting frequency is quarterly. Committee chair will be a physician member of the Committee.

3.4-2 Duties:

The Cancer Committee shall:

A. Appoint the Cancer Liaison Physician (3-year term).

B. Assure compliance with the eligibility standards as required by the certifying body.

C. Develop, implement and monitor at least 1 clinical and 1 programmatic goal related to cancer care.

D. Assure annual quality evaluation of cancer registry data and activity.

E. Monitor cancer conference activity.

F. Monitor community outreach activity.

G. Monitor patient accrual to cancer related clinical trials.

H. Offer at least 1 cancer related education activity (AJCC or other appropriate staging, use of prognostic indicators and evidence-based guidelines).

I. Monitor cancer registry staff annual education requirement.

J. Develop and disseminate a report of patient and program outcomes to the public.

K. Monitor adherence to the College of American Pathology protocols.

L. Annually review, approve and recommend actions to reports on:

1. Oncology nursing care.

2. Cancer risk assessment, genetic counseling and testing services.

3. Availability of palliative care services for patients.

4. Patient navigation (case management process).

5. Status and plan for psychosocial distress screening.

6. Status and progress for Survivorship care plan for patients completing treatment.

M. Monitor patient outcomes for:

1. Annual cancer prevention program to the community.

2. Annual cancer screening program targeted to decrease number of patients with late-stage disease.

3. Assure annual performance levels are met for each specified accountability and quality improvement measure.

4. Complete annual physician member study for evaluation and treatment according evidence-based national guidelines.

5. Complete studies on quality including development, analysis and documentation of quality of care outcomes.

6.Complete annual quality improvement studies.

N. Monitor cancer registry quality data.

O. Authorize participation in Commission on Cancer special studies.

P. Approval all Cancer Care Center Board minutes and agendas documenting compliance to standards.

3.4-3 Meetings:

A. The Cancer Committee shall meet as often as necessary to transact its business, but at least quarterly. The Cancer Committee shall maintain a permanent record of its findings, proceedings, and actions, and shall make a report thereof after each meeting to the Medical Executive Committee, the Cancer Care Center Board, and the President of the Hospital.

B. The Cancer Committee shall report any potentially unsafe or inappropriate activity related to cancer care to the appropriate facility committee for investigation and action, if required. Any uninvolved medical staff officer or the Physician VP of Acute Care should be the primary contact for questions.

3.5 Privileging Committee

3.5-1 Composition:

A. The Privileging Committee will consist of the members of the Medical Executive Committee, with the Vice Chief of Staff serving as the chair.

3.5-2 Duties:

The Privileging Committee will perform the following duties:

A. review the privileges of all applicants for appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, obtain and consider the recommendations of the appropriate departments, 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 Peer Review Committee, all information available regarding the current clinical competence of individuals currently appointed to the Medical Staff, Advanced Practice Provider Staff, or Allied Health Professional 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. recommend appropriate threshold eligibility criteria for clinical privileges, including clinical privileges for new procedures and clinical privileges that cross specialty lines.

3.5-3 Meetings and Reports:

The Privileging Committee will meet as often as necessary to accomplish its duties and will report its recommendations to the Medical Executive Committee, the President of the Hospital, and the Board. The presence of five members of the committee will constitute a quorum.

3.6 Medical Executive Committee

The composition, duties, and meeting and reporting requirements of the Medical Executive Committee are set forth in Section 12.3 of the Medical Staff Bylaws.

3.7 Medical Record Review Committee

3.7-1 Composition

The Medical Record Committee will consist of up to five (5) physician medical staff members and representatives from the following departments: Administration, Health Information Services and Nursing. Additional medical staff members may be appointed if deemed necessary by the Chief of Staff.

3.7-2 Duties

Formulate and establish governing information required for each medical record and determine whether records are pertinent, completed promptly, adequate as medical-legal documents and adequate for quality assessment, as accomplished in the medical record review process.

3.7-3 Meetings and Reports

The Medical Record Committee will meet at least quarterly or as often as necessary to accomplish its duties and will report to the Medical Executive Committee.

(Article amended 11/10/2021 as Utilization Review is now part of CentraCare's UR Plan & Committee)

3.8 Patient Care Committee

3.8-1 Composition

A. Physician membership shall consist of 5-7 medical staff members with the representation from the following areas:

1. Medical (Family Medicine, Internal Medicine, Hospitalist)
2. Surgical (General, OB-GYN, ENT, Urology)
3. Ad Hoc Specialist (Anesthesia, Emergency Medicine, Pathology, Pediatrics, Psychiatry, Radiology)

B. Additional members of this committee shall include, but not be limited to, representatives from the following hospital departments or services: Administration, Care Management, Dialysis, Infection Control, Laboratory, Nursing, and Pharmacy.

3.8-2 Duties

A. Evaluation and recommendation of specific action with regard to new services or major hospital equipment expenditures to the medical staff through the Executive Committee.

B. Infection evaluation leading to prevention and control shall include:

1. Development and implementation of a program to survey, isolate, document, and correct infection problems within the hospital.
2. A program of sensitivity testing of in-hospital strains of bacteria and informing the medical staff of problem areas.

C. Blood usage review and analysis shall include:

1. Evaluation of blood and blood product usage within the hospital, with tabulation and reporting results to appropriate quality review units of the staff.
2. Developing recommendations for appropriate changes in usage patterns.

D. Medication use review as a joint function with pharmacy, nursing, and administration shall be accomplished to maintain a formulary, monitor investigational drugs, monitor drug policy, and review drug reactions.

E. Drug usage evaluation shall address the prescribing practice of drugs used in the hospital. Varied categories of drugs shall be reviewed in turn. Appropriate recommendations shall be made to the Medical Staff based on the findings of this review.

3.8-3 Meetings and Reports

The Patient Care Committee will meet at least quarterly or as often as necessary to accomplish its duties and will report to the Medical Executive Committee.

3.9 Peer Review Committee

3.9-1 Composition

The Peer Review Committee is composed of five to seven physician medical staff members from several different specialties or departments. Each member serves a term of three years, with a staggering of the terms to provide continuity for the process. The Chief Medical Officer is a permanent, non-voting member of the committee.

The Peer Review Committee may request additional members of the Medical and Advanced Practice Provider Staff or other practitioners with applicable expertise to attend meetings and assist the committee in its discussions and deliberations as needed. Any such practitioner will attend as a guest, without a vote. These practitioners are considered 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.

3.9-2 Duties

The Peer Review Committee members act as the physician reviewers of the quality of care and shall perform the following functions:

A. Oversee the implementation of the Medical Staff Quality: Professional Practice Evaluation Policy (FPPE and OPPE);

B. Oversee the integration of CentraCare's Peer Review Policy (system-wide process) into the quality of care review process for Rice Memorial Hospital's Medical Staff, APP Staff and AHP Staff;

C. 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;

D. Routine review of quality will include ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE);

E. At a minimum, information reviewed will include specific cases identified through the quality monitoring process or referred by medical and hospital staff; quality indicator data collected on care provided; and patient satisfaction information;

F. Develop, when appropriate, performance improvement plans for practitioners. Monitor practitioner's compliance with such plans;

G. Participate in the system-level peer review process by:

1. Receiving and reviewing recommendations for cases referred by the system-level multidisciplinary committee.
    a) Meet with the practitioner to deliver outcome
    b) Forward the recommendation to the Privileging Committee/MEC regarding actions to be taken specific to the practitioners privileges. Include additional information, as applicable, regarding concerns identified via OPPE, complaints or other means.

2. Receiving and reviewing monthly reports of all cases that were sent for peer review by the system-level committees;

H. Review the effectiveness of the Medical Staff Quality: Professional Practice Evaluation Policy and recommendation revisions or modifications as may be necessary; and

I. In cases of an impaired practitioner completing a rehabilitation program the Peer Review Committee will monitor the licensed independent practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.

J. In making its determinations, the committee will utilize a number of resources, including, but not limited to, the clinical judgment of the members, input from department chairs, opinions from specialists on or outside the medical staff, and the use of applicable reference material. Determinations of quality of care are made by the committee as well as by the system-level multidisciplinary committees.

3.9-3 Meetings and Reports

The Committee meets at least quarterly and reports directly to the Medical Executive Committee. The presence of 3 members will constitute a quorum. The Committee will maintain a permanent record of its findings, proceedings and actions. All committee reports are confidential, are protected as part of the peer review process, and will be shared only with the Medical Executive Committee. Specific recommendations regarding improvement strategies for any physician will be made to the Medical Executive Committee.

3.10 Trauma Peer Review Committee

3.10-1 Composition

The Trauma Peer Review Committee will consist of members of the Medical Staff who have an explicit interest in ongoing trauma case management. Particular emphasis is placed on the specialties of Trauma Surgery, Orthopedic Surgery, and Emergency Medicine. Committee meetings are open to all Medical Staff members.

3.10-2 Duties

The Trauma Peer Review Committee will perform the following duties:

A. critically review, evaluate, and discuss the quality of care in cases of adverse outcome, particularly focusing on those deaths statistically expected to survive, which were identified using outcome norms;

B. review judgments regarding appropriateness and quality of care in each case of adverse outcome;

C. review all trauma deaths and determine whether there was an opportunity for improvement or no opportunity for improvement;

D. review trauma cases as required by the American College of Surgeons (ACS) and as identified by the Trauma Medical Co-Directors or Trauma Program Manager;

E. heighten the awareness of current trauma management through education and discussion; and

F. forward problems or issues that impact standards of trauma care and make recommendations to the appropriate department chairperson and/or the Medical Executive Committee.

3.10-3 Meetings

The Trauma Peer Review Committee will meet on a quarterly basis. All trauma surgeons and Emergency physicians are required to attend 50% of the meetings annually. Representatives from Anesthesia, Orthopedic Surgery, Pathology, Hospital Medicine and Radiology are encouraged to attend.

ARTICLE 4 - AMENDMENTS

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

ARTICLE 5 - ADOPTION

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

Adopted by the Medical Staff on:

Date: March 3, 2020
Frederick Hund, Chief of Staff

Approved by the Board:

Date: March 11, 2020
David Anfinson, Chair, Board of Directors

Amended Article 2.1: 08/04/2020 – Approved by MEC