



PAMC MEDICAL STAFF ORGANIZATION MANUAL

PAMC Bylaws Committee Approval: 07/25/2023

PAMC Medical Executive Committee Approval: 08/14/2023

PAMC Medical Staff Approval: 10/16/2023

PARB Board Approval: 11/22/2023

All approvals are documented in the official meeting minutes.

PAMC MEDICAL STAFF ORGANIZATION MANUAL
TABLE OF CONTENTS

ARTICLE 1: GENERAL.....	3
1.A. DEFINITIONS.....	3
1.B. TIME LIMITS	3
1.C. MEETINGS	3
ARTICLE 2: CLINICAL DEPARTMENTS.....	3
2.A. LIST OF DEPARTMENTS	3
2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND DEPARTMENT CHAIRS.....	3
ARTICLE 3: MEDICAL STAFF COMMITTEES	4
3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS.....	4
3.B. MEETINGS, REPORTS, AND RECOMMENDATIONS.....	4
3.C. ANTIMICROBIAL STEWARDSHIP COMMITTEE	4
3.D. BLOOD UTILIZATION REVIEW COMMITTEE	5
3.E. BYLAWS COMMITTEE	6
3.F. CANCER COMMITTEE	6
3.G. CREDENTIALS COMMITTEE	8
3.H. CRITICAL CARE COUNCIL	10
3.I. ENDOSCOPY COMMITTEE	11
3.J. GRADUATE MEDICAL EDUCATION COMMITTEE.....	11
3.K. INFECTION CONTROL COMMITTEE	13
3.L. NOMINATING COMMITTEE	15
3.M. PHARMACY AND THERAPEUTICS COMMITTEE.....	15
3.N. PHYSICIAN QUALITY COMMITTEE.....	17
3.O. TRAUMA COMMITTEE AND CHAIR AUTHORITY	18
3.P. UTILIZATION REVIEW COMMITTEE	21
3.Q. PAMC PICU COMMITTEE.....	22
ARTICLE 4: MEDICAL STAFF FUNCTIONS	23
4.A. THE MEDICAL EXECUTIVE COMMITTEE	23

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:

- (c) 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.
- (d) 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.
- (e) 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 Sub-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 (Vice-Chief of Staff)
 - (xvii) Sedation Medical Director
 - (xviii) Adult Trauma Medical Director
 - (xix) Pediatric Trauma Medical Director
 - (xx) General Surgery Sub-Section Chair or Designee
- (b) Ex-officio Members (non-voting)
 - (i) The Supervisor of the Blood Bank.
 - (ii) Adult Intensivist
 - (iii) Pediatrics Intensivist
 - (iv) Neonatologist
 - (v) Cardiovascular Surgeon
 - (vi) Director of Quality Regulatory Services or Designee
 - (vii) Clinical Effectiveness Nurses
 - (viii) Chief Nurse Executive
 - (ix) Chief Administrative Officer
 - (x) 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) Chief of Staff-Elect (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) Chair, PAMC Policies and Procedures Committee; and
 - (iv) 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 and the needs of the cancer program of Providence Alaska Medical Center.

Commission on Cancer: Created by the College of Surgeons in 1913, the CoC is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, which promotes cancer prevention, research, education, and monitoring of comprehensive quality care. (Commission on Cancer, Cancer Program Standards: Ensuring Patient Centered Care. American College of Surgeons. Chicago, IL 201.)

3.F.1 Composition:

The Cancer Committee shall be a multidisciplinary group consisting of physician and non-physician members, reflecting the needs of the program. *Those required by the COC Standards are indicated by **

- (a) Physician members
 - (i) Cancer Liaison Physician*;
 - (ii) Diagnostic Radiologist*;
 - (iii) Medical Oncologist*;
 - (iv) Palliative Care Physician*;
 - (v) Pathologist*;
 - (vi) Radiation Oncologist*;
 - (vii) Surgeon*;
 - (viii) Pediatric Oncologist;
 - (ix) Gynecologic Oncologist/Surgeon;
 - (x) Pediatric Surgeon;
 - (xi) Oncology Surgeon; and
 - (xii) Primary Care Physician
- (b) Non-physician members
 - (i) Cancer Program Administrator*;
 - (ii) American Cancer Society Representative;
 - (iii) Certified Tumor Registrar (CTR)*;
 - (iv) Genetics Counselor*;
 - (v) Oncology Nurse*;
 - (vi) Social Worker/ Case Manager/ Patient Navigation Representative*;
 - (vii) Medical Ethicist;
 - (viii) Medical Staff Office Representative;
 - (ix) Oncology Rehabilitation Therapist;
 - (x) Pastor;
 - (xi) Patient Survivorship Representative;
 - (xii) Pharmacist;
 - (xiii) Radiation Oncology Manager; and
 - (xiv) Registered Dietician.
- (c) Program Coordinators
 - (i) Cancer Conference Coordinator*;
 - (ii) Cancer Registry Quality Coordinator*;
 - (iii) Clinical Research Coordinator*;
 - (iv) Community Outreach Coordinator*;
 - (v) Psychosocial Services Coordinator*; and
 - (vi) Quality Improvement Coordinator*.
- (d) 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) 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 with curative intent, as a part of the standard of care;
- (g) Provide Community Outreach Activities
 - (i) Perform a Community Needs Assessment every 3 years;
 - (ii) Annually identify areas of community needs for cancer prevention and early detection screening;
 - (iii) 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;
 - (iv) Provide at least 1 cancer screening program that is targeted to decreasing the number of patients with late-stage disease, based on community needs; and
 - (v) Monitor and assess the effectiveness of these activities.
- (h) Annually offer at least one cancer-related educational activity, other than conferences, to all members of the Medical Staff & Nursing and Allied Health Professionals;
- (i) If possible, 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;
- (j) Strive to achieve meeting PAMC Cancer Program CoC standards and passing tri-annual on-site survey; 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

- (a) Regular meetings will be conducted at a minimum on a quarterly basis.
- (b) Additional meetings will be scheduled to meet the needs of the Cancer Program.
- (c) A quorum is defined as the Chair or their designated alternate and three physician members, who must be present to conduct business of the committee requiring a vote and/or a consensus.
- (d) Each required committee member-or their designated alternate, are required to attend at least 75% of the cancer committee meetings held each calendar year.

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, 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,
 - (v) Medical Director of Health and Wellness; and
 - (vi) Allied Health Professional representative.
 - (vii) 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) Chief Administrative Officer,
 - (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 Adult Intensive Care Medical Director will be the chairs and the Adult Intensive Care Surgical Vice-Director will serve as the co-chair of the Critical Care Council.

- (a) Invited physician members
 - (i) General Surgery;
 - (ii) Cardiothoracic Surgery;
 - (iii) Cardiology;
 - (iv) Anesthesiology;
 - (v) Intensivists;
 - (vi) Pulmonology;
 - (vii) Infectious Disease;
 - (viii) Emergency Medicine;
 - (ix) Palliative Care;
 - (x) Nephrology;
 - (xi) Chief Medical Officer
- (b) Required Department Representatives
 - (i) Nursing Leadership for the Adult Intensive Care Unit;
 - (ii) Adult Intensive Care Unit Nursing Staff
 - (iii) Pharmacy;
 - (iv) Respiratory Therapy;
 - (v) Infection Control;
 - (vi) Palliative Care;
 - (vii) Trauma Services;
 - (viii) Emergency Department Nursing Staff;
 - (ix) Quality Improvement or Quality Management Professional;
- (c) Additional individuals may attend upon approval by the committee.

3.H.2 Duties

The Critical Care Council oversees clinical and administrative activities in the Adult Intensive Care Unit 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) Review, and revise criteria for the purpose, format and content of multidisciplinary rounds;
- (b) Assist in the development and monitoring of evidence-based Critical Care protocols, guidelines, policies and procedures;
- (c) Establish and oversee a Critical Care quality improvement program consistent with the overall hospital QI program;

- (i) Determine goals and objectives for the Adult Intensive Care Unit 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;
- (d) Facilitate communication between the Critical Care program staff, the Medical Staff, the medical center administration, and other relevant medical center departments; and
- (e) Create mission statement in collaboration with Adult Intensive Care multi-disciplinary team.

3.H.3 Meetings

The Critical Care Council shall meet monthly or as agreed upon by members.

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)
 - (i) Ancillary Staff are welcome to attend, but do not have voting privileges.

3.I.2 Duties

- (a) Perform quality monitoring and improvement activities;
- (b) Review and provide recommendations regarding the purchase and utilization of technology related to endoscopy;
- (c) 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
- (d) 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. GRADUATE MEDICAL EDUCATION COMMITTEE

3.J.1 Composition

The Graduate Medical Education Committee shall consist of:

- (a) Voting Members:
 - (i) Designated Institutional Official
 - (ii) A member from the PH&SA Region Board
 - (iii) Chief of Staff of Providence Alaska Medical Center, or designee (vice chief of staff)
 - (iv) Chief Medical Officer or other patient safety and quality designee
 - (v) A minimum of two peer selected Residents and/or fellow representatives from among its ACGME accredited GME program at PAMC
 - (vi) The chief resident in family medicine
 - (vii) A physician from each of the primary, or core training areas (Family Medicine, Internal Medicine, OB/GYN; Psychiatry, Pediatrics, and General Surgery)
 - (viii) The Program Director from each ACGME accredited GME program at PAMC
 - (ix) At least one faculty member from each ACGME accredited GME program at PAMC
 - (x) At least one advanced practice provider, as a representative for advanced practice students and their rotations at PAMC
 - (xi) Regional Dean (or other representative) of Alaska WWAMI
 - (xii) Regional Dean (or other representative) for PNWU
 - (xiii) one Member-At-Large
- (b) Ex-officio Members (Non-voting):
 - (i) Manager, Medical Staff Services Department
 - (ii) GME Coordinator from Medical Staff Services Department
 - (iii) Program administrators from each GME program at PAMC
 - (iv) Program director, UW Pediatrics Alaska Track
- (c) Non-physicians may be appointed as non-voting ex-officio members by the GMEC. Non-voting members may attend and speak at all meetings, but may not offer motions or vote on questions before the committee. Their presence is valuable because of the unique information and perspective they provide.

3.J.2 Duties

- (a) The GMEC has oversight responsibilities of all Medical Student, Allied Health, and Resident and Fellowship programs at PAMC. The GMEC shall regularly review curriculum and ensure compliance with all accrediting body recommendations and requirements. GMEC must demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review.
- (b) The GMEC must identify institutional performance indicators for the AIR, to include, at a minimum:
 - (i) The most recent ACGME institutional letter of notification
 - (ii) Results of ACGME surveys of residents/fellows and core faculty members
 - (iii) each of its ACGME-accredited programs' ACGME accreditation information, including accreditation statuses and citations
- (c) The DIO must present an executive summary of the AIR and submit it in writing to the PH&SA Region Board. It must include a summary of institutional performance indicators for the AIR and action plans and performance monitoring procedures resulting from the AIR
- (d) The GMEC must demonstrate effective oversight of underperforming program(s) through a Special Review process. The Special Review process must include a protocol that establishes criteria for identifying underperformance; and results in a report that describes the quality improvement goals, the corrective actions, and the process for GMEC monitoring of outcomes.

- (e) Oversight of
 - (i) The ACGME accreditation status of the Sponsoring Institution and each of its ACGME-accredited programs;
 - (ii) The quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites
 - (iii) The quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty-/subspecialty-specific Program Requirements;
 - (iv) The ACGME-accredited program(s)' annual program evaluations and self-studies;
 - (v) all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution; and,
 - (vi) The provision of summary information of patient safety reports to residents, fellows, faculty members, and other clinical staff members. At a minimum, this oversight must include verification that such summary information is being provided.
- (f) Review and approval of
 - (i) Institutional GME policies and procedures
 - (ii) Annual recommendations regarding resident/fellow stipends and benefits
 - (iii) Applications for ACGME accreditation of new programs
 - (iv) Requests for permanent changes in resident/fellow complement
 - (v) Major changes in each of its ACGME-accredited programs structure or duration of education
 - (vi) Additions or deletions of each of its ACGME-accredited programs participating sites
 - (vii) Appointment of new program directors
 - (viii) Progress reports requested by a Review Committee;
 - (ix) Responses to Clinical Learning Environment Review (CLER) reports
 - (x) Requests for exceptions to clinical and educational work hour requirements
 - (xi) Voluntary withdrawal of ACGME program accreditation
 - (xii) Requests for appeal of an adverse action by a Review Committee
 - (xiii) Appeal presentations to an ACGME Appeals Panel
 - (xiv) Maintain liaisons with other institutions participating in GMEC approved programs
 - (xv) Provide oversight for other undergraduate or graduate medical education, such as for medical students, nurse practitioner students, physician assistant students, and other learners.

3.J.3 Meetings

GMEC shall meet at least once per quarter. Meeting minutes must document execution of all required GMEC functions and responsibilities. Each meeting of the GMEC must include attendance by at least one peer selected resident/fellow member.

3.K. INFECTION CONTROL COMMITTEE

3.K.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 Infection Control shall serve as the chair of the Infection Control Committee.

- (a) Voting Members
 - (i) Medical Director of Infection Control; or designee
 - (ii) Chief Medical Officer (CMO) or designee

- (iii) Medical Staff Representation from:
- (iv) Internal Medicine/ Hospitalist;
- (v) Pulmonology/Intensivist;
- (vi) Pathology;
- (vii) Surgery;
- (viii) Family Medicine;
- (ix) Pediatrics;
- (x) OB/GYN;
- (xi) Anesthesia
- (xii) Infectious Disease
- (xiii) Emergency Medicine
- (xiv) Director of the Laboratory; or designee
- (xv) Supervisor of Laboratory and Microbiology; or designee
- (xvi) Manager, Caregiver Health;
- (xvii) Manager, Infection Control; or designee
- (xviii) Director, Performance Improvement or designee;
- (xix) Infection Preventionists
- (xx) Representative from: PKIMC, PVMC, PSMC, St. Elias, PEC/PTCC, Ambulatory/Family Medicine Clinic, Long Term Care, and Home Health;
- (xxi) Director of Quality Regulatory Services; or designee
- (xxii) Director of Pharmacy
- (xxiii) AMS Pharmacist; or designee
- (xxiv) Director of Respiratory Therapy; or designee
- (xxv) Director of Performance Improvement; or designee
- (xxvi) Nursing administration representation from: TCHAP, ED, OR, MED/Surg and ICU
- (xxvii) Hospital administration representation from: CAO, and CNO; or designee
- (xxviii) Hospital operations representation from: HLD/SPD, EM/EOC, Facilities, EVS.
- (b) Ex-officio Members (non-voting)
 - (i) A representative from the Municipality of Anchorage;
 - (ii) A representative from the State of Alaska Department of Health and Social Services; and
 - (iii) CDC Quarantine Station representation;
 - (iv) Family Medicine Resident

3.K.2 Duties

This committee shall be responsible for:

- (a) The supervision of infection prevention in all phases of hospital activities;
- (b) The surveillance of healthcare associated infections;
- (c) The review and analysis of the causes associated with healthcare associated;
- (d) The prevention and correction of activities associated with the development of healthcare associated infections; and
- (e) The encouragement and implementation of activities designed to prevent healthcare associated infections.
- (f) Annual review of the Infection Control Plan.

3.K.3 Meetings

The Infection Control Committee shall meet at least 6 times per year.

3.L. NOMINATING COMMITTEE

3.L.1 Composition

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

3.L.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.M. PHARMACY AND THERAPEUTICS COMMITTEE

3.M.1 Purpose

The Providence Alaska Medical Center Pharmacy (PAMC) and Therapeutic Committee (P&T) will provide oversight and guidance for all medication use policies and procedures to ensure that medications are used in a safe, clinically appropriate, and cost-effective manner. The PAMC P&T will work in conjunction with the Providence Alaska Region P&T and the Providence St. Joseph Health System P&T (SP&T).

3.M.2 Composition

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

- **Chair and Secretary** – responsible for leading committee affairs and pursuit of goals. Responsible for formalizing committee goals, promoting safe and effective environment for committee activities, approving and distributing agenda, facilitating committee meetings and discussions, approving committee vote outcomes, delegating responsibilities. Alaska region voting members on System P&T.
- **All Members** – committee members are responsible for their meeting attendance, reviewing meeting agenda and consent agenda materials before each meeting, actively contributing to topic discussions, proposing agenda topics, completing assignments, leading committee initiatives.
- **Voting Members** – Designated voting members are responsible for participating in committee votes.

Membership shall consist of representatives of the PAMC Medical Staff as appointed by the Chair, representatives from the PAMC pharmacy department, and representatives from PAMC nursing and dietary services. Other members may be appointed by the Chair as deemed appropriate. Ad-Hoc

(nonvoting) members and guests (nonvoting) may be invited as needed to serve as content experts on topics. Membership is open-ended.

- (a) Voting Members:
 - (i) Representatives from the medical staff (15)
 - (ii) Representatives from pharmacy (3)
 - (iii) Committee Chair (1)
 - (iv) Committee Secretary (1)
 - (v) Representative from nursing (1)
 - (vi) Representative from dietary services (1)
- (b) Ex-officio Members (non-voting)
 - (i) Antimicrobial Stewardship pharmacy specialist
 - (ii) Pediatric pharmacy specialist
 - (iii) Oncology pharmacy specialist
 - (iv) Pharmacy Administration/Operations
 - (v) Pharmacy Informatics
 - (vi) Pharmacy Residents
 - (vii) Other hospital personnel as needed (non-voting members and ad hoc experts on specific subject matter).

Voting members will be appointed for an initial term of 2 years but may be reappointed for additional terms per the Chair. The term of the chair will be the same as a voting member. Voting members terms will be staggered to ensure committee continuity.

3.M.3 Definitions

- (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~~ NOT include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases.

3.M.4 Responsibilities

The responsibilities of the PAMC P&T Committee include, but are not limited to:

- a) Work in conjunction with the Providence Alaska Region P&T and the System Pharmacy and Therapeutics Committee (SP&T) to develop and implement one standard Providence St. Joseph Health (PSJH) formulary.
 - a. The P&T Committee, or an individual provider coordinating with P&T, can petition a PSJH formulary decision through an appeal process with the understanding that the burden of proof of value (safety, efficacy, and cost) is on those who advocate the alternative.
- b) Serve in an evaluative, educational, and advisory capacity to the Medical Staff and hospital administration in all matters pertaining to the use of medications.
- c) Assist with policy development and revisions regarding the evaluation, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital.
- d) Approve which emergency medications will be readily available in-patient care areas.

- e) Provide oversight of medication administration and distribution technologies such as automated dispensing cabinets and parenteral infusion pumps including medication ‘override’ status in profiled areas and pump drug libraries.
- f) Establish and maintain a medication use evaluation process to help ensure cost-effective drug therapy.
- g) Periodically review non-formulary medication use.
- h) Participate in performance improvement activities related to distribution, administration and use of medications.
- i) Monitor drug supply and provide oversight and approval of strategies to mitigate the impact of shortages on patient care.
- j) Provide support and recommendations to the Medication Safety Team.
- k) Monitor and evaluate all significant medication events (including adverse drug reactions and medication errors) and make recommendations to prevent reoccurrence.
- l) Develop and provide oversight for P&T Subcommittees as needed.
- m) Establish and review medication safety initiatives.
- n) Disseminate information on P&T decisions and approved recommendations to the healthcare staff.

3.M.5 Meetings

The P&T Committee shall meet at least 5 times per year.

The meeting agenda and associated materials will be finalized and distributed at least five days prior to each meeting. Committee members are encouraged to submit topics and materials to the Chair and Secretary for agenda inclusion. Agenda categories may include, but are not limited to: formulary recommendations, medication utilization, medication safety, policies and procedures, drug shortages, and subcommittee reports.

The Chair or Secretary will call meetings to order, recognize discussion leaders, and adjourn meetings. Discussion sessions will be facilitated in an orderly manner by the Chair, Secretary, or the topic presenter. The Chair and Secretary will be responsible for managing agenda items and time.

A quorum is defined as not less than three members of the voting Medical Staff and one member of the voting Pharmacy Staff.

3.N. PHYSICIAN QUALITY COMMITTEE

3.N.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 Sub-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 (Vice-Chief of Staff)
- (xvii) Sedation Medical Director
- (xviii) Adult Trauma Medical Director
- (xix) Pediatric Trauma Medical Director
- (xx) General Surgery Sub-Section Chair or Designee
- (xxi) GMEC Chair (if physician)
- (b) Ex-officio Members (non-voting)
 - (i) Adult Intensivist
 - (ii) Pediatrics Intensivist
 - (iii) Neonatologist
 - (iv) Cardiovascular Surgeon
 - (v) Manager Medical Staff Services or Designee
 - (vi) Clinical Effectiveness Nurses
 - (vii) Chief Nurse Executive
 - (viii) Chief Administrative Officer
 - (ix) Chief of Staff
 - (x) GMEC Chair (if non-physician)
 - (xi) Additional individuals may attend upon request by the chair of the committee as non-voters.

3.N.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 are forwarded to the Chief Medical Officer, Chief of Staff, or Director of Medical Staff for approval;
- (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; and
- (f) May create sub-committees as necessary.

3.O. TRAUMA COMMITTEE AND CHAIR AUTHORITY

3.O.1 Composition

The Trauma Committee is structured in three subcommittees: the “Trauma Systems and Process Committee”, the “Adult Trauma Multidisciplinary Peer Review Committee”, and the “Pediatric Trauma Multidisciplinary Peer Review Committee.”

3.O.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) Trauma Registrar;
- (xiv) Trauma services staff including injury prevention, outreach, PI and analyst;
- (xv) A representative from hospital administration; and
- (xvi) Hospital staff to include a representative from: ~~OBJ~~ED, OR, ACC, PICU, disaster management.

The adult and pediatric trauma medical directors must attend 60% of the TSPC meetings. General surgeons and pediatric surgeons who provide trauma care and liaisons from ED, orthopedics, neurosurgery, radiology, adult intensivist, pediatric intensivist, geriatric liaison, and anesthesia must attend 50% of the TSPC meetings. Others are encouraged to attend regularly.

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

(a) Membership

- (i) Adult Trauma Medical Director, Chair;
- (ii) The general surgeons who provide trauma care;
- (iii) A neurosurgeon liaison;
- (iv) An orthopedic surgeon liaison;
- (v) An emergency medicine physician liaison
- (vi) A radiology liaison
- (vii) An adult intensivist liaison
- (viii) Geriatric Liaison; and
- (ix) Anesthesiologist liaison.

(b) Ad Hoc

- (i) General surgeons on the trauma call panel;
- (ii) A psychiatrist; and

- (iii) Other physician members may be appointed as necessary to assist in the activities of the committee.

The adult trauma medical director must attend 60% of the Adult TMPRC meetings. General surgeons who provide trauma care and liaisons from ED, orthopedics, neurosurgery, radiology, adult intensivist, geriatric liaison, and anesthesia must attend 50% of the meetings. Others are encouraged to attend regularly.

3.O.5 Duties of the Adult 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; and
 - (ix) Privileging issues, changes, or mandated issues may be elevated to MEC.

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

3.O.6. Membership

- (a) Pediatric Trauma Medical Director, Chair;
- (b) Adult Trauma Medical Director;
- (c) The pediatric surgeons who provide trauma care;
- (d) The general surgeons who provide trauma care;
- (e) A neurosurgeon liaison;
- (f) An orthopedic surgeon liaison;
- (g) An emergency medicine physician liaison
- (h) A radiology liaison
- (i) A pediatric intensivist; and
- (j) Anesthesiologist liaison.

Ad Hoc

- (k) Child Abuse Physician
- (l) Other physician members may be appointed as necessary to assist in the activities of the committee.

1

The adult and pediatric trauma medical directors must attend 60% of the Pediatric TMPRC. General/pediatric surgeons who provide trauma care and liaisons from ED, orthopedics, neurosurgery, radiology, pediatric intensivist and anesthesia must attend 50% of the meetings. Others are encouraged to attend regularly.

3.O.7. Duties of the Pediatric 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:
 - (f) Focused review for a specified period of time;
 - (g) Additional Committee or Department review with determination;

- (h) Formal education e.g., Case presentation, verification of competency;
- (i) Practice review;
- (j) Process review;
- (k) Equipment and/or Supplies: Availability and safety;
- (l) Resource review: adequate staffing and/or plan to meet the standard of care;
- (m) Policy or Protocol review: development or revision to meet the standard of care;
- (n) Other; and
- (o) Privileging issues, changes, or mandated issues may be elevated to MEC.

3.O.8 Dissemination

- (a) The Adult and Pediatric Trauma Medical Directors will disseminate the information and findings from the peer review to the surgeons on the trauma call panel;
- (b) All cases reviewed by the adult and pediatric 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
- (c) 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.P. UTILIZATION REVIEW COMMITTEE

3.P.1 Composition

The Utilization Review 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) Two or more doctors of medicine or osteopathy members of the medical staff;
- (c) Chief Medical Officer or designee;
- (d) Chief Administrative Officer or designee;
- (e) Chief Nursing Officer or designee;
- (f) Chief Financial Officer;
- (g) UR Medical Director(s)
- (h) Revenue Integrity Director

- (i) Case Management Director;
- (j) Case Management Educator;
- (k) Invited subject matter experts/presenters

3.P.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 twice yearly
- (e) Refers any systems issues identified as a result of the Professional Practice Evaluation program to the Quality Council-

The committee's or group's reviews may not be conducted by any individual who:

- (a) Has a direct financial interest (for example, an ownership interest) in that hospital; or
- (b) Was professionally involved in the care of the patient whose case is being reviewed.

3.P.3 Meetings

Meetings are held every other month or more frequently if necessary to carry out the committee's responsibilities and meet the requirements of 42 CFR 482.30 - Conditions of Participation. The chair may cancel meetings if a quorum of two physicians are unable to attend. Two consecutive meetings may not be canceled. A quorum is defined as one or more physician members, and the Chief Medical Officer or the CMO's physician designee who must be present to conduct business of the committee requiring a vote and/or a consensus.

3.Q. PAMC PICU Committee

The Pediatric Intensive Care Medical Director will be the chair and the Pediatric Intensive Care Surgical Vice-Director will be the co-chair of the PAMC PICU Committee.

3.Q.1 Composition

- (a) Invited physician members
- (b) Pediatric Intensivists
- (c) Pediatric Hospitalists
- (d) Pediatric Surgeons
- (e) Pediatric Subspecialists
- (f) Emergency Medicine
- (g) Chief Medical Officer
- (h) Required Department Representatives
 - a. Pediatric Nursing Leadership
 - b. Pediatric Clinical Nurse Specialist
 - c. PICU Nursing Staff
 - d. Pediatric Therapies
 - e. Respiratory Therapy
 - f. Pharmacy
 - g. Trauma Services

Ad Hoc

- (i) Social Work
- (j) Child Life
- (k) Additional individuals may attend upon approval by the committee.

3.Q.2 Duties

The PAMC PICU Committee oversees clinical and administrative activities in the Pediatric Intensive Care Unit with the goal of promoting excellence and addressing the challenge of providing age-appropriate care in the most effective and efficient manner to the critically ill or injured patient. Its duties shall be:

- (a) Review, and revise criteria for the purpose, format, and content of multidisciplinary rounds.
- (b) Assist in the development and monitoring of evidence-based Critical Care protocols, guidelines, policies, and procedures.
- (c) Establish and oversee a Critical Care quality improvement program consistent with the overall hospital QI program.
- (d) Determine goals and objectives for the Pediatric Intensive Care Unit and review annually.
- (e) Oversee data collection and analysis.
- (f) Recommend actions to improve outcomes based on best available evidence.
- (g) Report Critical Care QI activity and outcomes to Medical Executive Committee.
- (h) Facilitate communication between the Critical Care program staff, the Medical Staff, the medical center administration, and other relevant medical center departments; and
- (i) Create mission statement in collaboration with Pediatric Intensive Care multi-disciplinary team.

3.Q.3 Meetings

The PAMC PICU Committee shall meet monthly or as agreed upon by members.

ARTICLE 4: MEDICAL STAFF FUNCTIONS

4.A. The Medical Executive Committee

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.