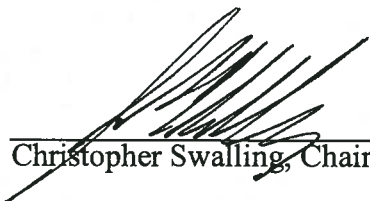




# MEDICAL STAFF ORGANIZATION MANUAL

APPROVED by the Providence Health & Services Alaska Region Community Ministry Board



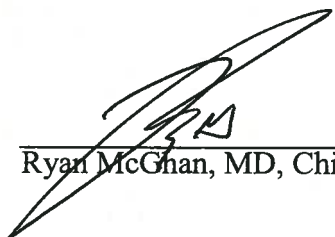
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Christopher Swalling, Chair

11/15/2016  
Final Approval at PHSA  
Regional Board Meeting  

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Date



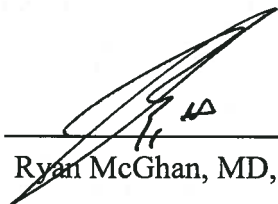
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Ryan McGhan, MD, Chief of Staff

11/14/2016  
Final Approval at Medical  
Executive Committee  
Meeting  

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Date



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Ryan McGhan, MD, Chief of Staff

10/17/2016  
Final Approval at General  
Staff Meeting  

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Date

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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 Medical Staff Bylaws.

### **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. MEETINGS**

#### **1.C.1 Regular Meetings:**

- (a) The Chief of Staff, the chair of each department, and the chair of each committee will schedule regular meetings for the year.
- (b) The Medical Staff will meet at least semi-annually.

#### **1.C.2 Special Meetings:**

- (a) A special meeting of the Medical Staff may be called by the Chief of Staff, a majority of the MEC, the CMO, the Chair of the Board, or by a petition signed by at least 25% of the voting members of the Medical Staff.
- (b) A special meeting of any department or committee may be called by the Chief of Staff, the relevant department or committee chair or by a petition signed by at least 25% of the voting members of the department or committee but in no event fewer than two members.
- (c) No business will be transacted at any special meeting except that stated in the meeting notice.

## **ARTICLE 2: CLINICAL DEPARTMENTS**

### **2.A. LIST OF DEPARTMENTS**

1. Anesthesia
2. Emergency Medicine
3. Family Medicine
4. Medicine
5. Obstetrics/Gynecology
6. Orthopedics
7. Pathology
8. Pediatrics
9. Psychiatry
10. Radiology
11. Surgery

### **2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND DEPARTMENT CHAIRS**

The functions and responsibilities of Departments and Department chairs are set forth in the Medical Staff Bylaws.

## **ARTICLE 3: MEDICAL STAFF COMMITTEES**

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

- (a) This Article outlines the Medical Staff Committees that carry out Medical Staff functions, including performance improvement and peer review functions.
- (b) Procedures for the appointment of Committee chairs and members of the Committees are set forth in the Medical Staff Bylaws.

### **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 written report to the Medical Executive Committee and to other Committees and individuals as may be indicated in this Manual. The Medical Executive Committee may consider reports as part of a consent agenda.

### **3.C. ANTIMICROBIAL STEWARDSHIP COMMITTEE**

#### **3.C.1 Composition**

The Antimicrobial Stewardship Committee shall consist of:

- (a) The Infectious Diseases/Antimicrobial Stewardship (ID/AMS) Pharmacist and ID Physician/Antimicrobial Stewardship Medical Director;
- (b) Representation from Infection Control, Microbiology, and Information Technology;
- (c) Up to nine (9) voluntary representatives of the Medical Staff from Providence Alaska Medical Center are designated as voting members of this committee;
- (d) Representation from nursing service; and
- (e) Other hospital personnel as needed.

#### **3.C.2 Duties**

The Antimicrobial Stewardship Committee at Providence Alaska Medical Center evaluates the clinical use of antimicrobial agents and develops policies for managing the use and administration of these medications. The actions of this committee are intended to optimize the use of antimicrobial agents with the overall goal of improving patient care, minimizing unintended consequences of antimicrobial use, and providing cost-effective therapy. Antimicrobial agent includes prescription medications, sample medications, or over-the-counter medications used on or administered to persons to diagnose, treat, or prevent viral, fungal, or bacterial infectious diseases. This committee shall work in conjunction with the Providence Health and Services System Antimicrobial Stewardship Subcommittee to serve in optimizing antimicrobial usage within Providence Alaska Medical Center in order to improve patient outcomes, reduce adverse consequences of antimicrobial use, and ensure cost-effective therapy. It shall perform the following specific functions:

- (a) Assist in the formulation of broad professional policies regarding the procurement, prescribing, monitoring, and all other matters relating to the utilization of antimicrobial agents in the hospital;
- (b) Develop clinical pathways/local guidelines to address disease states/clinical practice areas in which utilization of antimicrobial therapy is common;
- (c) Establish programs and procedures that optimize cost-effective drug therapy;
- (d) Participate in quality assurance activities related to distribution, administration, and use of antimicrobial agents (e.g., SCIP compliance and CMS audits);
- (e) Initiate, direct, and/or review drug use evaluation programs and studies pertaining to antimicrobial agents, in order to make appropriate recommendations and optimize use;

- (f) Evaluate all significant adverse drug reactions reported by the Pharmacy and Therapeutics Committee that pertain directly to antimicrobial agents and make recommendations to prevent their reoccurrence;
- (g) Collaborate with the Infection Control Committee on issues directly pertaining to antimicrobial agents themselves and/or their appropriate use; and
- (h) Disseminate information on its actions and approved recommendations to the healthcare staff as appropriate via infection control committee, who in turn reports to MEC.

### 3.C.3 Meetings

The Antimicrobial Stewardship Committee shall meet at least every other month. Meeting notices will be sent to members at least one week prior to the meeting.

## 3.D. BLOOD UTILIZATION REVIEW COMMITTEE

### 3.D.1 Composition

The Blood Utilization Review Committee shall consist of:

- (a) **Voting Members** One voting representative from the following specialties:
  - (i) Chief Medical Officer
  - (ii) Anesthesia Dept Chair or Designee
  - (iii) Cardiology Section Chair or Designee
  - (iv) Emergency Medicine Dept Chair or Designee
  - (v) Family Medicine Dept Chair or Designee
  - (vi) Family Medicine Residency Program Representative
  - (vii) Medicine Dept Chair or Designee
  - (viii) Medical Director of Health and Wellness
  - (ix) OB/GYN Dept Chair or Designee
  - (x) Orthopedics Dept Chair or Designee
  - (xi) Pathology Dept Chair or Designee
  - (xii) Pediatrics Dept Chair or Designee
  - (xiii) Psychiatry Dept Chair or Designee
  - (xiv) Radiology Dept Chair or Designee
  - (xv) Surgery Dept Chair or Designee
  - (xvi) Chief of Staff-Elect
  - (xvii) Sedation Medical Director
  - (xviii) Trauma Medical Director
- (b)
- (c) **Ex-officio Members (non-voting)**
  - (i) The Supervisor of the Blood Bank.
  - (ii) Adult Intensivist
  - (iii) Pediatrics Intensivist
  - (iv) Neonatologist
  - (v) Cardiovascular Surgeon
  - (vi) Pediatric Surgeon
  - (vii) Medical Director of the Children's Hospital at Providence (TCHAP)
  - (viii) Director of Performance Improvement
  - (ix) Director of Medical Staff Services & Risk Management
  - (x) Clinical Effectiveness Nurses
  - (xi) Chief Nurse Executive
  - (xii) Chief Executive Officer

- (xiii) Additional individuals may attend upon request by the chair of the committee as non-voters.

### 3.D.2 Duties

The Medical Staff at Providence Alaska Medical Center performs systemic monitoring, quality improvement activities, and other review functions on the delivery of blood and blood products at PAMC through the activities of the Blood Utilization Review Committee. The committee performs blood utilization review, to include the following:

- (a) The evaluation of the appropriateness of transfusions, including the use of whole blood and blood components;
- (b) The evaluation of all confirmed transfusion reactions;
- (c) The development or approval of policies and procedures relating to the distribution, handling, use and administration of blood and blood components;
- (d) The review of the adequacy of transfusion services to meet the needs of patients; and
- (e) The review of ordering practices for blood and blood products.

### 3.D.3 Meetings

The Blood Utilization Review Committee shall meet quarterly, or as frequently as necessary, to conduct business and shall maintain a permanent record of its proceedings and actions.

## 3.E. BYLAWS COMMITTEE

### 3.E.1 Composition

The Bylaws Committee shall consist of:

- (a) **Voting Members**
  - (i) The Chair will appoint three representatives from various medical staff departments to serve on the committee;
  - (ii) Vice Chief of Staff;
  - (iii) Members-At-Large; and
  - (iv) Physician and Allied Health Professional appointed members, broadly reflective of the specialty mix of the Medical and Allied Health Professional Staffs.
- (b) **Ex-officio Members (non-voting)**
  - (i) Chief Medical Officer or designee;
  - (ii) Manager, Medical Staff Services;
  - (iii) Medical Staff Coordinator from Medical Staff Services;
  - (iv) Chair, PAMC Policies and Procedures Committee; and
  - (v) Others may be requested to serve, as needed to provide administrative and clinical expertise.

### 3.E.2 Duties

This committee shall be responsible for creating, reviewing and making recommendations related to the Medical Staff Bylaws, Policies and Procedures. In addition, the committee shall review and make recommendations related to PAMC Policies and Procedures that impact practices of the medical staff. The committee shall invite appropriate staff members to explain or clarify clinical practices that affect physicians in patient care policies.

## 3.F. CANCER COMMITTEE

The Chair of the Cancer Committee will appoint the members of the Cancer Committee. The composition of the Committee will reflect the recommendations of the Commission on Cancer

Standards. **Commission on Cancer:** Created by the College of Surgeons in 1913, the CoC is a multidisciplinary consortium of professional organizations that provides standards for cancer care and accreditation to cancer programs. (Commission on Cancer, Cancer Program Standards 2012: Ensuring Patient Centered Care, v1.1. American College of Surgeons. Chicago, IL 2012.)

3.F.1 Composition:

The Cancer Committee shall consist of:

(a) **Required physician members**

- (i) Surgeon;
- (ii) Medical Oncologist;
- (iii) Radiation Oncologist;
- (iv) Pathologist;
- (v) Diagnostic Radiologist;
- (vi) Palliative Care Physician;
- (vii) Cancer Liaison Physician;
- (viii) Pediatric Oncologist;
- (ix) Gynecologic Oncologist/Surgeon; and
- (x) Pediatric Surgeon.

(b) **Required Non-physician members**

- (i) Cancer Program Administrator;
- (ii) Oncology Nurse;
- (iii) Social Worker or Case Manager;
- (iv) Certified Tumor Registrar (CTR);
- (v) Quality Improvement or Quality Management Professional;
- (vi) Genetics Counselor;
- (vii) Clinical Research Representative;
- (viii) Cancer Conference Coordinator;
- (ix) Community Outreach Coordinator;
- (x) Medical Ethicist; and
- (xi) Pharmacy Oncology Clinical Specialist.

(c) **Required Program Coordinators**

- (i) Cancer Conference Coordinator;
- (ii) Quality Improvement Coordinator;
- (iii) Cancer Registry Quality Coordinator;
- (iv) Community Outreach Coordinator;
- (v) Clinical Research Coordinator; and
- (vi) Psychosocial Services Coordinator.
- (vii) Additional individuals may attend upon approval by the chair of the committee.

3.F.2 Duties

The Cancer Committee is authorized by the Medical Staff to provide goal setting, quality improvements, implementation, evaluation and improvement for all cancer related activities:

- (a) Develop and evaluate the annual goals and objectives of the Cancer Program and for cancer-related care;
- (b) Annually assess and study the quality of cancer care and institute quality improvements;
- (c) Establish, monitor and annually review the cancer conference number, frequency, case selection, format and attendance requirements;

- (d) Continuously monitor and evaluate the quality of cancer registry data and activity, including:
  - (i) Abstracting currency;
  - (ii) Abstracting accuracy;
  - (iii) Abstracting follow-up of all analytic patients;
  - (iv) Support of registry data requests;
  - (v) Participation in Commission on Cancer special studies, if requested;
  - (vi) Submission of all requested data to the National Cancer Data Base; and
  - (vii) Annual participation of all cancer registry staff in one cancer-related educational activity;
- (e) Evaluate at least 10% of all cancer resection pathology reports for use of synoptic format and inclusion of required data elements, as outlined in the College of American Pathology tumor protocols;
- (f) If desired, develop and disseminate an annual report on patient or cancer program outcomes to the public, external to the facility and medical staff. The report may be in an electronic or printed format;
- (g) Annually offer at least 1 cancer-related educational activity, other than cancer conferences, to all members of the Medical Staff & Nursing and Allied Health Professionals;
- (h) Develop by 2015 and Oversee Continuum of Care Services, to include:
  - (i) Patient Navigation Process, driven by a community needs assessment, to address health care disparities and barriers to care for patients;
  - (ii) Psychosocial Distress Screening Process, to incorporate the screening of distress into the standard of care of oncology patients and provide identified patients with resources and/or referral for psychosocial needs; and
  - (iii) Survivorship Care Plan, to disseminate a comprehensive care summary and follow-up plan, which is clearly and effectively explained, to patients who are completing cancer treatment, as a part of the standard of care;
- (i) Monitor Effectiveness of Community Outreach Activities
  - (i) Annually identify areas of community needs for cancer prevention and early detection screening;
  - (ii) Provide at least 1 cancer prevention program targeted to the needs of the community and designed to reduce the incidence of a specific cancer type; and
  - (iii) Provide at least 1 cancer screening program that is targeted to decreasing the number of patients with late-stage disease, based on community needs;
- (j) Strive to achieve meeting PAMC Cancer Program CoC standards and passing tri-annual on-site inspection; and
- (k) Additional duties and responsibilities as defined in the Commission on Cancer standards or dependent on the scope of services provided.

### 3.F.3 Meetings

Regular meetings will be conducted at a minimum on a bimonthly basis. Additional meetings will be scheduled to meet the needs of the Cancer Program. A quorum is defined as the Chair or designee and three physician members and the Chair or Chair designee, who must be present to conduct business of the committee requiring a vote and/or a consensus. Required members attend at least 50% of the cancer committee meetings per year. If an appointed member is unable to attend, he or she will ensure a designee attends to represent their discipline.



### 3.G. CREDENTIALS COMMITTEE

#### 3.G.1 Composition

The Credentials Committee shall consist of representatives from the medical staff with Medical Executive Committee (MEC) experience whenever possible, broadly reflective of the major clinical specialties and the medical staff at large. Ideally, at least thirty percent (30%) of the appointment should consist of Past Chiefs of Staff.

(a) **Voting Members**

- (i) Chief of Staff-Elect (Vice Chief of Staff);
- (ii) Immediate Past Chief of Staff;
- (iii) Past Chiefs of Staff of the medical staff willing to serve,
- (iv) Other medical staff members assigned to the committee who are not designated as ex-officio members; and
- (v) Medical Director of Health and Wellness.
- (vi) The chair shall be nominated and elected by committee members and confirmed by the Chief of Staff. If a chair cannot be found, the Chief of Staff can appoint an interim chair in conjunction with the committee's approval.

(b) **Ex-officio Members (non-voting)**

- (i) Ex-officio members are non-voting members of the committee with the exception of the Chief Medical Officer who may have voting privileges subject to annual approval by Credentials Committee members;
- (ii) Administrator,
- (iii) Chief Nurse Executive;
- (iv) Chief of Staff;
- (v) and a member of the Board or their designee.

#### 3.G.2 Duties

The duties of the Credentials Committee shall be:

- (a) To interview applicants, review their credentials, and to make recommendations for appointment and/or delineation of clinical privileges in compliance with the Medical Staff Bylaws and Credentials Manual;
- (b) To make a report to the Medical Executive Committee on each applicant for medical staff appointment and/or clinical privileges, including specific consideration of the recommendations from the department chairs in which such applicant requests privileges;
- (c) To review periodically all information available regarding the competence of members and as a result of such reviews, to make recommendations for the granting of privileges, reappointments and the assignment of members to the various departments or services as provided in the Medical Staff Bylaws;
- (d) To review reports and credentialing policies and procedures that are referred by the Medical Executive Committee, or any other Committee or the Chief of Staff;
- (e) Make recommendations to the Medical Executive Committee on the delineation of privileges for new procedures;
- (f) Make recommendations to the Medical Executive Committee on the granting of new privileges that cross specialty lines;
- (g) Review and make recommendations to the Medical Executive Committee on the clarification of granted privileges when specific privileges are being questioned by the hospital or by another member of the medical staff,
- (h) To occasionally receive reports from the Medical Staff Leadership Council informing the committee of the recommendations to the Medical Executive Committee and Community

Ministry Board that could affect a medical staff member's practice, membership or privileges;

- (i) To receive routine reports from the medical staff services office and peer review department regarding Performance Improvement Plans, FPPE and OPPE progress
- (j) To receive routine reports from the Physician Quality Committee regarding decisions that could affect a medical staff member's practice, membership or privileges; and
- (k) Maintain confidentiality of information presented, discussions, and recommendations made by the committee. Voting and non-voting members of the committee shall sign a Confidentiality Agreement on an annual basis.

### 3.G.3 Meetings

The Credentials Committee shall meet monthly.

## 3.H. CRITICAL CARE COUNCIL

### 3.H.1 Composition

The Critical Care Service Medical Director and the Adult Critical Care ("ACC") Clinical Manager will act as co-chairs of the Critical Care Council.

#### (a) **Required physician members**

- (i) Medical Director of Adult Critical Care
- (ii) Medical Director of Respiratory Therapy
- (iii) General Surgery;
- (iv) Cardiothoracic Surgery;
- (v) Cardiology;
- (vi) Anesthesiology;
- (vii) Intensivists;
- (viii) Pulmonology;
- (ix) Infectious Disease;
- (x) Emergency Medicine;
- (xi) Palliative Care;
- (xii) Nephrology;
- (xiii) Chief Medical Officer

#### (b) **Required Non-physician members**

- (i) Nursing Executive Administration for the Critical Care Division
- (ii) ACC Nursing Staff
- (iii) Pharmacy;
- (iv) Respiratory Therapy;
- (v) Infection Control;
- (vi) Medical Ethicist;
- (vii) Palliative Care;
- (viii) Trauma Services;
- (ix) Emergency Department Nursing Staff;
- (x) Quality Improvement or Quality Management Professional;
- (xi) Additional individuals may attend upon approval by the chair of the committee.

### 3.H.2 Duties

The Critical Care Council oversees clinical and administrative activities in the ACC with the goal of promoting excellence and addressing the challenge of providing appropriate care in the most effective and efficient manner to the critically ill or injured patient. Its duties shall be:

- (a) Develop, review, and revise criteria for the purpose, format and content of multidisciplinary rounds;
- (b) Develop and/or assist in the development and monitoring of evidence-based Critical Care protocols, guidelines, policies and procedures;
- (c) Make recommendations to the Credentials Committee regarding changes in the privileging guidelines pertaining to new procedures and technologies affecting treatment and care of critical patients;
- (d) Establish and oversee a Critical Care quality improvement program using PDCA cycle method consistent with the overall hospital QI program;
  - (i) Determine goals and objectives for ACC and review annually;
  - (ii) Oversee data collection and analysis;
  - (iii) Recommend actions to improve outcomes based on best available evidence;
  - (iv) Report Critical Care QI activity and outcomes to Medical Executive Committee;
- (e) Facilitate communication between the Critical Care program staff, the Medical Staff, the medical center administration, and other relevant medical center departments;
- (f) Review cases with morbidity/mortality cases based on selected indicators and report to Physician Quality Committee and others as appropriate; and
- (g) Create mission statement in collaboration with ACC multi-disciplinary team.

### 3.H.3 Meetings

The Critical Care Council shall meet monthly.

## 3.I. ENDOSCOPY COMMITTEE

### 3.I.1 Composition

Voting members of the Endoscopy Committee shall consist of any Physician with Endoscopy privileges at PAMC. Members must be present or attending via conference call to vote. All committee members must be board certified or board eligible and have privileges to perform endoscopy procedures at Providence Alaska Medical Center. The chair shall be nominated and elected by committee members and confirmed by the Chief of Staff. If a chair cannot be found, the Chief of Staff can appoint an interim chair in conjunction with the committee's approval. The chair shall be allowed to vote on all matters before the committee.

- (a) **Voting Members:**
  - (i) Gastroenterologists;
  - (ii) General Surgeons;
  - (iii) Pulmonologists;
  - (iv) Pediatric Gastroenterologists, when available; and
  - (v) Pediatric Pulmonologists, when available.
- (b) **Ex-officio Members (non-voting)**  
Ancillary Staff are welcome to attend, but do not have voting privileges.

### 3.I.2 Duties

- (a) Perform quality monitoring and improvement activities;
- (b) Endoscopy Committee Chair review applications for privileges to perform any Endoscopy at Providence Alaska Medical Center;
- (c) Review and provide recommendations regarding the purchase and utilization of technology related to endoscopy;

- (d) The committee will make recommendations to the Credentials Committee regarding changes in the privileging guidelines pertaining to new procedures and technologies related to endoscopy; and
- (e) Other duties as assigned by the Chief of Staff and the Medical Executive Committee of Providence Alaska Medical Center.

### 3.I.3 Meetings

The Endoscopy Committee shall meet as needed, but not less than twice per year and shall maintain a permanent record of its proceedings and actions.

## 3.J. INFECTION CONTROL COMMITTEE

### 3.J.1 Composition

This committee shall consist of members of the medical staff from various specialties, representatives from administrative areas within the hospital as well as representatives from the community impacted by infectious disease issues. The Medical Director of Infectious Disease Control shall serve as the chair of the Infection Control Committee.

#### (a) **Voting Members**

- (i) Medical Director of Infection Control;
- (ii) Internal Medicine;
- (iii) Pulmonology/Intensivist;
- (iv) Pathology;
- (v) Surgery;
- (vi) Family Medicine;
- (vii) Pediatrics;
- (viii) OB/GYN;
- (ix) Supervisor, Microbiology Section of the Laboratory;
- (x) Manager, Employee Health;
- (xi) Manager, Infection Control;
- (xii) Director, Performance Improvement or designee; and
- (xiii) Infection Preventionists.

#### (b) **Ex-officio Members (non-voting)**

- (i) A representative from Nursing Administration;
- (ii) A representative from Hospital Administration;
- (iii) A representative from Home Health;
- (iv) A representative from the Municipality of Anchorage;
- (v) A representative from the State of Alaska Department of Health and Social Services; and
- (vi) Pharmacy representation, including the Pharmacy Clinical Manager, Director of Pharmacy and AMS Pharmacist.

### 3.J.2 Duties

This committee shall be responsible for:

- (a) The supervision of infection control in all phases of hospital activities;
- (b) The surveillance of hospital acquired, nosocomial infections;
- (c) The review and analysis of the causes associated with nosocomial infections;
- (d) The prevention and correction of activities associated with the development of nosocomial infections; and

- (e) The encouragement and implementation of activities designed to prevent nosocomial infections.

### 3.J.3 Meetings

The Infection Control Committee shall meet at least every other month.

## 3.K. NOMINATING COMMITTEE

### 3.K.1 Composition

The Nominating Committee is set forth in the Bylaws, Section 3.D.

### 3.K.2 Duties

- (a) The Nominating Committee shall submit one (1) or more names to a General Staff meeting for each of the following offices of the Medical Staff when positions are open:
  - (i) Chief of Staff-Elect;
  - (ii) Treasurer; and
  - (iii) Member-at-Large.
- (b) The Nominating Committee shall survey each Department of the medical staff, requesting submission of names of active Medical Staff members who demonstrate service and excellent leadership abilities.
- (c) The Nominating Committee shall review suggestions from the medical staff Departments, and may add additional names to the pool of possible candidates. Following review, the Nominating Committee shall contact the candidates to determine if they are willing to run for office. After ensuring the candidates are agreeable to the nomination, the Nominating Committee shall report to the Medical Executive Committee no later than the regularly scheduled Medical Executive Committee meeting, prior to a fall General Staff meeting.
- (d) After the Medical Executive Committee has been informed of the nominations, the names of the nominees will be forwarded to the active medical staff prior to the fall General Medical Staff meeting.

## 3.L. PHARMACY AND THERAPEUTICS COMMITTEE

### 3.L.1 Composition

The Pharmacy and Therapeutics (P&T) Committee shall consist of:

- (a) Voting Members:
  - (i) At least fifteen (15) representatives of the Medical Staff;
  - (ii) Director of Pharmacy
  - (iii) Pharmacy Clinical Manager;
  - (iv) Pharmacy Oversight Administrator
  - (v) Representation from nursing service and dietary
- (b) **Ex-officio Members (non-voting)**
  - (i) Other hospital personnel as needed (non-voting members and ad hoc experts on specific subject matter).

### 3.L.2 Meetings

The P&T Committee shall meet at least 5 times per year.. Meeting notices will be sent to members at least one week prior to the meeting. The committee may meet jointly with the comparable committee at Alaska Regional Medical Center, where such collaboration promotes patient safety initiatives provided that, no peer review information shall be shared

absent direction from Medical Staff and Administration leadership. PAMC shall independently comply with applicable accreditation and regulatory requirements.

### 3.L.3 Duties

The committee shall work in conjunction with the System Medication Therapeutics Committee, to make final decisions regarding formulary content with the goal of creating one standard Providence Health and Services (PH&S) formulary:

- (a) Medication: Medication includes prescription medications, sample medications, herbal remedies, vitamins, nutraceuticals, over-the-counter drugs, vaccines, diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives; intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. The definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases.
- (b) PAMC and its providers will be engaged in the centralized PH&S formulary determination process, which ensures patients of Providence and its affiliates are provided with safe, high-quality, and affordable medications throughout the continuum of care.
- (c) The PAMC Pharmacy and Therapeutics Committee accepts and adheres to the outcomes of the centralized PH&S formulary process.
- (d) The PAMC Pharmacy and Therapeutics Committee meetings will include and document decisions of the PH&S formulary committee, which is comprised of representatives from medicine, pharmacy, and nursing throughout the system and continuum of care.
- (e) The PAMC Pharmacy and Therapeutics Committee, or an individual provider in coordination with a P&T lead pharmacist, may petition a PH&S formulary decision through the centralized PH&S formulary appeal process with the understanding the burden of proof of value (safety, efficacy, cost) is on those who advocate the alternative.
- (f) The committee shall serve in an evaluative, educational and advisory capacity to the Medical Staff and hospital administration in all matters pertaining to the use of medications.
- (g) It shall perform the following specific functions:
  - (i) Assist in the formulation of broad professional policies regarding the evaluation, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital;
  - (ii) Approve which emergency medications and/or supplies will be readily available in patient care areas with input from respective committees;
  - (iii) Establish programs and procedures that help ensure cost-effective drug therapy;
  - (iv) Participate in performance improvement activities related to distribution, administration and use of medications;
  - (v) Initiate, direct or review drug use evaluation programs and studies and make appropriate recommendations to optimize drug use;
  - (vi) Monitor and evaluate all significant adverse drug reactions and make recommendations to prevent their reoccurrence;
  - (vii) Establish and review medication safety initiatives;
  - (viii) In collaboration with the PH&S formulary determination process, develop and provide for continuous revision, a formulary or list of drugs accepted for use in the organization using written criteria\*, for determining what medications are available for dispensing or administration. \*(Indication, clinical effectiveness, pharmacokinetics, comparative trials, population specific considerations, benefits over similar formulary agents, contraindications, warnings, precautions, adverse

- reactions, drug interactions, risk for medication errors, abuse potential, sentinel events and other safety issues, dosing, product availability, cost); and
- (ix) Disseminate information on its actions and approved recommendations to the healthcare staff.

### 3.M. PHYSICIAN QUALITY COMMITTEE

#### 3.M.1 Composition

The Chief Medical Officer (CMO) or member by a vote of voting members shall serve as the chair of the committee. Appointment will primarily consist of medical staff members indicated below:

(a) **Voting Members**

- (i) Chief Medical Officer
- (ii) Anesthesia Dept Chair or Designee
- (iii) Cardiology Section Chair or Designee
- (iv) Emergency Medicine Dept Chair or Designee
- (v) Family Medicine Dept Chair or Designee
- (vi) Family Medicine Residency Program Representative
- (vii) Medicine Dept Chair or Designee
- (viii) Medical Director of Health and Wellness
- (ix) OB/GYN Dept Chair or Designee
- (x) Orthopedics Dept Chair or Designee
- (xi) Pathology Dept Chair or Designee
- (xii) Pediatrics Dept Chair or Designee
- (xiii) Psychiatry Dept Chair or Designee
- (xiv) Radiology Dept Chair or Designee
- (xv) Surgery Dept Chair or Designee
- (xvi) Chief of Staff-Elect
- (xvii) Sedation Medical Director
- (xviii) Trauma Medical Director

(b) **Ex-officio Members (non-voting)**

- (i) Adult Intensivist
- (ii) Pediatrics Intensivist
- (iii) Neonatologist
- (iv) Cardiovascular Surgeon
- (v) Pediatric Surgeon
- (vi) Medical Director of the Children's Hospital at Providence (TCHAP)
- (vii) Director of Performance Improvement
- (viii) Director of Medical Staff Services & Risk Management
- (ix)
- (x) Clinical Effectiveness Nurses
- (xi) Chief Nurse Executive
- (xii) Chief Executive Officer
- (xiii) Additional individuals may attend upon request by the chair of the committee as non-voters.

#### 3.M.2 Duties

The Physician Quality Committee (PQC) is responsible for oversight of the Professional Practice Evaluation program carried out by medical staff departments and committees. This committee is focused on review of practitioner-specific performance issues and patterns, and

identifies pertinent system issues that impact clinical practices. The committee reports to the Medical Executive Committee (MEC) regarding Professional Practice Evaluation steps and implementation.

- (a) Oversees implementation of MS 920-045 Professional Practice Evaluation policy;
- (b) Makes recommendations for changes to the Professional Practice Evaluation policy when necessary;
- (c) Maintains knowledge of regulatory and legal requirements related to Professional Practice Evaluation and promotes compliance with requirements;
- (d) May obtain External Peer Review. All requests for external Peer Review (excluding Risk Management reviews) are forwarded to PQC for approval(?); and
- (e) Maintains strict confidentiality of information presented, discussions; and recommendations made by the committee. Voting and non-voting members of the committee shall sign a Confidentiality Agreement on an annual basis.

### 3.N. TRAUMA COMMITTEE AND CHAIR AUTHORITY

#### 3.N.1 Composition

The Trauma Committee is structured in two subcommittees: the “Trauma Systems and Process Committee” and the “Trauma Multidisciplinary Peer Review Committee.”

3.N.2 Trauma Systems and Process Committee (TSPC) oversees the operational components of the trauma program. The TSPC addresses, assesses, and corrects global trauma program and system issues.

#### (a) **Membership**

- (i) Trauma Medical Director;
- (ii) Pediatric Trauma Medical Director;
- (iii) Trauma Program Manager;
- (iv) The general surgeons who provide trauma care;
- (v) The pediatric surgeons who provide trauma care;
- (vi) A neurosurgeon;
- (vii) An orthopedic surgeon;
- (viii) An emergency medicine physician;
- (ix) Anesthesiologist;
- (x) Adult intensivist;
- (xi) A pediatric intensivist;
- (xii) A radiologist;
- (xiii) A physiatrist;
- (xiv) Trauma Registrar;
- (xv) Trauma services staff including injury prevention, outreach, PI and analyst;
- (xvi) A representative from hospital administration; and
- (xvii) Hospital staff to include a representative from: ED, OR, ACC, PICU, disaster management.

#### 3.N.3 Duties of the TSPC

- (a) Develop or maintain criteria for the establishment of a trauma service;
- (b) Develop and/or assist in the development and monitoring of trauma protocols, guidelines, policies and procedures;
- (c) Establish and oversee a trauma quality improvement program consistent with the overall hospital QI program;



- (d) Oversee the operations of the hospital trauma registry and, at least on an annual basis, report outcomes and trend data to the Medical Executive Committee; and
- (e) Facilitate communication between the trauma program staff, the medical staff, the medical center administration, and other relevant medical center departments.

3.N.4 Trauma Multidisciplinary Peer Review Committee (TMPRC) reviews trauma care of selected cases with objective identification of issues and appropriate responses.

(a) **Membership**

- (i) Trauma Medical Director;
- (ii) Pediatric Trauma Medical Director;
- (iii) The general surgeons who provide trauma care;
- (iv) The pediatric surgeons who provide trauma care;
- (v) A neurosurgeon liaison;
- (vi) An orthopedic surgeon liaison;
- (vii) An emergency medicine physician liaison; and
- (viii) Anesthesiologist liaison.

(b) **Ad Hoc**

- (i) General surgeons on the trauma call panel;
- (ii) Adult intensivist;
- (iii) A pediatric intensivist;
- (iv) A radiologist;
- (v) A physiatrist;
- (vi) Other physician members may be appointed as necessary to assist in activities of the committee; and

The trauma medical directors, general/pediatric surgeons who provide trauma care and liaisons from ED, orthopedics, neurosurgery and anesthesia must attend 50% of the meetings. Others are encouraged to attend regularly.

3.N.5 Duties of the TMPRC

- (a) Review the care of all mortalities, transfers and selected cases;
- (b) Provide appropriate leveling of cases;
- (c) Use ACS nomenclature in the leveling of mortalities;
- (d) Recommend corrective action when performance does not meet expectations; and
- (e) Demonstrate process loop closure, examples:
  - (i) Focused review for a specified period of time;
  - (ii) Additional Committee or Department review with determination;
  - (iii) Formal education e.g., Case presentation, verification of competency;
  - (iv) Practice review;
  - (v) Process review;
  - (vi) Equipment and/or Supplies: Availability and safety;
  - (vii) Resource review: adequate staffing and/or plan to meet the standard of care;
  - (viii) Policy or Protocol review: development or revision to meet the standard of care;
  - (ix) Other; and
  - (x) Privileging issues, changes, or mandated issues may be elevated to MEC.

3.N.6 Dissemination

- (a) The Trauma Medical Director will disseminate the information and findings from the peer review to the surgeons on the trauma call panel;
- (b) The trauma service will provide an internal educational process to meet the ACS requirements for trauma credentialing;

- (c) All cases reviewed by this peer review committee that were referred to other departments will return to this committee to allow for documentation compliance and completion of the peer review process; and
- (d) All cases reviewed will be reported to PQC and if any case is called into question, it will be referred back to this committee for a final input and decision.

### 3.O. UTILIZATION REVIEW AND CASE MANAGEMENT COMMITTEE

#### 3.O.1 Composition

The Utilization Review and Case Management Committee shall consist of:

- (a) The chair who shall be nominated and approved by committee members. In the event the committee does not elect a chair, the Chief of Staff shall appoint the chair;
- (b) Three or more doctors of medicine or osteopathy members of the medical staff;
- (c) One Administration Representative;
- (d) Representation from Nursing Service;
- (e) Representation from Quality Support Services;
- (f) Representation from Pharmacy Department; and
- (g) Representation from Case Management and Social Services.

#### 3.O.2 Duties

The committee performs utilization and case management review to include the following:

- (a) Review admissions, duration of stays, and professional services furnished;
- (b) Review cases of continuous extended duration while the patient is in the hospital and inpatient admissions that were not medically necessary; and
- (c) Review cases involving outliers and develop tools to achieve expected outcomes and to maximize use of hospital resources.
- (d) Reports to the MEC on a quarterly basis. The committee refers any systems issues identified as a result of the Professional Practice Evaluation program to the Quality Council, via the MEC.

#### 3.O.3 Meetings

Meetings are held quarterly or more frequently if necessary to carry out the committee's responsibilities. The chair may cancel meetings if there is no significant business. Two consecutive meetings may not be canceled. A quorum is defined as three physician members and the Chief Medical Officer or the CMO's designee who must be present to conduct business of the committee requiring a vote and/or a consensus.

## **ARTICLE 4: MEDICAL STAFF FUNCTIONS**

### 4.A. The Medical Executive Committee may:

- (a) create standing Committees to perform one or more staff functions and dissolve or rearrange Committee structure, duties, or composition as needed to better accomplish Medical Staff functions;
- (b) create new Departments, eliminate Departments, create sections within Departments, or otherwise reorganize the Department structure; and
- (c) appoint special task forces to carry out tasks and report to the Medical Executive Committee.