# MEDICAL STAFF COMMITTEE MANUAL

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Reviewed and approved by Medical Staff Executive Committee: 9/5/06, 4/7/09, 4/6/10, 4/3/12, 4/12, 11/5/13
Board of Directors: 9/20/06, 4/15/09, 4/21/10, 6/18/12 12/17/12, 12/18/13
PREAMBLE

All minutes, reports, recommendations, communications, and actions made or taken pursuant to the Medical Staff Bylaws and Credentialing Procedural Policies are deemed to be covered by the provisions of RCW 4.24.250 and 70.41.200 or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees, continuing medical education activities and/or individuals with special expertise assigned to the committees making reports, findings, recommendations or investigations pursuant to the Medical Staff Bylaws and Credentialing Procedural Policies shall be considered to be acting on behalf of the Medical Center and its Board when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, as amended. All committees whose duty it is to evaluate the competency and qualifications of health care professionals or to review and evaluate the quality of patient care shall report as needed through the coordinated quality improvement program so that ultimately the Medical Executive Committee and the Board of Directors shall receive reports of the committees’ activities as required by state law. See RCW 70.41.200(4).

Committee charters will be established for any performance improvement committees which are not defined in the medical staff bylaws or credentialing policies. All committees/meetings which discuss and evaluate practitioner performance as a quality control mechanism or for educational purposes will be responsible to follow Peer Review Committee (PRC) processes and procedures. Such discussions will be considered part of the medical staff quality function and will be protected from discovery. Committees will be accountable to refer any cases which meet the defined peer review indicator criteria to the PRC.

DISCLOSURE OF MINUTES

With the exception of the Physicians Committee, committee minutes may be disclosed to:
- Medical Staff Officer
- Chair or member of the committee
- Officer of the Board of Directors
- CEO or his designee
- Member of the Executive Team
- Any regular or special meeting of the Board of Directors
- Any regular or special meeting of the Executive Committee
- The physician and members of any committees under the Medical Staff or corporate bylaws responsible for determining or recommending whether the physician may have clinical privileges or Medical Staff membership, or the scope or condition of such privileges or membership, or the change or modifications of such privileges or membership.

The subject documents are the property of the Medical Staff and the Medical Center and may not be removed from the Medical Center premises for any purpose. Any request received for the above information from outside agencies, by subpoena or by any person or agency other than those noted above, shall be referred to the CEO or appropriate Medical Staff Officer.
LEGAL PROTECTION

Regularly Constituted Committees of the Medical Staff when engaged in peer review activities are entitled to such legal protection. They include the following:

Bylaws Committee
Cancer Committee,
CME Library Committee
Continuing Medical Education (CME) presentations which discuss and evaluate medical management
Credentials Committee
Endovascular Committee
Ethics Committee, Breast
Heart and Vascular Performance Improvement Team (pending)
ICU/CCU Committee
Infection Control Committee,
Medical Executive Committee
Peer Review Committee
Perinatal Committee
Pharmacy & Therapeutics Committee
Physician Well-Being Committee
Physicians Committee
Robotic Surgery
Stroke Committee
Transfusion Committee
Trauma Review Committee

Additional committees may be formed from time to time and conduct activities related to peer review. Such committees shall also be entitled to the legal protections specified above.

ADOPTION/REVISIONS

The Medical Staff shall adopt a Committee Manual for the purpose of defining committees as may be necessary to conduct medical staff activities. The Committee Manual shall be reviewed at a minimum of once every 3 years by the Executive Committee, may be amended or repealed by the Executive Committee, subject to approval by the Governing Body.

COMMITTEE ASSIGNMENTS

The Chair of each committee may recruit committee members according to the defined membership requirements. The Medical Staff President may assign Active Staff members to any medical staff committee when representation from a specific specialty is needed. Membership and committee terms will be defined by each committee.
DEPARTMENT COMMITTEES

Department Committee responsibilities are defined in the medical staff bylaws. All Departments report to the Medical Executive Committee. Departments are accountable to report any specific practitioner clinical quality variations of concern to the Peer Review Committee.

ADDITIONAL COMMITTEES

The President, with the approval of the Executive Committee, may appoint such other committees as may be required from time to time, and shall specify the responsibilities and functions of each committee.
a. Composition

The Breast Program Leadership Committee (BPL) shall consist of a Chair and Co-Chair. The Chair shall be an Active Medical Staff Member and the Co-Chair shall be Director of Breast Services. Additional members shall include members of the Active Medical Staff representing the departments of surgery, medical oncology, radiation oncology, diagnostic radiology, and pathology. Other Committee members to be included are an administration representative, oncology nursing and social services representation, a performance improvement representative, research, cancer registry, outreach representatives and nurse navigator in breast care.

b. Responsibilities

This Committee shall organize, publicize, conduct, and evaluate regular educational and consultative breast cancer conferences that are multi-disciplinary, Medical Center-wide, and patient oriented. It shall ensure that these multidisciplinary services are available to all patients. The Committee shall plan and conduct a minimum of two patient-care studies annually, that measure quality and/or outcomes. It shall also ensure that cancer rehabilitation services, as well as supportive care services, are available to all breast cancer patients.

The Breast Program Leadership is responsible for goal setting, planning, initiating, implementing, evaluating and improving all breast related activities in the center.

c. Meetings

This Committee shall meet at least quarterly and provide documentation of its policy advisory function and as needed provide updates to Medical Staff Department meetings and the Medical Staff Executive Committee. The Committee will refer to the Peer Review Committee when any practitioner specific quality of care related variations need to be addressed.

Reviewed 11/16/09
Bylaws Committee

a. Composition

This committee shall be a standing Medical Staff Committee and consist of members appointed by the Medical Staff President. The members shall be at least three (3) of the following Executive Committee members; 1) President-Elect; 2) Credentials Committee Chair; 3) Member at Large; or 4) Department Chair, to include a Chair, appointed by the President of the Medical Staff.

The committee shall be meet on an as needed basis or whenever called by the Medical Staff President.

b. Duties:

1. Perform annual review of the Medical Staff Bylaws, Credentialing Procedural Policies and Rules and Regulations

2. Review proposed revisions to the clinical department Rules and Regulations.

3. Prepare correspondence to the Medical Staff regarding proposed revisions for review and a vote. Report to the Medical Staff via the Executive Committee for vote at a general Medical Staff Meeting.

Reviewed 1/13/09
Cancer Committee

a. **Composition**

The Cancer Committee shall consist of a Chair and Co-Chair. The Chair shall be an Active Medical Staff Member and the Co-Chair shall be Director of Cancer Services. Additional members shall include members of the Active Medical Staff representing the departments of surgery, medical oncology, radiation oncology, diagnostic radiology, and pathology. Other Committee members to be included are the ACoS liaison physician, an administration representative oncology nursing and social services representation, a performance improvement representative, research nursing, pain control/palliative care physician or specialist, pharmacy and dietary, the American Cancer Society representative and the cancer registry.

d. **Duties**

This Committee shall organize, publicize, conduct, and evaluate regular educational and consultative cancer conferences that are multi-disciplinary, Medical Center-wide, and patient oriented. It shall ensure that these multidisciplinary services are available to all patients. The Committee shall plan and conduct a minimum of two patient-care evaluation studies annually, one of which shall include survival data and, if available, comparison data. It shall also ensure that cancer rehabilitation services, as well as supportive care services, are available to all cancer patients.

The Cancer Committee shall establish and supervise the cancer registry, which is required for approval by the American College of Surgeons. This includes active supervision for quality control of abstracting, staging, and reporting. The Registry and data shall be used to help determine the need for cancer prevention programs, the need for public and/or professional education, based on comparison data, the appropriateness of pretreatment workups and staging, a review of types of treatment, patient survival analysis by stage and treatment, patterns of recurrence and multiple primaries, encourage lifelong surveillance, and encourage studies using registry data.

As required by the American College of Surgeons, the Cancer Committee shall present educational programs covering all major cancer sites, and shall appoint Cancer Committee members to act as physician advisors to the registry.

**Meetings:** It shall meet at least quarterly and provide documentation of its policy advisory function and as needed, provide updates to Medical Staff Department meetings and the Medical Staff Executive Committee. The Committee will refer to the Peer Review Committee when any practitioner specific quality of care related variations need to be addressed.

Reviewed and revised: 1/12/09
CME Library Committee

a. Composition

This committee shall consist of a Chair and Co-Chair. The Chair shall be an Active Medical Staff Member and the Co-Chair shall be the Medical Center’s CME Coordinator. Additional members shall include a representative of each clinical department appointed by the President of the Medical Staff and a Medical Librarian. Additional members may be appointed from the Medical Staff, Quality Care Resources, Family Medicine of Southwest, Pharmacy and Nursing. Physician members shall be appointed by the President of the Medical Staff for a two-year term, with the potential for extension. Non-physician members shall be appointed by the Director of the department which they represent.

b. Role of the Committee: Support the CME Program Mission: to offer a variety of innovative and timely educational opportunities for members of the PHSW medical staff to enhance their ability to provide quality medical care and improve the health of the community.

Related to CME:
1. Promote education that will positively impact the quality of patient care and satisfaction.
2. Develop long-range institutional educational goals and plans, both clinical and professional.
3. Use the ACCME Essentials and Standards in determining program compliance.
4. Develop and enforce policies germane to CME, such as Commercial Support Guidelines, Honoraria policy, etc. which are consistent with accreditation guidelines.
5. Assist in the needs assessment process for department education and general programs.
6. Approve programs for Category I CME credit.
7. Review evaluations of individual programs and use in future program planning.
8. Conduct annual evaluation of CME program, including review and possible revision of Mission Statement, updating policies, etc.

Be a forum for the discussion of overall library activities related to the Medical and Allied Health Professional Staff including:

1. Promotion of Library usage among PHSW Medical and Allied Health Staff.
2. Review of long-range goals for the Medical Library and its services.
3. Review and approval of requests for library funding from the Medical Staff.
4. Discussion and review of the Library’s effectiveness in meeting informational needs of patrons.
5. The CME Committee will review Peer Review quality indicator trends and statistics and accept referrals from the Peer Review Committee for educational purposes. All quality data will be protected from disclosure.

The committee shall meet at least quarterly and shall report to the Executive Committee on as needed basis.

Reviewed and approved by CME Committee 9/07, 1/6/09, 8/21/12
CME Activities

All CME activities where medical management is discussed and practitioner specific performance is addressed will be considered part of the medical staff quality function and will be protected from discovery. The CME activity leader will be accountable to refer any cases which meet the defined peer review indicator criteria to the Peer Review Committee.
**Objective:** To define a medical staff structure with equal representation from the Radiology, Cardiac & Vascular, and Surgery Departments to ensure that patients who receive vascular diagnosis and treatments receive quality care and excellent service. This will be accomplished through interdisciplinary collaboration in the following functions:

- Support peer review process
- Provide Continuing medical education
- Address performance improvement initiatives
- Define call coverage and sub-specialty referrals
- Development and standardization of privilege criteria

**Structure:** The Interventional Radiologists will be reassigned from the Cardiac & Vascular Department to the Radiology Department. An Interventional & Vascular Committee will be created which includes representation from the Cardiac & Vascular Department, the Radiology Department and the Surgery Department. Representatives from the following specialties will be appointed by the Department Chair and will hold a two-year term:

- 2 Interventional Radiologists
- 2 Cardiologists
- 3 Endovascular Surgeons
- Ex-officio (non-voting) members to include: Director of the Heart & Vascular Center, Director of Medical Staff Services, Chief Medical Officer, and other practitioners per request.

The Chair position will be elected by the group to serve a two-year term.

**Accountability & Authority:** The committee will meet quarterly or as needed. Representatives will share committee discussions with their Department monthly and will request input from the Department on an ad hoc basis. The Committee will have the authority to recommend action and follow-up directly to the Credentials Committee. If the Committee is unable to come to an agreement, the issue will be presented to the Credentials Committee for resolution. The Committee will refer to the Peer Review Committee (PRC) when any practitioner specific quality of care variations need to be addressed. The Committee may also be asked by the PRC to review peer cases and provide recommendations.

**Approvals:**
Endovascular Committee 1/18/10
Executive Committee 5/3/05, 5/6/08, 2/2/10
Board of Directors 5/18/05, 5/21/08, 2/17/10
I. Purpose
The Graduate Medical Education Committee (GMEC) has responsibility for monitoring and advising on all aspects of residency education for PHSW. For the Accreditation Council on Graduate Medical Education (ACGME) Institutional Requirements, the committee should include the directors of general and specialty residency programs, faculty, residents and administrators including the accountable institutional official. For purposes of PeaceHealth Southwest Medical Center GMEC, membership shall consist of both permanent and rotational membership.

II. Membership
Permanent Members:
- Family Medicine of Southwest Washington Program Director
- Administrative members to include the Vice President of Medical Affairs, Director of Graduate Medical Education, FMSW Administrator and the Institutional Representative.

Rotating Members:
- Resident representatives (2) shall be selected by their peers, and serve two-year terms from June to June.
- Chief Resident.
- Chair and Past-Chair of the GMEC.
- Faculty, attendings and other members of the Medical Staff of PeaceHealth Southwest Medical Center as designated.

III. Appointments and Terms
- The Chair of the GMEC is appointed by the President of the Medical Staff, in consultation with members of the GMEC.
- Faculty, attendings and other members of the Medical Staff shall be invited by the GMEC Chair, at his/her discretion, to join the GMEC.

IV. Committee Term of Service
- Members shall serve on the GMEC for two (2) years, renewable terms from June through June.

V. Function and Goals
A. Compliance: Responsible for insuring compliance of the Graduate Medical Education program consistent with the requirements of the Accreditation Council for Graduate medical Education and other official credentialing bodies. Specific accreditation requirements are included on the GMEC’s annual agenda. The Committee will serve as the institutional support body as outlined by the JCAHO guidelines.

B. Responsible for resident disciplinary action as stated in the ACGME Institutional Requirements (1.3.c) and applicable Family Medicine of Southwest policies.

C. Serves as a reference source for graduate medical education affairs to departments of PHSW and other institutions involved in graduate medical education program of FWSW.

D. Serves as a clearinghouse for GME issues, and provides a forum of communication among all PHSW sponsored, affiliated and integrated residency programs. Ensures consistency in the quality of all GME programs, and the level of support provided.

V. Voting Privileges
All GMEC members, with the exception of the administrative members, shall have one vote on committee business. The Vice President of Medical Affairs, or his/her designated proxy if he/she is absent, shall have one vote.

The GMEC Chair votes in the case of a tie.

VI. Committee Structure
The business of the GMEC shall be conducted via the two-tier system as follows:

A. General Committee: The GME shall be comprised of the permanent and rotating members listed above, and shall meet quarterly. Additional meetings may be called as needed:

1. A committee member may send a proxy to a GMEC meeting if he/she is unable to attend, for less than one-half of the annual meetings.
2. All GMEC members must serve on at least one of the GMEC subcommittees if so assigned.

B. GMEC Subcommittees: Subcommittees shall be formed as deemed appropriate by the GMEC and meet on an ad hoc basis. The frequency and regularity of the meetings shall be determined by the business before the subcommittee. Subcommittee membership shall be a one-year, renewable term. Each subcommittee shall elect its own chair for a one-year renewable term. The subcommittee’s agendas shall be determined by the GMEC.

1. Internal Review Subcommittee – shall be responsible for conducting regular internal reviews of the residency program as outlined by the ACGME Institutional Requirements, section 3.c
2. GMEC Policy Subcommittee – routinely reviews all policies in the Resident Manual, and generates additional policies as needs arise, or as directed by the GMEC.
3. GME Curriculum Subcommittee – evaluates proposals for changes in the existing training program and makes recommendations to the full GME Committee. This subcommittee shall consist of the FMSW Associate Director, three physician members of the GMEC and the VP of Medical Affairs.
a. **Composition**

The Committee shall consist of a Chair and a Co-Chair. The Chair shall be the Medical Director of Critical Care. The Co-Chair shall be the Medical Center’s Director of Critical Care. Additional members shall include at least three (3) Active Medical Staff members and ancillary staff as appropriate.

b. **Duties**

The committee shall be responsible for the formulation, evaluation, and improvement of care and treatment in the special care areas of coronary and intensive care, including planning and development of physical facilities. Periodic review of the clinical care in the special units will be performed and documented. The committee shall report any findings of questionable care to the Peer Review Committee for review and appropriate action.

Reviewed by ICU Committee 11/24/08. No revisions 1/09
Infection Prevention and Control Committee

a. **Composition**
   
   This committee shall consist of a Chair and Co-Chair. The Chair shall be an Active Medical Staff member and the Co-Chair shall be a Medical Center-Infection Prevention Coordinator. Additional medical staff members shall include a minimum of one (1) Medical Staff representative from Pathology, Surgery, Medicine, NICU and Infectious Disease. Hospital representatives include representatives Intensive Care, NICU, Central Processing, Facilities Management, Employee Health, Environmental Services and Homecare / Hospice. Ad Hoc representatives from Pharmacy, Medical Rehabilitation, Public Health and Memorial Campus will be invited as needed.

   Pertinent findings will be communicated to Chairs of the appropriate Medical Staff clinical departments.

b. **Duties**
   
   The Infection Control Committee shall be responsible for the surveillance of inadvertent Medical Center infection potentials, the review and analysis of actual infections, the promotion of preventative and corrective programs designed to minimize infection hazards, and the supervision of infection control in all phases of the Medical Center's activities including:

   1. Operating rooms, delivery rooms, recovery rooms, and special care units.
   2. Sterilization and disinfection procedures by heat, chemicals, or otherwise.
   3. Isolation procedures.
   4. Prevention of cross-infection by medical equipment.
   5. Disposal of infectious material.
   6. Other situations as requested by the Executive Committee.

c. **Authority**
   
   The Infection Control Committee, through its Chair or a physician member, shall have the authority to institute any appropriate control measures or studies when there is reason to feel there is a danger to any patient or personnel. Administration shall be notified of actions taken.

d. **Meetings**
   
   This committee shall meet bi-monthly, shall maintain a record of its proceedings and activities, and provide updates to Medical Staff Department meetings, the Medical Staff Executive Committee as needed. The Committee will refer to the Peer Review Committee when any practitioner specific quality of care related variations need to be addressed.

Reviewed: 2005, 1/14/09
Revised: 8/2006, 9/19/07, 11/12
MEC: 12/14/12
BOD: 12/17/12
Committee Objective
The Laboratory Committee shall provide a platform to discuss test utilization in the PHSW community. The committee would provide a platform to identify best practice in the use of laboratory tests and make recommendations to the medical staff and provide education.

Scope
The Laboratory Committee shall provide a platform to give feedback to the lab about ways to improve service and help support the hospital and best practices. There would be a chance to introduce new technologies to the medical staff and provide education on new technologies.

Accountability and Authority
The Committee will have the authority to recommend action and follow-up directly to the respective departments as applicable and ultimately to the Medical Executive Committee.

Membership
- Chair – Laboratory Medical Director, Laboratory Services
- Co-Chair – Community provider
- Others as identified by Committee or Medical Staff Department Committees who are willing to participate in the overall objectives of the Committee.

Member Roles
- Serve as a communication link between respective constituents and laboratory services.
- Represent the view of their individual departments while maintaining institutional perspective and patient focus.
- Proactiveness and creativity in identifying processes and systems toward enhancement of the patient care experience.
- Willingness to participate in problem identification, resolution and elimination of preventable errors.
- Regular attendance at meetings and follow-up regarding assignments.
- Willing to model prudent use of laboratory tests and advocate for the principles and policies developed by the committee.

Functions
A. Conduct quality improvement and regulatory compliance activities as follows:
   1. Review of unusual events relevant to laboratory services that require analysis by providers to determine cause, effect, and severity with the goal of identifying opportunities for system improvement.
   2. Develop policies, procedures, and protocols to ensure quality laboratory services. Recommendations that will potentially impact changes to the medical practice of the Medical Staff will be referred to the respective Department Committee for review and/or action. If differences result, the Department Committee will submit a resolution and/or action plan to the Laboratory Committee for review and/or action.
   3. The Laboratory Committee will refer to the Peer Review Committee when any practitioner specific quality of care related variations need to be addressed.
B. Assist the laboratory and the community in developing optimum testing algorithms and testing policy recommendations.
C. Review test utilization data and make recommendations to the medical staff and the Medical Executive Committee. This function may be further developed if Accountable Care Organizations are created in Southwest Washington.

**Meeting Frequency**
The group will meet at least quarterly. Additional meetings will be called at the discretion of the Chair.

Newly Formed:
MEC: 12/4/12
BOD: 12/17/12
Goal
To establish a centralized, multi-specialty approach for the Medical Staff to evaluate practitioner performance on an individual and aggregate level and help create a positive culture for peer review.

Scope
- The PRC will be responsible for measuring and evaluating all areas of practitioner competency for care provided at PeaceHealth Southwest Medical Center and its facilities under the responsibilities of the Medical Staff unless otherwise indicated in this charter.
- Although the PRC will be a source of competency data, credentialing and privileging decisions are the responsibility of the department chairs and the Credentials Committee.
- Performance measurement and evaluation for hospital systems and processes are the responsibility of the appropriate hospital committee or department.

Responsibilities
The primary responsibilities of the PRC are:
1. Measurement System Management
2. Evaluation of Practitioner Performance
3. Improvement Opportunity Accountability
4. Oversight of Other Medical Staff Practitioner Performance Evaluation Committees

These responsibilities and specific medical staff quality functions outside the PRC scope are described in detail below:

1. Measurement System Management
   - At least annually review all the indicators, attribution, targets, screening tools and referral systems for effectiveness in collaboration with the medical staff department chairs and recommend changes to the MEC. The PRC will have the authority to develop and implement specialty-specific indicators if not provided by the departments in a reasonable timeframe.
   - Data from sub-specialty databases supported by the hospital shall be shared with the PRC based on MEC approved indicators.
   - As needed, approve requests for additions or deletions to medical staff indicators, criteria or targets.
   - Design and approve focused studies when necessary to further analyze practitioner performance.
   - In coordination with the Credentials Committee, define the appropriate content and format for practitioner performance feedback reports and reappointment profiles as approved by the MEC.

2. Evaluation of Practitioner Performance

A. Evaluation of Individual Cases
   - Perform initial practitioner review of all cases identified as described in the Case Review Process and Timeframes policy. Members of the PRC will be paid per case reviewed in accordance with Section 8 of the Medical Staff Bylaws.
   - Make determinations regarding individual practitioner opportunities for improvement based on: individual or multiple case reviews.
   - Perform focused practice evaluation when necessary to further define if an improvement opportunity exists.
   - Identify potential Hospital systems or nursing practice opportunities for improvement.
B. Evaluation of Rate and Rule Indicators

- Perform regular review of medical staff Rule or Rate indicator data for individual practitioner outliers for all practitioner competencies within the PRC scope. This function may be delegated by the PRC to an individual PRC member or to a subcommittee.
- Identify potential individual practitioner opportunities for improvement or determine if focused practice evaluation is needed to define if an improvement opportunity exists.
- Identify potential medical staff wide opportunities for improvement.
- Identify potential nursing practice or hospital system opportunities for improvement.

3. Improvement Opportunity Accountability

The role of the PRC is to assure when potential improvement opportunities are identified via case review or evaluation of rule or rate data, the appropriate individuals are notified of the potential issues and either further evaluation is performed or a reasonable improvement plan is developed. This will be accomplished through by the process described in the OPPE/FPPE policy (Peer Review Policy Attachment H):

4. Oversight of Other Medical Staff Practitioner Performance Evaluation Committees

Some medical staff departments or committees may continue to evaluate practitioner performance as a quality control mechanism or for educational purposes. Such discussions will be considered part of the medical staff quality function and are protected from discovery as long as the appropriate policies and procedures of the PRC are followed.

The PRC will oversee the process used to perform this evaluation and the indicators selected by the specialty for the following areas:

- **Image Based Specialties** (Pathology, Radiology, Cardiac Images): Routine quality reviews of diagnostic image interpretation by practitioners (e.g. surgical pathology or cytology slides, radiological images) will be performed internally. Department wide and practitioner specific data based on MEC approved indicators, will be reported to the PRC as rule or rate data at least every six months. Cases potentially meeting review indicator criteria will be referred to Quality Care Resources (QCR) to be reviewed by the PRC using the case review process.

- **Other Hospital-based Departments or Units**: (Emergency Department, Anesthesia Department, Critical Care, Perinatal M&M): Review of specific processes and outcomes as appropriate for departmental performance improvement and education may be performed internally. Department wide and practitioner specific data, based on MEC approved indicators, will be reported to the PRC as rule or rate data at least every six months. Cases potentially meeting review indicator criteria will be referred to QCR to be reviewed by the PRC using the case review process.

- **Trauma Committee**: Perform functions as required by ACS standards. Cases resulting in significant adverse outcomes potentially related to practitioner care as defined by Review indicators will be referred to the PRC.

5. Specific Medical Staff Quality Related Functions outside of the PRC scope

Although the PRC will be responsible for defining the medical staff performance measures for all practitioner competencies as described above, the evaluation of practitioner performance and the determination of medical staff policies for key quality functions or competencies may be performed by other mechanisms. The table below describes the responsibilities for these functions:
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<td>Case Management Department Utilization Management Committee</td>
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<td>Infection control practices not related to practitioner compliance Infection Control polices requiring med staff approval</td>
<td>Infection Prevention and Control Committee</td>
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<td>Operative and Invasive Procedures (System-based Practice)</td>
<td>Define performance measures and targets Monitor for practitioner specific outliers</td>
<td>Operational policies and procedures and management issues affecting the med staff</td>
<td>OR Governance committee</td>
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<td>Patient Safety (System-based Practice)</td>
<td>Define practitioner measures and targets Monitor for practitioner specific outliers</td>
<td>Patient Safety policies and procedures requiring med staff approval.</td>
<td>MEC</td>
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<td>Focused Professional Practice Evaluation (FPPE) of New Practitioners/New Privileges</td>
<td>Provide data from ongoing practitioner performance measures</td>
<td>Routine criteria based auditing of charts specifically for FPPE Evaluation of data from FPPE</td>
<td>QM with Dept chair or designee Dept Chair and Credentials Committee</td>
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</tbody>
</table>

**PRC Composition**

The PRC will be comprised of twelve (12) voting members who are active members of the medical staff from each of the following specialties: Internal Medicine Hospitalist, Critical Care Intensivist, 2 additional medical Subspecialties, Family Medicine, General Surgery, 1 Surgical Specialty, OB/GYN, Emergency Medicine, Anesthesiology, and Radiology, and the current Medical Staff President Elect regardless of specialty. Practitioners from other specialties may be invited to the meeting as needed. Current department chairs and voting MEC members are not eligible to be PRC members.
**Ex-Officio Members**
The Medical Staff President, Chief Medical Officer, Medical Director for Quality, the Chief Nursing Officer, a representative Allied Health Professional, a representative Board member, the director of QPS and QPS support staff as determined by the Chair are non-voting ex-officio members of the PRC.

**Appointment and Terms**
The voting PRC members will be appointed by the Chief of Staff based on the recommendations from the department chairs and the PRC Chair and approved by the MEC. Voting members will be appointed for a three year term except for initial committee members who will have staggered terms to initiate the process (i.e. 1/3 for 4 years, 1/3 for 2 years and 1/3 for 3 years). Voting members may serve up to two consecutive terms and are eligible for reappointment to the committee after one year after their last term is completed. However, voting members may serve more than two consecutive terms if no one else is available to serve from that specialty with the approval of the MEC for each additional term.

The Medical Staff President Elect shall serve as the Chair of the PRC throughout his/her two-year term. To assist with the workload of the Chair and to enhance continuity of experience the Medical Staff President will appoint a co-chair with the approval of the MEC. To be eligible for appointment as Co-Chair, the individual must be a current voting PRC member and have served as a voting PRC member at some point in time for at least one year. The Co-Chair will serve for a term of one year and may have an unlimited number of consecutive terms as long as the co-chair is eligible to be PRC member. The PRC co-chair will be an ex-officio member of the MEC without vote.

**Member Responsibilities**
PRC members will be expected to attend at least two thirds of the scheduled PRC meetings over a twelve-month period and perform assigned case reviews according to PRC policies to maintain membership. If a member fails to fulfill their responsibilities, they will be replaced by the process used for initial appointment to the PRC. PRC members will be expected to participate in appropriate educational programs provided by the Hospital or Medical Staff to increase their knowledge and skills in performing PRC responsibilities.

**Meetings**
The PRC will meet at least 10 times per year. A quorum for purposes of making final determinations or recommendations for individual case reviews or improvement opportunities based on aggregate data will require the presence of 50% of the voting PRC members at a regularly scheduled meeting. A majority will consist of a majority of voting PRC members present.

**PRC Oversight**
The PRC reports to the MEC. No changes can be made to the PRC charter and policies without MEC approval. The PRC Chair will provide a report to the MEC for each PRC meeting.

Revised: 11/07/12, 05/16/13, 9/20/13
MEC: 12/4/12, 11/5/13
BOD: 12/17/12, 12/18/13
Committee Objective
The objective of the Perinatal Quality Committee of the Medical Staff is to optimize maternal and neonatal quality and patient safety based on best practices, evidence-based research and by preventing and reducing potential patient harm. Emphasis will be placed on continuous performance improvement, systematically evaluating and assuring that quality care is delivered to the patient. Focus is patient-centered and designed towards the development of a highly reliable perinatal unit.

Scope
The Perinatal Quality Committee is an interdepartmental committee with representation from Obstetrics, Neonatology, Pediatrics, Family Medicine medical staff, nursing, and allied health professionals who participate in the care of the maternal and neonatal patients. This committee is responsible for monitoring and evaluating care and other quality improvement activities that relate to perinatal services. The Perinatal Committee will refer to the Peer Review Committee when any practitioner specific quality of care related variations need to be addressed.

Accountability and Authority
The Perinatal Quality Committee is responsible for maintaining an environment that supports and facilitates the perinatal performance improvement process. The Committee will have the authority to recommend action and follow-up directly to their respective departments, and ultimately to the Executive Committee.

Membership
Co-Chair – Medical Director, Obstetrical Services
Co-Chair – Medical Director, Neonatal Services
OB-GYN, Chair or Designee
Family Medicine, Chair or Designee
Pediatrics, Chair or Designee
Program Director, Maternal-Fetal Medicine or designee
Director, Perinatal Services
Clinical Manager, Family Birth Center
Clinical Educator, Family Birth Center
Clinical Manager. NICU
Chief Nurse Anesthetist, OB Anesthetist
Representative, FMSW Faculty
Representative, FM Resident
Representative, Neonatal Nurse Practitioner
Representative, Midwife
Representative, Each Ob/Gyn Group
Coordinator, Quality and Patient Safety
Others as identified by Committee or Medical Staff Department Committees who are willing to participate in the overall objectives of the Committee.

Member Roles
- Serve as a communication link between respective constituents and perinatal services.
- Represent the view of their individual departments while maintaining institutional perspective and patient focus.
- Proactivity and creativity in identifying processes and systems toward enhancement of the patient care experience.
• Willingness to participate in problem identification, resolution and elimination of preventable errors.
• Regular attendance at meetings and follow-up regarding assignments. If a department chair is unable to attend a meeting, the respective chair-elect or designee will be requested to attend.

**Benefits**

- A high quality patient experience
- Excellent clinical quality in perinatal services
- An informed and supportive hospital and administrative staff
- Overall improvement of patient care
- Optimization of resources committed to perinatal services
- Optimization of revenue and minimization of costs
- Collaboration among health team members providing perinatal care

**Functions**

A. Conduct quality improvement and regulatory compliance activities as follows:

1. Review of unusual events relevant to neonatal and obstetrical services that require analysis by providers to determine cause, effect, and severity with the goal of identifying opportunities for system improvement.

2. Cases or issues identified as a potential quality of care or competency concern of an individual practitioner requiring peer review will be forwarded to the respective department committee for review and assignment as appropriate.

3. Review of aggregate indicator data of relevance to obstetrical and perinatal services, primarily for system improvement. Data may also be used to identify opportunities for education to change or improve clinical practice.
   1) Regulatory and standards compliance
   2) The Joint Committee/Centers for Medicare and Medicaid Services
   3) OB Department indicators - including PRC indicators and Crimson data
   4) Neonatal indicators
   5) Department of Health/WA Perinatal Quality Improvement initiatives

4. Develop policies, procedures, and protocols to ensure quality perinatal care. Recommendations that will potentially impact changes to the medical practice of the Medical Staff will be referred to the respective Department Committee for review and/or action. If differences result, the Department Committee will submit a resolution and/or action plan to the Perinatal Quality Committee for review and/or action.

Revised: Perinatal Quality Committee - 07/10/07, 10/08/07, 8/10/09, 9/24/09, 11/7/12
Executive Committee: 09/04/07, 12/4/07, 11/3/09, 12/4/12
Board of Directors: 09/19/07, 12/19/07, 11/18/09, 12/17/12

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Originally: Maternal Child PI Committee 11.2003,
Approved/Revised: Maternal/Child PI Committee 11/11/03, 3/14/06, 4/10/07
Executive Committee 12/2/03
Pharmacy and Therapeutics Committee

Recommendations will be made by majority vote of the P&T Committee and shall be forwarded to the Medical Executive Committee for final approval. The P&T Chair shall report the P&T recommendations to the Medical Executive Committee. The physician chair members for other Medical Staff Committees (Cardiac & Vascular, etc.) shall be responsible for reporting these decisions of the Medical Executive Committee back to their respective committees.

Goals: The Committee’s goals are to:

- Make appropriate choices regarding medication therapy relating to patient safety, efficacy, and overall economic impact. At a minimum, the criteria for evaluating medications shall include the indication for use, effectiveness, risks (including propensity for medication errors, abuse potential and sentinel events), and costs.
- Build multidisciplinary consensus around critical therapeutic decisions.
- Proactively review medications/therapies coming into the market.
- Evaluate medication safety warnings (black box warnings, ISMP or JCAHO Sentinel Event alerts) and determine what type of safety features should be put in place.
- Continuously seek out improvements in communication and education to medical and Medical Center staff.
- Develop a formulary management system.
- Perform medication usage evaluations as a criteria-based, ongoing, planned and systematic process for monitoring and evaluating the usage of drugs to help assure that they are provided appropriately, safely, and effectively (Performance Improvement Initiatives).
- Work toward integrating continuity of care and community standards with Medical Center decisions.
- Suggest Medical Staff performance and improvement and educational opportunities related to pharmaceuticals to the Continuing Medical Education (CME) Program.

a. Composition

Membership shall consist of a Chair and Co-Chair and at least three (3) representatives from the Active Medical Staff. The Chair shall be an Active Medical Staff member and the Co-Chair shall be the Director of Pharmacy, or designee. Additional Medical Center representatives shall include one (1) each from nursing service and Medical Center management. Selection of members shall be done by the Co-Chairs with the goal of keeping a balance of practitioners from multiple specialties with no conflict of interest. Length of term on the committee will be at least two years.

b. Duties

This committee shall be responsible for the development and surveillance of all medication utilization policies and practices within the Medical Center in order to assure optimum clinical results and a minimum potential for hazard. The committee reviews medication and therapy practice and utilization within the Medical Center at least quarterly. The Medical Staff performs the pharmacy and therapeutics function in cooperation with the pharmaceutical department/service, the nursing department/service, management and administrative services, and other departments/services and individuals as required. It shall also perform the following specific functions:

1. Interface with PHSW’s quality improvement process to enhance patient safety and efficacious medication utilization.
2. The review of the appropriateness of empirical, prophylactic and therapeutic use of drugs through the analysis of individual or aggregate patterns of medication practices;

3. The development of and approval of policies and procedures relating to the selection, distribution, handling, use and administration of medications and diagnostic testing materials;

4. The definition and review of all significant untoward medication reactions; and

5. The maintenance of a formulary or medication list. Evaluation of formulary status for pharmaceuticals may be requested by any PHSW Medical Staff member or initiated from the P&T Committee. The request shall be in writing. The committee will decide the appropriate level of review. A full review will include input from committee members and the requesting physician, if any. The committee may seek additional input from other Medical Staff members with relevant expertise or request input from the relevant department Chairperson or his/her designee. At its discretion, the Committee may seek additional input from non-PHSW staff. All participants in the review process must follow PHSW conflict of interest disclosure policy.

6. Distribute a quarterly P&T report to physicians describing the P&T decisions

7. Promote performance improvement in prescribing patterns by the Medical Staff through education and academic detailing.

c. Medication Usage Evaluation

1. Medication usage evaluation is performed by the Medical Staff as a criteria-based, ongoing, planned and systematic process for monitoring and evaluating the prophylactic, therapeutic, and empirical use of drugs to help assure that they are provided appropriately, safely, and effectively.

   a. This process includes the routine collection and assessment of information in order to identify opportunities to improve the use of drugs and to resolve problems in their use.

2. There is ongoing monitoring and evaluation of selected medications that are chosen for one or more of the following reasons:

   a. Based on clinical experience, it is known or suspected that the drug causes adverse reactions or interacts with another medication (or medications) in a manner that presents a significant health risk;

   b. The medication is used in the treatment of patients who may be at high risk for adverse reactions because of age, disability, or unique metabolic characteristics;

   c. The medication has been designated, through the Medical Center's infection control program or other quality assurance activities, for monitoring and evaluation; and/or

   d. The medication is one of the most frequently prescribed medications.

3. The process for monitoring and evaluating the use of medications:
a. Is performed by the Medical Staff in cooperation with, as required, the pharmaceutical department/service, the nursing department/service, management and administrative staff, and other departments/services and individuals;

b. Is based on the use of objective criteria that reflect current knowledge, clinical experience, and relevant literature; and

c. May include the use of screening mechanisms to identify, for more intensive evaluation, problems in or opportunities to improve the use of a specific medication or category of medications.

4. Written reports of the findings, conclusions, recommendations, actions taken and results of actions taken are maintained and reported at least quarterly through channels established by the Medical Staff.

5. Evaluate clinical data concerning new medications or preparations requested for use in the Medical Center.

d. **Meetings**

This committee should meet at least quarterly and send quarterly reports to the Executive Committee regarding its activities. Any specific practitioner related quality of care issues identified will be referred to the Peer Review Committee.

Revised: Pharmacy & Therapeutics Committee 03/16/06, 6/18/08,1/15/09 (review only)
a. Composition

The committee will be composed of eight (8) physicians from the Active or Courtesy Medical Staff. The President of the Medical Staff will make appointments to the committee as vacancies occur as a result of the expiration of terms, resignations, etc., and the president may also remove physicians from the committee. The president of the Medical Staff will appoint a Chair of the committee annually. The committee may, but need not, consist of one (1) anesthesiologist, one (1) internist, one (1) family practitioner, one (1) gynecologist, one (1) surgeon, one (1) recovering physician, and one (1) psychiatrist, preferably a psychiatrist who has experience in the treatment of alcoholism.

b. Duties

The purpose of this committee is to assist those members of the Medical Staff whose capacity to practice has become impaired by reason of personality disorder, mental disorder, behavioral dysfunction or alcohol or other substance abuse. The committee recognizes that these conditions are treatable and seeks to assist in the restoration of the impaired member to full performance.

The committee will review the behavior, interactions, adverse incidents, and clinical course of patients pertinent to referral of any members of the Medical Staff. The member’s department Chair will usually make referrals to the committee. However, any committee of the Medical Staff or the Medical Center Quality Improvement Council may also identify an appropriate referral.

The committee will base a decision to recommend intervention on the results of that review. It is the intent for this committee to recommend interventions, which can correct the difficulty before disciplinary action is necessary. The committee will identify the condition, supportively confront the physician, and help obtain indicated treatment, and monitor the recovering physician during rehabilitation. The committee will function in a non-punitive and confidential manner. If egregious behavior continues and there may be potential risk of patient harm all activities will be reported promptly to the president of the Medical Staff and Vice President of Medical Affairs. All findings and records shall be considered confidential and not a part of disciplinary records.

Bylaws Committee Review: 1/09
### Physician Well-Being Committee

**Composition**

The committee will include at least five (5) physicians from the Active and/or Courtesy Medical Staff, who will be appointed by the President of the Medical Staff. The president of the Medical Staff will make appointments to the Committee as vacancies occur as a result of the expiration of terms, resignations, etc., and the president may also remove physicians from the committee. The president of the Medical Staff will appoint a chair of the Committee. The Committee may, but need not, consist of one (1) anesthesiologist, one (1) internist, one (1) family practitioner, one (1) surgeon, one (1) chaplain, and one (1) psychiatrist or psychologist, preferably one who has experience or a special interest in a psychological sense of community vital to personal well-being.

PeaceHealth Southwest Medical Center is committed to creating a work environment that promotes appreciation for personalized physician well-being and respect for colleagues’ dignity, time and privacy. The Physician Well-Being Committee has adopted the following guiding beliefs as a foundation for development and preservation of this program at PHSW:

**Physician Health is Important**
- Healthy physicians are a community asset to be fostered and maintained.
- Healthy physicians are fundamental to quality patient care.
- A psychological sense of community with one’s peers is vital to personal well-being.
- Healthy physicians are more productive and enhance the workplace environment.

**The Medical Professional Should Foster Physician Well-Being**
- Changes in the healthcare environment are contributing to personal and professional challenges and stresses for physicians.
- The medical profession has inherent stresses that require specific attention to ensure physician well-being.
- Physicians should train and work in environments that promote healthy lives for them, their families, their support personnel and their patients.
- Well-being depends on responsible behavior and decision-making by all parties in the healthcare environment.
- Physicians should have resources available to them to anticipate and manage episodic personal issues.
- Continuous learning is fundamental to a healthy lifestyle.
- Educational programs should foster physician well-being.
- Medical education programs have a responsibility to develop the knowledge, attitudes and skills necessary for personal wellness.

**Meetings:** It shall meet quarterly and provide updates as needed to Medical Staff Department meetings and the Medical Staff Executive Committee. The Committee will refer to the Peer Review Committee when any practitioner specific quality of care related variations need to be addressed.

Reviewed: 1/09, 2/12
Robotic Surgery Committee

Objective: To define a medical staff structure with representation from all providers with Robotic Assisted Surgery privileges to ensure that patients who receive Robotic Assisted Surgery procedures receive quality patient care and excellent service. The Committee will be responsible for the following Robotic Surgery functions:

- Continuing medical education
- Development and standardization of privilege criteria
- Provide recommendations to the Board of Directors regarding program expansion and future robotic services

Structure: A Robotic Surgery Committee will be created which includes representation from all providers with Robotic Assisted Surgery privileges.

The Co-Chair positions will be elected by the group to serve a two-year term and are to be from different specialties who have Robotic-Assisted Surgery privileges.

Ex-officio (non-voting members to include: Chief Medical Officer, a representative from Medical Staff Services and Quality and Patient Safety as needed.

Accountability & Authority: The committee will meet quarterly or as needed. Representatives will share committee discussions with their Department monthly and will request input from the Department on an ad hoc basis. The Committee will refer to the Peer Review Committee when any practitioner specific quality of care related variations need to be addressed. The Committee may also be asked by the PRC to review peer cases and provide recommendations.

Approvals:
Robotic Committee: 6/10/08 (Add Anesthesia Member & clarify role of Dept); 10/2/12 (Revised structure and PRC accountability)
Medical Executive Committee: 5/6/08, 12/4/12
Board of Directors: 5/21/08, 12/17/12
Section 3 - Transfusion Committee

a. Composition

This committee shall consist of a Chair and Co-Chair. The Chair shall be an Active Medical Staff member and the Co-Chair shall be the Medical Center’s Technical Specialist for the Blood Bank. The committee shall have at least three members of the Active Medical Staff who represent principal blood user groups (e.g., Surgery, Anesthesia, Internal Medicine), and shall include one clinical pathologist. Other committee members to be included are representatives from Nursing, Quality Care Resources Department, IV Therapy, Blood Bank and Administration.

b. Duties

The Transfusion Committee shall monitor all activities of the Medical Center transfusion service, shall be responsible for the coordination of the Medical Center laboratory and pathology services and review of the use of blood and its products within the institution, and shall maintain the standards of transfusion therapy. It shall review all transfusions according to the criteria established. It shall maintain active cooperation and liaison with other community organizations of a similar nature.

c. Meetings

The committee shall meet at least quarterly and report regularly to the Peer Review Committee of the Medical Staff. The Committee will refer to the Peer Review Committee when any practitioner specific quality of care related variations need to be addressed.

Revised: Transfusion Committee 5/10/12
MEC: 12/4/12
BOD: 12/17/12
**Composition:** The committee at PHSW shall consist of interested physicians who participate in the treatment of trauma patients. Medical Center personnel may participate as invited by the Chair. The President of the Medical Staff shall appoint the Chair and this committee will be under the direct auspices of the Trauma Medical Director.

**Purpose:** The purpose of the committee is 1) to review all trauma cases and report any findings of questionable care to the appropriate clinical department Chair and/or Medical Center director, 2) plan and organize a regular educational trauma conference based upon the selective review of trauma cases, as determined by the Chair and 3) review and approve all trauma related PHSW trauma program protocols.

**Goal:** The goal of the Trauma Review Committee’s quality assessment and improvement is to continuously improve patient trauma care outcomes. The committee will evaluate selected sentinel cases and trends for potential adverse patient care and make recommendations for protocol development or change existing protocols.

**Cases:** The Trauma Committee will select specific cases for review by Oregon Trauma Audit Group (TAG) who will provide objective reviews of PHSW trauma care based on regional standards and quality. It is the role of the TAG to:

- Assess the care delivered to the trauma patients in the greater Portland/Southwest Washington area;
- Focus the reviews on issues identified by TAG;
- Advise the Trauma Committee if the case generated any research questions or subsequent study; and,
- Submit subsequent case review findings to the Trauma Committee.

The PHSW Trauma Committee will designate a representative to regularly attend the TAG sub-committee to present sentinel cases, and to report back to the Trauma Committee the findings of the TAG.

Periodically, the PHSW Trauma Committee will offer the opportunity for trauma specialists to present cases for discussion, clarification, and education.

To ensure statutory protection, no copies of the Trauma Committee documents may be removed from the room at the conclusion of TAG meetings. All packets of the documents are to be returned to the Trauma Committee. The “Statement of Compliance with Confidentiality Requirements for the Area Trauma Advisory Board

Quality Improvement Subcommittee” signed by TAG members will be signed by all PHSW representatives regularly attending the TAG meetings.

**Meetings:** It shall meet at least quarterly and will refer to the Peer Review Committee when any practitioner specific quality of care related variations need to be addressed.