HSHS Sacred Heart Hospital Medical Staff Committee Manual

June 25, 2021

TABLE OF CONTENTS
Medical Staff Committee Manual

MEDICAL STAFF COMMITTEE MANUAL

The committees described in the Medical Staff Committee Manual shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the chair and members of all standing Medical Staff committees shall be appointed by the Medical Staff President, in consultation with the Medical Executive Committee. Department committees shall be appointed by the Department Chair. All Medical Staff committees shall be responsible to the Medical Executive Committee.

Committee meetings will be conducted in accordance with provisions set forth in the Medical Staff Bylaws.

TERMS OF COMMITTEE MEMBERS

Unless otherwise specified, committee members shall be appointed by the President of the Medical Staff, in consultation with the Medical Executive Committee, for a term of one (1) year. No limitation shall be imposed on the number of consecutive terms a committee member may serve.

VACANCIES

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

PROVISIONS FOR TERMINATION OF A COMMITTEE BY THE MEDICAL EXECUTIVE COMMITTEE

The MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions.

CONFIDENTIALITY

All attendees at any committee meetings shall be subject to the confidentiality requirements identified in the Medical Staff Bylaws regardless of whether they are Appointees.

VOTING

All members have voting privileges, unless otherwise specific. Those who serve *ex-officio* do not have voting privileges.

A. CANCER COMMITTEE

1. **Chair**: The chair of the committee will be a physician member appointed by the Board upon recommendations from the committee members and President of the Medical Staff. Appointment will be made by the Board, at its first meeting after the end of the Medical Staff year, for an initial term of one (1) year. After serving an initial term, the Chair may be reappointed by the Board from year to year, upon recommendations from the committee members and the President of the Medical Staff and the CEO.

2. **Composition**:

   a. The Cancer Committee shall be multidisciplinary, with representation covering the full scope of cancer/oncology care. It shall be comprised of required and ancillary physician members, and non-physician members. Other representatives may attend as guests when requested to report information and to participate in discussions of the committee. Required physician members shall include one of each of the following practitioners: diagnostic radiologist, pathologist, general surgeon, medical oncologist, and radiation oncologist. The required non-physician members shall include one of each of the following professionals: cancer program administrator, oncology nurse, social worker or case manager, certified tumor registrar (CTR) and performance improvement or quality improvement professional. The ancillary members shall include a representative from each of the following: The American Cancer Society (ACS), Organizational Learning, Internal Medicine Physician, Medical Oncology Clinic Manager, Nutritional Services, thoracic surgeon, and any other representatives as determined by the Cancer Committee Chairperson and approved by the committee.

   b. Four Program Activity Coordinators shall be selected from the Cancer Committee membership to coordinate the following activities: Cancer Conference, Quality of Cancer Registry Data, Community Outreach, and Quality Improvement.

   c. The Cancer Committee Chairperson shall be a required physician member who will be selected by the committee members. A Cancer Liaison Physician shall be a required physician member of the committee who shall serve as a physician champion for cancer within the hospital, act as a liaison between the hospital and the Commission on Cancer, and partner with the American Cancer Society to serve as a change agent in the community.

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

   a. The presence of twenty-five percent (25%) of the total membership of the committee eligible to vote at any regular or special meeting (but in no event less than three (3) members) shall constitute a quorum. Ex officio members shall not be counted in determining the presence of a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

b. The Cancer Committee shall meet as often as necessary, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee, the Performance Improvement Committee and the Administration.

c. The Cancer Committee shall also report (with or without recommendation) to the Executive Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

4. **Duties and Responsibilities:** The Cancer Committee shall:

a. Develop and evaluate annual goals and objectives for the clinical, community outreach, quality improvement, and programmatic activities related to cancer;

b. Promote a coordinated, multidisciplinary approach to patient management;

c. Ensure that educational and consultative cancer conferences include all major sites and related topics;

d. Ensure that an active supportive care system is in place for patients, families and staff;

e. Monitor quality management and improvement through completion of quality management studies that focus on quality access to care and outcomes;

f. Promote clinical research;

g. Supervise the cancer registry and ensure accurate, timely abstracting, staging and follow-up reporting;

h. Perform quality control of registry data;

i. Encourage data usage and regular reporting;

j. Uphold medical ethical standards;

k. Recommend improvements where indicated;

l. Collaborate with medical and hospital departments on operational issues related to cancer and/or special care units;

m. Document and report results to the appropriate medical and hospital departments and committees; and

n. Comply with the American College of Surgeons Standards of the Commission on Cancer.

B. CONTINUING MEDICAL EDUCATION COMMITTEE

1. **Chair**: The chair of the committee will be a physician member appointed by the Board upon recommendations from the committee members and President of the Medical Staff. Appointment will be made by the Board, at its first meeting after the end of the Medical Staff year, for an initial term of one (1) year. After serving an initial term, the Chair may be reappointed by the Board from year to year, upon recommendations from the committee members and the President of the Medical Staff and the CEO.

2. **Composition**: The Continuing Medical Education Committee shall be a standing committee of the Medical Staff and shall consist of one (1) Active Staff appointee from each clinical department. The Coordinator of Continuing Medical Education, one (1) representative from the Education Department and one (1) representative from the Communications/ Marketing Department shall serve on the committee without vote.

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

   a. The presence of twenty-five percent (25%) of the total membership of the committee eligible to vote at any regular or special meeting (but in no event less than three (3) members) shall constitute a quorum. Ex officio members shall not be counted in determining the presence of a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.
   b. The Continuing Medical Education Committee shall meet as often as necessary to fulfill its duties but at least quarterly, and shall make a written report of its findings, proceedings and actions after each meeting to the Executive Committee and the CEO.

4. **Duties and Responsibilities**: The Continuing Medical Education Committee shall:

   a. Encourage and coordinate continuing medical education activities;

   b. Develop, plan, and participate in programs of continuing medical education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to evaluation findings;

   c. Evaluate the effectiveness of the educational programs developed and implemented;

   d. Make recommendations regarding professional library services;

e. Act upon continuing medical education recommendations from the Executive Committee, clinical departments and/or other committees;

f. Cooperate, where appropriate, with universities and other institutions in medical staff continuing education;

g. Review and approve various hospital-sponsored continuing medical education programs for continuing education credits;

h. Prepare an annual report of activities and annual budget; and

i. Report (with or without recommendation) to the Executive Committee for its consideration and appropriate action any situation involving questions related to the completion of continuing education requirements by any individual appointed to the Medical Staff.

C. CPR ("Cardiopulmonary Resuscitation") COMMITTEE

1. **Chair**: The chair of the committee will be a physician member appointed by the Board upon recommendations from committee members and the President of the Medical Staff. Appointment will be made by the Board, at its first meeting after the end of the Medical Staff year, for an initial term of one (1) year. After serving an initial term, the Chair may be reappointed by the Board from year to year, upon recommendations from committee members and the President of the Medical Staff and the CEO.

2. **Composition**: CPR Committee members shall be appointed by the President of the Medical Staff, in consultation with the Medical Executive Committee, for a term of one (1) year. No limitation shall be imposed on the number of consecutive terms a committee member may serve. The CPR Committee shall be composed of Physicians and Hospital colleagues.

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

   a. The presence of twenty-five percent (25%) of the total membership of the committee eligible to vote at any regular or special meeting (but in no event less than three (3) members) shall constitute a quorum. Ex officio members shall not be counted in determining the presence of a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

   b. The CPR Committee shall maintain a permanent record of its findings, proceedings and actions and shall make a written report after each meeting to the Medical Executive Committee and the CEO.

c. The CPR Committee shall meet at least quarterly. The agenda for the meeting and its general conduct shall also be set by the committee chairperson.

4. **Duties and Responsibilities:** The CPR Committee shall:

   a. Review Code Blue data; and

   b. Make recommendations for process change based on current evidence based research by the American Heart Association.

D. CRITICAL CARE COMMITTEE

1. **Chair**: The chair of the committee will be a physician member appointed by the Board upon recommendations from committee members and the President of the Medical Staff. Appointment will be made by the Board, at its first meeting after the end of the Medical Staff year, for an initial term of one (1) year. After serving an initial term, the Chair may be reappointed by the Board from year to year, upon recommendations committee members and from the President of the Medical Staff and the CEO.

2. **Composition**: The Critical Care Committee shall be comprised of Medical Staff members who are involved in critical care and shall include, but not be limited to, the following specialties: Critical Care Medicine, Hospital Medicine, Cardiovascular Surgery, General Surgery, Nephrology, Cardiology and Anesthesia. There shall also be hospital representatives from the following areas: Critical Care (including the Director of Critical Care), Nursing Leadership, Pharmacy and Organizational Learning. Committee membership term is one (1) year. No limitation shall be imposed on the number of consecutive terms a committee member may serve.

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

   a. The presence of twenty-five percent (25%) of the total membership of the committee eligible to vote at any regular or special meeting (but in no event less than three (3) members) shall constitute a quorum. Ex officio members shall not be counted in determining the presence of a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

   b. The Critical Committee shall maintain a permanent record of its findings, proceedings and actions and shall make a written report after each meeting to the Medical Executive Committee and the CEO**.**

   c. The Critical Care Committee shall meet at least quarterly. The agenda for the meeting and its general conduct shall also be set by the committee chairperson.

4. **Duties and Responsibilities:**

a. Assess and evaluate the quality, appropriateness, and effectiveness of critical care;

b. Make recommendations for the ongoing improvement of critical care;

c. Establish and review policies and procedures related to critical care;

d. Assure the provision of a multidisciplinary approach to the care of critical care patients

e. Recommend policies and procedures on matters common to critical care; and

f. Recommend the procurement, operation and maintenance of equipment necessary for critical care.

E. ETHICS COMMITTEE

1. **Chair**: A chair will be selected from the *ex officio* group in three year renewable terms. The chair of the committee will set the agenda with feedback from other committee members. The Chair will work to maintain the relationship with the Bishop of the Diocese of La Crosse.

2. **Composition**: The Ethics Committee shall be comprised of an *ex officio* group consisting of the Chief Executive Officer, President of the Medical Staff, Chief Operating Officer, Chief Physician Executive, Chief Nursing Officer, Director of Palliative Medicine, Palliative Care Director and Director of the Center of Spiritual Care. Ethics Committee members will be appointed by the Chief Executive Officer, with recommendations from current committee members, for staggered three year renewable terms based upon expressed interest and clinical expertise. Diversity among medical specialties, thought and gender will be promoted. Within the Hospital Sister Health System, it is ultimately the Chief Executive Officer's role to ensure Catholic identity within the hospital.

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

   a. The presence of twenty-five percent (25%) of the total membership of the committee eligible to vote at any regular or special meeting (but in no event less than three (3) members) shall constitute a quorum. Ex officio members shall not be counted in determining the presence of a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

   b. The Center for Spiritual Care will maintain the minutes and consultation recommendations of the Ethics Committee and shall meet at least quarterly.

4. **Duties and Responsibilities:** The responsibility of the Ethics Committee is to ensure compliance with the Ethical and Religious Directives that are published periodically by the United States Conference of Catholic Bishops and to serve as a forum to address complex medical issues with moral implications. With these responsibilities, the Ethics Committee has three primary purposes:

    a. To create a culture where issues are addressed in a consistent and transparent manner that promotes the moral practice of medicine consistent with the mission of Hospital Sisters Health System and the Ethical and Religious Directives.

    b. To provide education and facilitate communication for colleagues and physicians who work at Sacred Heart Hospital. The Ethics Committee will review and edit hospital Ethics policies and discern opportunities for greater ethical growth in the hospital community.

    c. The Ethics Committee will provide consultation and guidance on ethical issues when requested by the hospital staff. At committee meetings, consultation cases will be reviewed for process improvement and greater insight.

F. MORTALITY REVIEW COMMITTEE

1. **Chair**: The chair of the committee will be a physician member appointed by the Board upon recommendations from committee members and the President of the Medical Staff. Appointment will be made by the Board, at its first meeting after the end of the Medical Staff year, for an initial term of one (1) year. After serving an initial term, the Chair may be reappointed by the Board from year to year, upon recommendations from committee members and the President of the Medical Staff and the CEO.

2. **Composition**: The Mortality Review Committee will be composed of Physician Leadership, Physician Reviewer's, Chief Performance Improvement Officer, Quality, Pharmacist, Nursing and ad hoc ancillary/specialty reviewer's as indicated. Term of committee membership is one (1) year. No limitation shall be imposed on the number of consecutive terms a committee member may serve.

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

   a. The presence of twenty-five percent (25%) of the total membership of the committee eligible to vote at any regular or special meeting (but in no event less than three (3) members) shall constitute a quorum. Ex officio members shall not be counted in determining the presence of a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

   b. The Mortality Review Committee shall maintain a permanent record of its findings, proceedings and actions and shall make a written report after each meeting to the Medical Executive Committee and the CEO.

   c. The Mortality Review Committee shall meet at least quarterly. The agenda for the meeting and its general conduct shall also be set by the committee chairperson.

4. **Duties and Responsibilities:** The purpose of the Mortality Review Committee is intended to improve quality by identifying process issues that may lead to a lack of recognition of severity of illness and failure to rescue patients who might have otherwise survived. Focus is on process and opportunity to reduce harm.

   a. The Mortality Review Committee will perform first level review to screen for cases not identified as "comfort care" within 24 hours of admission and second level review to screen for opportunities related to recognition/communication/plan of severity of illness. Input will be sought from the Physician/Nurse who cared for the patient on opportunities for improvement.

   b. Classification of findings for purposes of trending/tracking will be compiled and opportunities for improvement will be identified with recommendations made to appropriate parties for follow-up in cases of:

      1. Unanticipated death with opportunity for improvement;

      2. Anticipated death with opportunity for improvement; and

      3. Anticipated death with no opportunity for improvement.

G. <u>OR MANAGEMENT COMMITTEE</u>

1. **Chair**: The chair of the committee will be a physician member appointed by the Board upon recommendations from committee members and the President of the Medical Staff. Appointment will be made by the Board, at its first meeting after the end of the Medical Staff year, for an initial term of one (1) year. After serving an initial term, the Chair may be reappointed by the Board from year to year, upon recommendations committee members and from the President of the Medical Staff and the CEO.

2. **Composition**: Committee members shall be appointed by the President of the Medical Staff, in consultation with the Medical Executive Committee, for a term of one (1) year. No limitation shall be imposed on the number of consecutive terms a committee member may serve. The OR Committee is comprised of Surgical Services Leadership, Infection Prevention, Director of Supply Chain, Surgical Services Business Analyst, Director of Quality and members of Surgical Services, Obstetrics & Gynecology and Anesthesia.

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

    a. The presence of twenty-five percent (25%) of the total membership of the committee eligible to vote at any regular or special meeting (but in no event less than three (3) members) shall constitute a quorum. Ex officio members shall not be counted in determining the presence of a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

    b. The OR Management Committee shall maintain a permanent record of its findings, proceedings and actions and shall make a written report after each meeting to the Medical Executive Committee and the CEO.

    c. The OR Management Committee shall meet monthly. The agenda for the meeting and its general conduct shall also be set by the committee chairperson.

4. **Duties and Responsibilities:**

    a. Develop and monitor performance metrics to measure effectiveness and present goals for improvement;

    b. Develop and monitor quality metrics, address any quality or customer (patient, surgeon) service issues and present goals for improvement;

    c. Create and set consequences for non-compliance with operational policies in accordance with hospital rules and regulations and Medical Staff bylaws;

    d. Review and approve Surgical Services policies;

    e. Approve block requests, monitor block utilization and recommend block changes;

    f. Achieve positive surgical services result through optimal use of resources and effective patient throughput and present goals for improvement, recommending actions to meet identified cost initiatives.

H. PERFORMANCE IMPROVEMENT COMMITTEE

1. **Chair**: The chair of the committee will be a physician appointed by the President of the Medical Staff, and approved by MEC.

2. **Composition**:

   a. The Performance Improvement Committee shall be a standing committee of the Medical Staff and shall consist of those appointees selected by the President of the Medical Staff in consultation with the CEO to serve as Medical Staff representatives of the respective Medical Staff departments within the organizational Medical Staff structure for this hospital. Membership shall include representation from the Medical Staff panels as determined by the Chairperson of the Performance Improvement Committee, in furtherance of the review and actions to support quality care. Hospital representatives will serve as ex-officio members and include the Chief Physician Executive, Chief Nursing Officer, President-Elect, Chief Performance Improvement Officer and the quality support staff as determined by the Chair. Additional members may be appointed by the Chairperson of the Performance Improvement Committee after consultation with the President of the Medical Staff and CEO to ensure clinical department representation, as appropriate.

   b. The Performance Improvement Committee and the performance improvement panels or panel leaders shall have available to them necessary resources as deemed appropriate by the hospital, including, but not limited to, performance improvement/quality data and representatives with expertise from hospital departments, to aid them in the development and implementation of policies and procedures that guide and support the provision of quality patient care services and continuous assessment and improvement of the quality of care and services provided.

3. **Meetings**: The Performance Improvement Committee shall meet at least 10 times per year, shall maintain a permanent record of its proceedings and recommendations, and shall make a written report after each meeting to the Executive Committee and the CEO.

4. **Duties and Responsibilities**: The Performance Improvement Committee shall assume responsibility for directing the ongoing development and maintenance of the Performance Improvement Program as it affects the Medical Staff. Specifically, the committee shall:

   a. Coordinate the quality review and performance improvement activities of the Medical Staff, including but not limited to: important aspects of care, efficiency and appropriateness of care provided specific to the patient's condition, timeliness of intervention, effectiveness and continuity of care, consistency and standard of

care rendered within and among the different clinical departments, and the safe manner in which care is provided to patients to reduce patient exposure to risk;

b. Review all patient care reports and studies to ensure that such findings are appropriately integrated into the performance improvement activities;

c. Recommend tasks and responsibilities to clinical departments, committees, multi-disciplinary subcommittees, ad hoc committees, panels and individuals in order to identify and resolve patient care problems and problems of institutional waste and duplication;

d. Review summaries of PRO citations and quality denial letters as presented by the Director of Utilization Review;

e. Document the effectiveness of the overall performance improvement activities as they pertain to the Medical Staff;

f. Make recommendations to the Executive Committee, after consultation with department chairperson or their designees, regarding appropriate performance improvement indicators to be used to create performance improvement profiles that will be prepared for each staff appointee and considered at the time of reappointment;

g. Notify and confer with the appropriate department chairperson (s) (with or without recommendation) regarding any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies, rules or regulations, or unacceptable conduct on the part of any individual appointed to the Medical Staff; and

h. After consultation with the appropriate department chairperson, or in cases where consultation with the department chairperson is inappropriate due to conflict of interest, the Performance Improvement Committee may report (with or without recommendation) to the Executive Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies, rules or regulations, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

5. **Performance Improvement Panels**

a. Unless otherwise specified in this manual, the performance improvement functions pertaining to oncology, pharmacy and therapeutics, procedure review, blood usage, infection control, medical records and utilization review shall be performed by the Director of Utilization Review and individual physician leaders of the performance improvement panels appointed by the President of the Medical Staff in consultation with the CEO.

b. The performance improvement panels shall consist of individuals who are actively interested or experienced in and willing to perform the responsibilities associated with the processes of quality assessment and performance improvement data analysis. Panel members shall be appointed by the respective panel leaders, in consultation with the Chairperson of the Performance Improvement Committee. Additional panel members may be appointed at the discretion of the panel chairperson in consultation with the President of the Medical Staff and Chairperson of the Performance Improvement Committee. Panel members may be removed for conduct detrimental to the interests of the hospital or if the member cannot fulfill the responsibilities of the panel competently and/or safely. Vacancies may be filled at the discretion of the panel leaders, in consultation with the Chairperson of the Performance Improvement Committee and the President of the Medical Staff.

c. Performance improvement panels shall meet as often as requested by their physician leaders to address specific performance improvement issues or to review ongoing monitoring of performance improvement functions related to the expertise of the panel. All performance improvement panels shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Performance Improvement Committee.

d. The performance improvement objectives and functions shall be as follows:

1) **<u>Comprehensive Patient Blood Management (cPBM)</u>**:

a) **Objective**: to promote pre-emptive clinical strategies for transfusion avoidance and to promote the safe and effective use of blood and blood products by utilizing clinical evidence and quality improvement approaches.

b) **Composition**: The cPBM Panel shall consist of at least one (1) staff appointee each from the specialties of anesthesiology, hematology/medical oncology, medicine, obstetrics and gynecology, pathology and laboratory medicine and surgery. Other members of the panel shall include one (1) representative each from nursing, the hospital pharmacy and the Performance Improvement Department. Consultation shall be available to the panel from the Emergency Medicine Department and hospital administration. Ad Hoc members may be added as needed to address issues requiring specialized expertise, at the discretion of the chair(s).

c) **Functions**:

(i) Develop, recommend, and periodically review transfusion guidelines for all blood components and patient groups to ensure they are consistent with current published evidence

(ii) Review and analyze transfusion utilization data as a system, by hospital, by clinical service, and by physician including all blood components and blood derivatives
    a. Identify areas of over (or under) utilization
    b. Evaluate trends and progress of the PBM program

(iii) Make recommendations on evidence-based practice changes to improve transfusion medicine including transfusion safety, anemia management, and anticoagulation management. Possible clinical initiatives might include:
    a. Anemia clinic including preoperative anemia
    b. Perioperative cell collection and administration (Cell Saver, ANH)
    c. Anticoagulant and anti-platelet reversal strategies

(iv) Promote evidence-based use of pharmacologic agents that reduce blood loss and improve red cell mass (e.g. anti-fibrinolytic agents, intravenous iron, erythropoietic stimulating agents)

(v) Provide reports to the site specific working groups, clinical departments, and hospital quality department
    a. Provide specialty and physician level reports

(vi) Evaluate needs for lab support for patient blood management activities

(vii) Monitor, evaluate, and recommend improvements in the EMR and computerized ordering process to support PBM activities

(viii) Ensure strategies are in place for management of patients with massive blood loss (trauma, obstetrical hemorrhage, etc.)

(ix) Participate in development and review of HSHS nursing and interdisciplinary clinical policies and procedures related to blood transfusion therapy
    a. Support standardization of transfusion practice across hospitals
    b. Facilitate consistency across disciplines within hospitals

(x) Support and prioritize educational activities and content for caregivers involved in transfusion process based on identified needs
    a. Physician education: Evidence-based, best practice review articles and Patient Blood Management strategies (anemia management, prevention/management of bleeding)
    b. Nursing Education: Evidence based transfusion guidelines and blood administration and transfusion reactions
    c. Targeted education based on transfusion reports, blood administration audits and other audits/reports

2) **<u>Infection Prevention</u>**:

a) **Objective**: To develop effective measures to prevent, identify and control infections acquired in the hospital or brought into the hospital from outside sources and to evaluate and measure the effectiveness of the hospital infection prevention program.

b) **Composition**: The Infection Prevention Panel shall consist of at least one (1) staff appointee from the specialties of pathology and laboratory medicine, critical care, obstetrics and gynecology. Other members of the panel shall include one (1) representative each from the Emergency Medicine Section, surgery, microbiology, nursing, and hospital administration.

c) **Functions**:

(i) Be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of preventive and corrective programs designed to minimize infection hazards, and the supervision of infection control in all phases of the hospital's activities;

(ii) Establish a system for surveillance of all hospital infections, including infections among patients and hospital personnel, to provide a basis for studying infection sources;

(iii) Review the results of any antimicrobial susceptibility/resistance trend studies and make recommendations in conjunction with the Pharmacy and Therapeutics Panel regarding the same, as appropriate;

(iv) Review proposals and protocols for all special infection control studies to be conducted throughout the hospital and report on any subsequent findings relating to such review;

(v) Develop and recommend standard criteria for reporting various types of infections, including, but not limited to, respiratory, gastrointestinal, surgical wound, skin, urinary tract, septicemia, and other types of infections related to the use of intravascular catheters;

(vi) Monitor the standards and the bacteriological services available to the hospital;

(vii) Review and recommend proper aseptic, isolation and sanitation techniques; and

(viii) Recommend infection control programs, including but not limited to prevention, immunization, post-exposure prophylaxis and continuing education programs on infectious disease, prevention and control for medical staff appointees and hospital personnel.

3) **Pharmacy and Therapeutics**:

a) **Objective**: To review the appropriateness, safety and effectiveness of the prophylactic, empiric and therapeutic use of drugs, and evaluate and make recommendations relating to the use of foods and nutritional supports.

b) **Composition**: The Pharmacy and Therapeutics Panel shall consist of at least three (3) Medical Staff appointees selected by the panel leader, in consultation with the Chairperson of the Performance Improvement Committee, and one (1) representative each from the hospital pharmacy, nursing, dietary and hospital administration.

c) **Functions**:

(i) Develop and recommend to the Executive Committee policies relating to the selection, distribution, handling, use, administration and safety procedures of drugs and diagnostic testing agents/materials;

(ii) Define and review all significant untoward/ adverse drug reactions and make recommendations as appropriate;

(iii) Assist in developing and periodically review the hospital formulary or drug list;

(iv) Review, in conjunction with the Performance Improvement Department, the Infection Control Officer and/or the performance improvement panel leader, the appropriateness, safety, and effectiveness of the prophylactic, empiric and therapeutic use of antibiotics in the hospital;

(v) Recommend drugs to be stocked on the nursing unit floors and by other services; and

(vi) Recommend policies concerning the safe use of drugs in the hospital, including new drugs, drug preparations requested for use in the hospital, hazardous drugs and investigational drugs.

4) **Procedure Review**:

a) **Objective**: To review surgical and other invasive procedures performed by various clinical departments within the hospital for acceptability and quality of service provided.

b) **Composition**: The Procedure Review Panel shall consist of at least one (1) representative each from the specialties of anesthesia, medicine, obstetrics and gynecology, pathology and laboratory medicine, radiology and surgery, and one (1) representative from the Performance Improvement Department.

c) **Functions**:

(i) Evaluate complications;

(ii) Review and analyze data to identify trends concerning surgical and other invasive procedures;

(iii) Develop and update annually screening criteria to measure indications for and outcomes of surgical and other invasive procedures;

(iv) Review all surgical and other invasive procedures in which a major discrepancy exists between the preoperative and postoperative (including pathologic) diagnosis; and

(v) Make a written report to clinical department chairperson as appropriate and to the Performance Improvement Committee reflecting the results of evaluations performed and actions recommended.

5) **Utilization Review**:

a) **Objectives**:

(i) To monitor utilization to evaluate the appropriateness of hospital admissions, length of stays, discharge practices, use of medical and hospital services and resources, and other factors related to utilization of hospital and physician services;

(ii) To recommend action to the CEO on matters of an administrative and hospital management nature such as cost efficiency measures concerning medical practices in the hospital; and

(iii) To monitor changes in the requirements of payors and recommend a method by which to comply.

b) **Composition**: The Director for Utilization Review shall serve as a member of the Utilization Review Panel and may be appointed panel leader. Other members of the panel shall consist of at least three (3) Medical Staff appointees selected by the panel leader, in consultation with the Chairperson of the Performance Improvement Committee.

c) **Functions**:

(i) Study patient utilization of hospital services and patterns of care relating to utilization and make recommendations concerning the hospital's written utilization review plan. The plan shall at least be in accordance with all applicable accreditation, regulatory and third-party payor requirements; and

(ii) Evaluate the medical necessity for continued hospital services for particular patients, where appropriate, and make recommendations to the attending staff physician, the Executive Committee and the CEO. No staff appointee shall have review responsibility for any extended stay cases in which that appointee has been professionally involved.

I. PRACTITIONER HEALTH COMMITTEE

1. **Chair:** The President of the Medical Staff shall appoint one (1) of the committee members upon recommendation from committee members to serve as chairperson of the committee.

2. **Composition**:

a. The Practitioner Health Committee shall be a sub-committee of the Credentials Committee whose primary objective is to protect patients and to promote the physical, mental and emotional well-being and fitness of health care practitioners who practice at the hospital. The role of the committee shall be to provide assistance to Medical Staff members and allied health professionals who may have problems of health which might impair their ability to practice competently and safely in the hospital and to deal with incidents of inappropriate conduct of Medical Staff members and allied health professionals. The committee shall consist of at least five (5) members of the Medical Staff appointed by the President of the Medical Staff based upon their knowledge about and/or interest or expertise in health issues that might impact on the ability of a practitioner to exercise clinical privileges competently and safely.

b. Any committee member who has been identified as an individual with possible health issues or who is potentially impaired, has conduct/behavior issues, or who is a member of the same group practice as a practitioner who has health issues, has been identified as a potentially impaired individual, or has been identified as having

conduct/behavior issues, shall be excused from the committee during its consideration of such matter.

c. Each member of the committee shall be appointed for a three (3) year term to provide continuity, and may serve additional terms if reappointed.

3. **Meetings:**

a. The presence of twenty-five percent (25%) of the total membership of the committee eligible to vote at any regular or special meeting (but in no event less than three (3) members) shall constitute a quorum. Ex officio members shall not be counted in determining the presence of a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

b. The Practitioner Health Committee shall maintain a permanent record of its findings, proceedings and actions and shall make a written report after each meeting to the Credentials Committee and PI Committee as appropriate.

c. The Practitioner Health Committee shall meet at least quarterly. The agenda for the meeting and its general conduct shall also be set by the committee chairperson.

4. **Duties & Responsibilities:** The Practitioner Health Committee shall:

a. Review and facilitate further evaluation and treatment and make recommendations in accordance with the Practitioner Health Issues Policy regarding any practitioner health issue or impairment concerns that are brought to the committee's attention;

b. Evaluate and investigate all reports regarding impairment of a provider's ability to practice, serious mental, emotional, or physical problems, alcohol or other drug abuse, or behavioral problems (including unethical conduct);

c. Facilitate collegial efforts to address concerns regarding inappropriate conduct/behavior by Medical Staff and Allied Health Professionals and/or refer matters appropriately according to the Code of Conduct: Managing Disruptive Behavior Policy.

d. Recommend to the Credentials and Executive Committees and the CEO educational materials about practitioner health issues that emphasize prevention, diagnosis and treatment of physical, psychiatric and emotional illness;

e. Handle health, impairment and/or conduct matters in a confidential manner and consistent with the Practitioner Health Policy and Code of Conduct: Managing Disruptive Behavior Policy, and keep the CEO, the President of the Medical Staff and the Chairperson of the Credentials Committee apprised of the matters under review; and

f. Recommend updates and/or revisions as necessary to the Practitioner Health Policy and Code of Conduct: Managing Disruptive Behavior Policy.

J. TRAUMA SERVICES COMMITTEE

1. **Chair:** The Chair of the Trauma Services Committee shall be selected by the Committee and shall be an emergency or trauma physician. The Medical Director of Trauma Services may serve as chairperson at the discretion of the committee. After serving an initial term, the Chair may be reappointed by the Board from year to year, upon recommendation from the President of the Medical Staff and the CEO.

2. **Composition:** The Trauma Services Committee shall be a standing committee of the Medical Staff and shall consist of at least one (1) representative each from the specialties of emergency medicine, anesthesiology, general surgery, orthopedic surgery, neurosurgery, the Medical Director of Trauma Services and a representative from hospital management appointed by the CEO who shall serve on the committee, *ex officio*, without vote.

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

   a. The Trauma Services Committee shall meet as often as necessary, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee, the Performance Improvement Committee, and the CEO.

   b. The Trauma Services Committee shall also report (with or without recommendation) to the Executive Committee for its consideration and appropriate action any situation involving questions of clinical competency, patient care and treatment, professional ethics, infraction of hospital or Medical Staff bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff.

4. **Duties and Responsibilities:** The Trauma Services Committee shall:

   a. Monitor and evaluate the appropriateness and quality of patient care provided on the Trauma Service;

   b. Develop and recommend administrative and patient care policies necessary to attain and maintain at least Level III Trauma Center designation and/or verification as prescribed by the American College of Surgeons and/or State of Wisconsin;

   c. Review and evaluate the quality of care provided on the Trauma Service in cases involving complications and death, focusing particularly on all sentinel events and deaths statistically expected to survive based on the use of outcome norms;

d. Be responsible for trend analysis of complications, and designate focused audits;

e. Foster cooperation and coordination of surrounding ambulance and rescue units for advanced life support equipment and quality trauma care; and

f. Encourage and help plan continuing medical education programs for all trauma service personnel and participate in public educational activities as they relate to the area of trauma and trauma prevention.

K. ROBOTICS COMMITTEE

1. **Chair:** The chair of the committee will be a physician member appointed by the Board upon recommendations from committee members and the President of the Medical Staff. Appointment will be made by the Board, at its first meeting after the end of the Medical Staff year, for an initial term of one (1) year. After serving an initial term, the Chair may be reappointed by the Board from year to year, upon recommendations from committee members and the President of the Medical Staff and the CEO.

2. **Composition:** The Robotics Committee shall be a standing committee of the Medical Staff and shall consist of the Robotics Medical Director, Vice President, Director of Surgical Services, Robotics Service Line Leader, and one (1) representative each from Quality and Marketing/Communications who will serve on an ad hoc basis. Additional members may be appointed by the Chairperson of the Robotics Committee after consultation with other committee members to ensure clinical department representation, as appropriate.

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

   a. The presence of twenty-five percent (25%) of the total membership of the committee eligible to vote at any regular or special meeting (but in no event less than three (3) members) shall constitute a quorum. Ex officio members shall not be counted in determining the presence of a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

   b. The Robotics Committee shall meet as often as necessary, but at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a written report after each meeting to the Executive Committee and the CEO.

4. **Duties and Responsibilities:** The Robotics Committee is responsible in providing oversight of the robotics program at Sacred Heart Hospital. The Committee shall:

   a. Monitor and evaluate of robotics procedure volume trends;

b. Review and evaluate new applications and business opportunities for the robot;

c. Review, develop and recommend policies and procedures necessary to maintain the delivery of high quality patient care; and

d. Monitor and evaluate the quality and operational efficiencies of patient care provided through the robotics program.