MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF THE SAINT CLOUD HOSPITAL

MEDICAL STAFF ORGANIZATION AND FUNCTIONS MANUAL

TABLE OF CONTENTS

PAGE

PAGE

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.

1.C. 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.A. DEPARTMENTS

The Medical Staff will be organized into the following departments:

Anesthesia

Cardiovascular Services

Emergency Medicine

Family Medicine

Medicine

Neurology

Neurosurgery

Obstetrics-Gynecology

Ophthalmology

Orthopedics

Otolaryngology

Pathology

Pediatrics

Psychiatry

Radiology

Surgery

Urology

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS

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

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Procedures for the appointment of committee chairpersons and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

3.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) 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.C. BYLAWS COMMITTEE

3.C.1. Composition:

The Bylaws Committee will consist of at least four members of the Medical Staff.

3.C.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 annually 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.C.3. Meetings and Reports:

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

3.D. CANCER CARE CENTER BOARD QUALITY COMMITTEE ("CANCER QUALITY COMMITTEE")

3.D.1. Composition:

The Cancer Committee shall consist of at least seven members of the Medical Staff. These members must meet the qualifications as outlined in the Cancer Care Center Board Policy and must include representation from Medical Oncology, Surgery, Radiation Oncology, Diagnostic Radiology, Pathology, Genetics, and Palliative Care. 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, cancer registry team, and case management team, 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 is Medical Director of the Cancer Section of CCH.

3.D.2. Duties:

The Cancer Committee shall:

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

(b) Assure compliance with twelve eligibility standards.

(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:

a. Oncology nursing care.

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

c. Availability of palliative care services for patients.

d. Patient navigation (case management process).

e. Status and plan for psychosocial distress screening.

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

(m) Monitor patient outcomes for:

a. Annual cancer prevention program to the community.

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

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

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

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

f. 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.D.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 (with or without recommendation) to the Credentials Committee, the Practice Evaluation Committee and/or the appropriate department for consideration and appropriate action, any situation involving questions of the clinical competency, patient care and treatment, case management, professional ethics, infraction of the Hospital or medical staff bylaws or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

3.F. PRIVILEGING COMMITTEE

3.F.1. Composition:

(a) The Privileging Committee will consist of the current Chief of Staff and the Chief-of-Staff-Elect, the two most recent past Chiefs of Staff who are current Active Staff members, and a member of the System Credentials Committee who is a representative from St. Cloud Hospital. The current Vice President of Medical Affairs will also serve on the committee, ex officio, with no vote. The chairperson will be the committee member who has served the longest on the committee, who did not serve as chair the previous term or two consecutive years.

(b) The Chief of Staff will appoint or reappoint up to five additional members of the committee for terms of up to three years. The appointment(s) are subject to approval by the Medical Executive Committee. Reasons for appointment include:

a. The inability or unwillingness of a Past Chief of Staff to serve.

b. To maintain at least five voting members of the committee.

c. Provide necessary perspective and/or general assistance deemed necessary to the committee.

(c) Committee members will be active members of the medical staff. Appointed members will need to have demonstrated strong leadership capability such as

prior service as Chief of Staff. Committee members to include Advanced Practice Registered Nurse regarding APRN/PA-C privileging and credentialing matters. If there are no matters of concern regarding APRN/PA-C, they will receive a cancelation notice.

3.F.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, 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 Practice Evaluation Committee, all information available regarding the current clinical competence of individuals currently appointed to the Medical Staff, Advanced Practice Provider Staff, or Medical Associate Staff and, as a result of such review, make a written report of its findings and recommendations;

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

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

(e) recommend appropriate threshold eligibility criteria for clinical privileges, including clinical privileges for new procedures and clinical privileges that cross specialty lines.

3.F.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. Fifty percent of the committee membership will constitute a quorum.

3.G. LEADERSHIP COUNCIL

3.G.1. Composition:

(a) The Leadership Council will consist of the following:

(1) the Vice President of Medical Affairs;

(2) the Chief of Staff;

(3) the Chief of Staff-Elect;

(4) the St. Cloud Hospital member of the Systems Credentials Committee

(5) the Chairperson of the Practice Evaluation Committee; and

(6) the Chairperson of the St. Cloud Hospital Privileges Committee.

(b) Other Medical Staff members or Hospital personnel may be invited to attend a particular Leadership Council meeting to assist the Leadership Council in its discussions and deliberations. Any such individual will attend as a guest, without vote, but will be considered an integral part of the professional practice evaluation process and will be bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.G.2. Duties:

The Leadership Council shall perform the following functions:

(a) review and address issues regarding practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy;

(b) serve as a forum to discuss and help coordinate quality and patient safety initiatives; and

(c) perform any additional functions as may be requested by the Practice Evaluation Committee, the Medical Executive Committee, and the Board.

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

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 Practice Evaluation Committee, the Medical Executive Committee, and others as described in the policies noted above.

3.H. MEDICAL CARE REVIEW COMMITTEE

3.H.1. Composition:

The Medical Care Review Committee will consist of between five and ten members of the Active Staff. A family medicine resident, appointed by the Director of the Family Medicine Residency Program, will serve as an ex officio, non-voting member. The Vice President of Medical Affairs will serve on the committee in an ex officio capacity, without vote. Appropriate Hospital personnel will serve as staff resource persons appointed by the President of the Hospital.

3.H.2. Duties:

The Medical Care Review Committee will perform the following duties:

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

(b) select, prioritize and monitor medical care processes and outcomes by use of rate-based indicators or other measurement approaches whenever possible to determine whether systems are appropriate and, if not, evaluate data and refer to the appropriate group or committee for follow-up;

(c) coordinate medical care review activities between Medical Staff departments and committees as appropriate;

(d) monitor and review information in the following key activities:

(i) medication safety review findings;

(ii) utilization of blood and blood components;

(iii) patient safety findings, to include root cause analysis;

(iv) Medical Staff care associated with core measures and other key processes;

(v) medical record review findings;

(vi) resuscitation review findings; and

(viii) other key patient outcomes or data;

(e) evaluate new methods and techniques to review medical care and assist in their implementation when appropriate;

(f) assure compliance with, and propose changes in, medical care review as required by the Joint Commission, third-party payors, and other regulatory bodies and assist Medical Staff departments and committees with implementation;

(g) refer concerns regarding the performance of individual physicians to the relevant department and/or the Credentials Committee;

(h) refer policy considerations to the Medical Executive Committee or appropriate department, committee, or Care Center Board;

(i) refer recommendations for performance improvement processes to the appropriate department, committee, or Care Center Board and monitor for compliance or response to recommendation and performance itself;

(j) be responsible for infection control oversight by:

(i) monitoring results of targeted surveillance of all Hospital infection potentials;

(ii) conducting the review and analysis of actual infection trends; and

(iii) recommending implementation of any appropriate infection control measures or studies when there is reason to believe a danger to any patient or personnel exists;

(k) 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;

(l) provide oversight of the pharmacy and therapeutics monitoring function, which may include:

(i) reviewing the appropriateness of empiric and therapeutic use of drugs through the analysis of individual or aggregate patterns of drug practice;

(ii) reviewing significant medication safety events and adverse drug reactions; and

(iii) reviewing medication use, safety, and clinical outcomes for the Hospital's patient care services;

(m) be responsible for review of blood therapy by:

(i) causing to be established broad policies for blood transfusion, component therapy, and tissue products;

(ii) developing ongoing objective assessment of blood transfusion, component therapy, and tissue products in addition to reevaluating previously-identified problem areas, and reviewing and analyzing the statistical reports of the Hospital transfusion service and tissue banking service;

(iii) developing criteria for evaluation of blood transfusion, component therapy, and tissue products;

(iv) reviewing blood use with particular attention to whole blood, components, and adverse reactions;

(v) providing input for education in transfusion practices as appropriate and in tissue banking;

(vi) assisting the Hospital, as appropriate, in blood procurement and tissue banking efforts, with special attention to the autologous blood transfusion service;

(vii) assessing periodically the adequacy and safety of blood and tissue supplies; and

(viii) assuring that the work of the Blood Bank is in compliance with the American Association of Blood Banks Standards for Blood Banks and Transfusion Services and the Standards of the Joint Commission;

(n) monitor utilization review activities and refer key findings to Care Center Board(s) as appropriate; and

3.H.3. Meetings and Reports:

The Medical Care Review Committee will meet at least ten times a year and will report to the Medical Executive Committee and the Quality/Safety Committee of the Board of Directors.

3.I. 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.

3.J. PHARMACY AND THERAPEUTICS COMMITTEE

3.J.1. Composition:

(a) The Pharmacy and Therapeutics Committee will consist of at least three members of the Medical Staff and one representative from the nursing service and Hospital administration.

(b) The Director of Pharmacy, the Medication Safety Pharmacist, and the Pharmacy Clinical Coordinator will be *ex officio* members of the committee, with one vote representing the Pharmacy. Other professionals may also be invited to attend committee meetings on an as-needed basis.

(c) The chairperson of the committee will serve as the "lead physician" for the Pharmacy and Therapeutics Committee, who, together with a lead pharmacy representative, will be responsible for the committee's agenda and flow of information through the structure of the Medical Staff.

3.J.2. Duties:

The Pharmacy and Therapeutics Committee will perform the following duties:

(a) develop and recommend to the pharmacy and the Medical Executive Committee policies and/or procedures relating to the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials;

(b) define the process for physicians to obtain a non-formulary drug and hold prescribers, pharmacy staff and nursing staff accountable for the process;

(c) maintain a formulary or drug list and actively promote the cost-effective use of medications throughout the Hospital. This may be accomplished in cooperation with the departments of the Medical Staff using tools ranging from consensus based on expert opinion, to consensus based on medical information, to consensus based on quality improvement studies and research; and

(d) review the existing formulary at least yearly and make appropriate suggestions for change.

3.J.3. Meetings and Reports:

The Pharmacy and Therapeutics Committee will meet at least quarterly or as often as necessary to fulfill its duties and will report to the Medical Executive Committee and the President of the Hospital after each meeting.

3.K. PRACTICE EVALUATION COMMITTEE

3.K.1. Composition:

(a) The Practice Evaluation Committee will consist of at least seven Medical Staff members who are broadly representative of the clinical specialties on the Medical Staff and who are also experienced in peer review, credentialing, or other Medical Staff affairs. An effort will also be made to appoint members so that there is diversity in membership and so that there is an appropriate mix of CentraCare and non-CentraCare providers. The Leadership Council will make recommendations for appointment to the Practice Evaluation Committee, subject to approval by the Medical Executive Committee.

(b) The Chairperson of the Credentials Committee and the Chairperson of the Medical Care Review Committee will serve as *ex officio* members. A representative from the Medical Staff Office and the Quality Department will also serve as *ex officio* members, without vote, to facilitate the activities of the committee.

(c) The President of the Medical Staff will appoint one of the members to serve as the chairperson of the committee. The chairperson will serve for an initial term of two years and may be reappointed.

(d) Practice Evaluation Committee members will serve staggered three-year terms, so that the committee always includes experienced members.

(e) The Practice Evaluation Committee will include members of the Advanced Practice Provider (APP) Staff. The Leadership Council will make recommendations for appointment to the PEC, subject to approval by the MEC. Any such practitioner will attend as a nonvoting member, unless the care being discussed involves an APP at which time they will participate as a voting member. 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.

(f) The Practice Evaluation 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.K.2. Duties:

The Practice Evaluation Committee shall perform the following functions:

(a) oversee the implementation of the Professional Practice Evaluation Policy;

(b) 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;

(c) review and maintain familiarity with patient care protocols and guidelines developed by national organizations;

(d) review and approve patient care protocols or guidelines adopted by departments;

(e) 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;

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

(g) develop, when appropriate, performance improvement plans for practitioners;

(h) review the effectiveness of the Professional Practice Evaluation Policy and recommend revisions or modifications as may be necessary; and

(i) 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.K.3. Meetings and Reports:

The Practice Evaluation Committee will meet at least monthly and will maintain a permanent record of its findings, proceedings, and actions. The Practice Evaluation Committee will submit reports of its actions and recommendations to the Medical Executive Committee and the Quality and Patient Safety Committee of the Board on a regular basis.

3.L. TRAUMA PEER REVIEW COMMITTEE

3.L.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, Oral and Maxillofacial Surgery, Neurosurgery, Emergency Medicine, and Radiology. Committee meetings are open to all Medical Staff members.

3.L.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 Director or Director of Trauma Services;

(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.L.3. Meetings:

The Trauma Peer Review Committee will meet on a monthly basis. All trauma surgeons and representatives from Anesthesia, Critical Care, Emergency Medicine, Neurosurgery, Orthopedic Surgery, and Radiology are required to attend 50% of the meetings annually.

3.M. TRAUMA OPERATIONS COMMITTEE

3.M.1. Composition:

The Trauma Operations Committee will consist of the following individuals with vote: Trauma Medical Director, Director of Trauma Services, Director of ETC, Surgery Section Director, Director of Perioperative Services, Director of Lab, Director of Imaging Services, and Director of Respiratory Therapy; ETC and Outreach Educators; Injury Prevention Specialist; representatives from ICU, inpatient units, and Pharmacy; local and regional EMS personnel; Trauma Registrars and Trauma Liaisons as available.

3.M.2. Duties:

The Trauma Operations Committee will develop and review trauma performance improvement measures to recommend additions or changes in policy, rules, regulations and procedures when indicated. The policies, guidelines, regulations and rules for the trauma service should cover at least the following:

(a) develop/revise/maintain trauma care guidelines;

(b) standardize equipment needs and training;

(c) evaluate trauma registry data to improve performance;

(d) maintain compliance with ACS guidelines to maintain Level II verification;

(e) recommend trauma system revisions/additions; and

(f) review activities in research, outreach, and public education.

3.M.3. Meetings and Reports:

The Trauma Operations Committee will meet quarterly and will report quarterly to the Vice President of Medical Affairs and the Chief Nursing Officer.

ARTICLE 4

AMENDMENTS

The process for amending this Medical Staff Organization and Functions Manual is set forth in Section 8.B of the Medical Staff Bylaws.

ARTICLE 5

ADOPTION

This Medical Staff Organization and Functions Manual is adopted and made effective upon approval of 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: June 11, 2024

Approved by the Board:

Date: September 11, 2024