

MEDICAL STAFF ORGANIZATION MANUAL

**Ridgeview Medical Center
Ridgeview Le Sueur Medical Center
Ridgeview Sibley Medical Center**

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the 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. Medical Staff Leaders will strive to be fair under the circumstances.

1.C. DELEGATION OF FUNCTIONS

- (1) When a function is to be carried out by a Medical Staff Leader, a Medical Staff committee, or a member of Hospital Administration, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees.
- (2) When a member of the Medical Staff 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

SERVICES

2.A. SERVICES

The following services and service lines may function at the Hospital:

- Surgical Specialties Services
 - General Surgery Service Line
 - Orthopedic Service Line

- Women's and Children's Services
 - Neonatal Service Line
 - OB Service Line
 - Pediatric Service Line

- Emergency Medicine Services
 - Emergency Medicine Service Line

- Adult/Family Medicine Services
 - Adult Medicine Service Line
 - Cardiology Service Line
 - Mental Health Service Line
 - Neurology Service Line
 - Oncology Service Line
 - Urogynecology Service Line

- Integrated Critical Access Services including adult medicine, emergency medicine, and surgery services.

2.B. FUNCTIONS AND RESPONSIBILITIES OF SERVICES

The functions and responsibilities of services and service chairpersons (and service co-chairpersons) are set forth in Article 4 of the Medical Staff Bylaws.

2.C. CREATION AND DISSOLUTION OF SERVICES

- (1) Services will be created and may be consolidated or dissolved by the Medical Executive Committee as set forth below.

- (2) The following factors will be considered in determining whether a service 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 service. This number must be sufficiently large to enable the service to accomplish its functions as set forth in the Bylaws;
 - (b) the level of clinical activity that will be affected is substantial enough to warrant imposing the responsibility to accomplish service functions on a routine basis;
 - (c) a majority of the voting members of the proposed service vote in favor of the creation of such;
 - (d) it has been determined by Medical Staff leadership, in consultation with the President and Chief Executive Officer, that there is a clinical and administrative need for a new service; and
 - (e) the voting Medical Staff members of the proposed service have offered a reasonable proposal for how the new service 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 service is warranted:
- (a) there is no longer an adequate number of members of the Medical Staff to enable the service to accomplish the functions set forth in the Bylaws and related Medical Staff 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 service;
 - (c) the service fails to fulfill designated responsibilities and functions, including, where applicable, its meeting requirements;
 - (d) no qualified individual is willing to serve as service chairperson; or
 - (e) a majority of the voting members of the service vote for its dissolution.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

- (1) Articles 4 and 5 of the Medical Staff Bylaws describe 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) Except as otherwise provided, the procedures for the appointment of committee chairpersons and members of the committees in Article 5 of the Medical Staff Bylaws will be followed.

3.B. DUTIES, MEETINGS, REPORTS, AND RECOMMENDATIONS

- (1) 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.
- (2) Except as otherwise provided, Medical Staff committees will meet as often as necessary to accomplish their functions and will maintain minutes which include their findings, proceedings, and actions.
- (3) Medical Staff committees will make written reports to the Medical Executive Committee through committee minutes and other committees and individuals as may be indicated in this Manual. Minutes of committee meetings will be kept and maintained under the supervision of the Medical Staff Office.

ARTICLE 4

SYSTEM MEDICAL STAFF COMMITTEES

4.A. CONTINUING MEDICAL EDUCATION (CME) COMMITTEE

4.A.1 Composition:

The Continuing Medical Education (CME) Committee will consist of the following:

- (a) representatives from each Hospital Medical Staff; and
- (b) representatives from other departments as may be necessary.

4.A.2 Duties:

- (a) provide educational opportunities that are designed to improve provider competence, enhance practice performance, and improve patient outcomes; and
- (b) seek to serve the educational needs of the health care community within Ridgeview and within the local community.

4.A.3 Meetings, Reports, and Recommendations:

The Continuing Medical Education (CME) Committee will meet as often as necessary to accomplish its functions and will maintain a permanent record of its findings, proceedings, and actions. The Continuing Medical Education (CME) Committee will make a timely written report as necessary to each Medical Executive Committee and the President and Chief Executive Officer.

4.B. CREDENTIALS COMMITTEE

4.B.1. Composition:

- (a) The Credentials Committee will consist of the following members from Ridgeview Medical Center: The Chief of Staff, most recent Past Chief of Staff, and two (2) physician members at large to provide broad representation of specialties, and a representative from the Board.
- (b) The Chief of Staff from Ridgeview Le Sueur Medical Center and the Chief of Staff from Ridgeview Sibley Medical Center will serve as *ex officio* members, with vote on the Credentials Committee. It is expected that these members will

attend when an issue involves appointment, clinical privileges, professional behavior, or clinical performance of a member of their Medical Staff. For clean/streamlined appointments outlined in the Credentials Policy 3.B.5.e, nothing herein prohibits the Medical Executive Committees for the Ridgeview LeSueur Medical Center and the Ridgeview Sibley Medical Center from acting on behalf of the Credentials Committee and performing the procedures outlined in this section.

- (c) The President and Chief Executive Officer or his or her designee will be a member, *ex officio*, without vote.
- (d) The System Medical Staff Leadership Committee will appoint the chairperson of the Credentials Committee and may appoint additional members to this committee.
- (e) Members of the Credentials Committee will be appointed for an initial three (3)-year term and will be replaced on a rotating basis to promote continuity. Members may be reappointed for subsequent terms.
- (f) The chairperson of the Credentials Committee may appoint a representative(s) from the Advance Practice Clinician Staff to serve as a member(s) of the committee on an as-needed basis.

4.B.2. Duties:

The Credentials Committee will:

- (a) review the credentials of all applicants for appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, and make written reports of its findings and recommendations;
- (b) review, as may be requested by the Medical Executive Committee, all information available regarding the current clinical competence and behavior of individuals currently appointed to the Medical 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 clinical service and addressed in the peer review process;

- (e) recommend appropriate threshold eligibility criteria for clinical privileges, including clinical privileges for new procedures and clinical privileges that cross specialty lines; and
- (f) develop and oversee performance improvement plans for practitioners when appropriate.

4.B.3. Meetings, Reports, and Recommendations:

The Credentials Committee will meet as often as necessary to accomplish its functions and will maintain a permanent record of its findings, proceedings, and actions. The Credentials Committee will make a timely written report after each meeting to each Medical Executive Committee.

4.C ETHICS COMMITTEE

4.C.1 Composition:

The Ethics Committee will consist of the following:

- (a) representatives from each Hospital Medical Staff;
- (b) representatives from each Hospital, include nursing and Hospital Administration; and
- (c) representatives from other departments as may be necessary.

4.C.2 Duties:

- (a) advisory only;
- (b) serves as a resource for patients, families and staff when they have difficulty sorting out patient care and/or organizational ethical issues; and
- (c) a resource for ethical information and materials.

4.C.3 Meetings, Reports, and Recommendations:

The Ethics Committee will meet as often as necessary to accomplish its functions and will maintain a permanent record of its findings, proceedings, and actions. The Ethics Committee will make a timely written report as necessary to each Medical Executive Committee and the President and Chief Executive Officer.

4.D. MEDICAL STAFF INFORMATICS COMMITTEE

4.D.1. Composition:

- (a) The Medical Staff Informatics Committee will consist of the following:
 - (1) at least five members of the Medical Staff, representing the fields of medicine, surgery, emergency medicine, and Hospital-based practice (such as anesthesiology, pathology, or radiology); and
 - (2) the Vice President of Patient Care in Nursing Administration, the President and Chief Executive Officer, and the Chief Information Officer (CIO), who will all service as *ex officio* members, without vote.
- (b) Other members may be appointed to the committee as non-voting members as needed to fulfill the duties of the committee.
- (c) The chairperson of the Medical Staff Informatics Committee will be appointed by the System Medical Staff Leadership Committee.

4.D.2. Duties:

The Medical Staff Informatics Committee will perform the following functions:

- (a) create and implement policy for the utilization of Health Information Technology (“HIT”) for those aspects of HIT that require provider input;
- (b) standardize and certify provider workflow with respect to clinical HIT applications;
- (c) monitor and report on physician utilization of HIT;
- (d) identify outlying practice (utilization or workflow) from policy/procedure, recommend corrective tactics, support, or education, and report to the Medical Staff QI Committee, if necessary;
- (e) champion the optimal use and deployment and communicate and promote proficiency in HIT applications;
- (f) evaluate and inform organizational decisions with provider perspectives with respect to HIT;
- (g) receive, consider, evaluate, inform, and respond to Hospital requests for provider directions with respect to clinical HIT applications;

- (h) align provider utilization and workflow with organizational needs to eliminate gaps and minimize redundancy with nursing and other clinical services; and
- (i) respect patient safety and the patient experience as well as regulatory requirements and organizational financial impact in addressing policy and workflow.

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

The Medical Staff Informatics Committee will meet as often as necessary to accomplish its functions and will maintain a permanent record of its findings, proceedings, and actions. The Medical Staff Informatics Committee will make a timely written report after each meeting to each Medical Executive Committee.

4.E. MEDICAL STAFF QUALITY IMPROVEMENT (QI) COMMITTEE

4.E.1. Composition:

- (a) The Medical Staff QI Committee will consist of:
 - (1) the Vice President of Patient Care Services;
 - (2) the Director of Quality; and
 - (3) at least one representative from each Hospital Medical Staff representing different specialties practicing at the Hospitals.
- (b) The chairperson of the Medical Staff QI Committee will be appointed by the System Medical Staff Leadership Committee.
- (c) To the fullest extent possible, Medical Staff QI Committee members will serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.
- (d) Other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Staff QI Committee meeting (as guests, without vote) in order to assist the committee in its discussions and deliberations regarding an issue on its agenda. These individuals will be present only for the relevant agenda item and will be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the Medical Staff QI Committee.

4.E.2. Duties:

The Medical Staff QI Committee will perform the following functions:

- (a) oversee the implementation of the Hospital's peer review process;
- (b) review and approve, and periodically revise, quality data elements for ongoing professional practice evaluation and specialty-specific triggers for professional practice evaluation that are identified by each service;
- (c) review and maintain familiarity with patient care protocols and guidelines adopted by the Medical Executive Committee;
- (d) identify variances from rules, regulations, policies or protocols which may require the sending of an informational letter to the practitioner involved in the case;
- (e) review cases referred to it as outlined in the peer review process;
- (f) develop and oversee, when appropriate, performance improvement plans for practitioners at reappointment;
- (g) review the effectiveness of the peer review process at least yearly and recommend revisions or modifications as may be necessary;
- (h) oversee the Hospital's compliance with quality measures;
- (i) act as the peer review committee in accordance with the Peer Review Policy;
- (j) maintain peer review and performance improvement records consistent with any applicable federal and state protections and in a manner that will preserve the confidentiality of such information under federal and state laws;
- (k) review reports or concerns that a member may be impaired and facilitate further evaluation and treatment;
- (l) recommend educational materials that address practitioner health and emphasize prevention, diagnosis and treatment of physical, psychiatric and emotional illness;
- (m) handle impairment matters in a confidential fashion and keep the appropriate Chief of Staff, service chairperson, chairperson of the Credentials Committee, and President and Chief Executive Officer apprised of the matters under review; and

- (n) routinely monitor the rehabilitation process for those practitioners undergoing treatment.

4.E.3. Meetings, Reports, and Recommendations:

The Medical Staff QI Committee will meet as often as necessary to accomplish its functions, but at least quarterly, and will maintain a permanent record of its findings, proceedings, and actions. The Medical Staff QI Committee will make a timely written report after every meeting to each Medical Executive Committee.

4.F. PHARMACY AND THERAPEUTICS COMMITTEE

4.F.1. Composition:

The Pharmacy and Therapeutics Committee will consist of the following:

- (a) representatives from each Hospital Medical Staff;
- (b) representatives from each Hospital, include nursing and Hospital Administration; and
- (c) a representative from the pharmacy department, and representatives from other departments as may be necessary.

4.F.2. Duties:

The Pharmacy and Therapeutics Committee shall:

- (a) evaluate and recommend procedures and practices concerning drug utilization and administration within the Hospitals;
- (b) develop and review periodically a formulary or drug list for use in the Hospitals;
- (c) recommend standards regarding the use and control of investigational drugs and research in the use of recognized drugs;
- (d) evaluate clinical data concerning new drugs or preparations required for use in the Hospitals;
- (e) make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

- (f) establish procedures which will present unnecessary duplication in stocking drugs;
- (g) make recommendations concerning drugs for which automatic stop drug orders are necessary;
- (h) recommend policies for, and maintain surveillance of, infusion and transfusion practices; and
- (i) review all adverse drug and transfusion reactions.

4.F.3. Meetings, Reports, and Recommendations:

The Pharmacy and Therapeutics Committee will meet as often as necessary to accomplish its functions and will maintain a permanent record of its findings, proceedings, and actions. The Pharmacy and Therapeutics Committee will make a timely written report as necessary to each Medical Executive Committee and the President and Chief Executive Officer.

4.G. SYSTEM MEDICAL STAFF LEADERSHIP COMMITTEE

4.G.1. Composition:

- (a) The System Medical Staff Leadership Committee will consist of the following:
 - (1) the Chief of Staff of each Medical Staff;
 - (2) the chairperson of the Credentials Committee; and
 - (3) the chairperson of the Medical Staff QI Committee.
- (b) The President and Chief Executive Officer, or his or her designee, and Chief Medical Officer will be members, *ex officio*, without vote, on the System Medical Staff Leadership Committee.
- (d) A representative from the Medical Staff Office will serve as an *ex officio* member, without vote, to facilitate the Medical Staff Leadership Council's activities.
- (c)
- (d) The members of the System Medical Staff Leadership Committee will select one of the members of the committee to serve as chairperson.

- (e) Other members of the Medical Staffs, or Hospital personnel, may be invited to attend a particular meeting of the System Medical Staff Leadership Committee (as guests, without vote) in order to assist the committee in its discussions and deliberations regarding an issue on its agenda. These individuals will be present only for the relevant agenda item and will be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the System Medical Staff Leadership Committee.

4.G.2. Duties:

The System Medical Staff Leadership Committee will:

- (a) except as otherwise provided, appoint members and chairpersons to System Medical Staff committees;
- (b) review and make recommendations pertaining to amendments to the Medical Staff Bylaws;
- (c) review, propose, and adopt changes to the Credentials Policy, Organization Manual and other Medical Staff policies;
- (d) review and address issues regarding the clinical practice of members as part of the peer review process;
- (e) serve as the primary body responsible for addressing concerns about the professional conduct of members by engaging in collegial intervention and other progressive steps;
- (f) review and address concerns about the health status of practitioners as needed;
- (g) meet, as necessary, to consider and address any situation that may require immediate action involving a member of the Medical Staff;
- (h) serve as a forum to discuss and help coordinate quality and patient safety initiatives; and
- (d) perform any additional functions as may be requested by the Medical Executive Committees and the Board.

4.G.3. Meetings:

The System Medical Staff Leadership Committee will meet as often as necessary to carry out its duties and will maintain a permanent record of its findings, proceedings, and actions. If peer review related, System Medical Staff Leadership Committee will report to the Medical Staff QI Committee and each Medical Executive Committee. Copies of all minutes will be provided to the Medical Executive Committees and the President and Chief Executive Officer.

ARTICLE 5

HOSPITAL MEDICAL STAFF COMMITTEES

The following committees may exist at some or all of the Hospitals.

5.A. MEDICAL EXECUTIVE COMMITTEE

The composition, duties, and meeting and reporting requirements of the Medical Executive Committee are set forth in Section 5.B of the Medical Staff Bylaws.

5.B. NOMINATING COMMITTEE

The composition, duties, and meeting and reporting requirements of the Nominating Committee are set forth in Section 3.D of the Medical Staff Bylaws.

ARTICLE 6

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 and all other Bylaws, Medical Staff Rules and Regulations, and Hospital or Medical Staff policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: 12/08/2023_____

Approved by the Board: 12/18/2023_____