ORGANIZATION MANUAL

Medical Staff
Indu and Raj Soin Medical Center
Beavercreek, Ohio

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TABLE OF CONTENTS

ARTICLE 1. FUNCTIONS OF THE MEDICAL STAFF 1

SECTION 1.1 GENERAL 1

SECTION 1.2 POSITION DESCRIPTIONS 1

ARTICLE 2. COMMITTEES OF THE MEDICAL STAFF 7

SECTION 2.1 DESIGNATION 7

SECTION 2.2 MEDICAL EXECUTIVE COMMITTEE 7

Subsection 2.1.1 Purpose and Composition 7

Subsection 2.2.2 Duties 8

Subsection 2.2.3 Meetings 10

Subsection 2.2.4 Audience 10

SECTION 2.3 CREDENTIALS COMMITTEE 11

Subsection 2.3.1 Composition 11

Subsection 2.3.2 Duties 11

Subsection 2.3.3 Meetings, Reports, and Recommendations 12

SECTION 2.4 WELLNESS COMMITTEE 12

Subsection 2.4.1 Purpose 12

Subsection 2.4.2 Composition 13

Subsection 2.4.3 Meetings, Reports, and Recommendations 14

SECTION 2.5 PERFORMANCE IMPROVEMENT COUNCIL 14

Subsection 2.5.1 Purpose 14

Subsection 2.5.2 Composition 15

Subsection 2.5.3 Meetings, Reports, and Recommendations………………....15

SECTION 2.6 UTILIZATION REVIEW COMMITTEE…………………………….……16

Subsection 2.6.1 Purpose…………………………………………………….……16

Subsection 2.6.2 Composition……………………………………………………..16

Subsection 2.6.3 Meetings, Records and Recommendations………………...17

SECTION 2.7. CLINICAL QUALITY REVIEW COMMITTEE……………….…………17

Subsection 2.7.1 Purpose…………………………………………………….…17

Subsection 2.7.2 Composition……………………………………………………..17

Subsection 2.7.3 Meetings, Reports, and Recommendations…………………18

SECTION 2.8. PHARMACY & THERAPEUTICS COUNCIL…………………………18

Subsection 2.8.1 Purpose…………………………………………………….…18

Subsection 2.8.2 Composition…………………………………………………....19

Subsection 2.8.3 Meetings, Records, and Recommendations………………...19

SECTION 2.9 PER-OPERATIVE SERVICES GOVERNANCE COUNCIL…………20

Subsection 2.9.1 Purpose……………………………………………………....20

Subsection 2.9.2 Composition………………………………………………….....20

Subsection 2.9.3 Meetings, Records, and Recommendations…………………20

SECTION 2.10 OSTEOPATHIC METHODS AND CONCEPTS COMMITTEE…..….21

Subsection 2,10.1 Purpose…………………………………………………………21

Subsection 2.10.2 Composition……………………………………………………..21

Subsection 2.10.3 Meetings, Records, and Recommendations………….……..21

SECTION 2.11 MEDICAL RECORDS COMMITTEE……………………………………21

Subsection 2.11.1 Purpose…………………………………………………………21

Subsection 2.11.2 Composition……………………………………………………..22

Subsection 2.11.3 Meetings, Records, and Recommendations……………...22

SECTION 2.12 JOINT CONFERENCE COMMITTEE……………………………….22

Subsection 2.12.1 Purpose………………………………………………………….22

Subsection 2.12.2 Composition…………………………………………………….23

Subsection 2.12.3 Meetings, Reports and Recommendations…………….........23

SECTION 2.13 ETHICS COMMITTEE………………………………..……………….23

Subsection 2.13.1 Purpose…………………………………………………….….23

Subsection 2.13.2 Composition……………………………………………..…...24

Subsection 2.13.3 Meetings, Reports and Recommendations………………....24

ARTICLE 3. MEDICAL STAFF MEETINGS AND PROCEDURES………………………25

SECTION 3.1 NOTICE OF COMMITTEE/COUNCIL MEETINGS 25

SECTION 3.2 MANNER OF ACTION... 25

SECTION 3.3 MINUTES 25

SECTION 3.4 PARTICIPATION BY CHIEF OF STAFF 25

SECTION 3.5 VOTING AND MEETING OPTIONS 25

ARTICLE 4. RULES AND REGULATIONS 26

SECTION 4.1 OUTPATIENT (AMBULATORY), OBSERVATION AND ADMISSION STATUS 26

SECTION 4.2 PATIENT SAFETY.. 29

SECTION 4.3 UTILIZATION.. 29

SECTION 4.4 PEER REVIEW.. 30

SECTION 4.5 ORDERS 33

SECTION 4.6 RECORDS... 34

SECTION 4.7 CONSULTATION 44

SECTION 4.8 DISCHARGE 45

SECTION 4.9 BASIC RULES FOR THE USE OF HOSPITAL FACILITIES 45

SECTION 4.10 EMERGENCY DEPARTMENT ON-CALL PHYSICIANS 45

SECTION 4.11 SOURCES OF PATIENT CARE PROVIDED OUTSIDE THE 46

SECTION 4.12 CONDUCT 46

SECTION 4.13 DISRUPTIVE PRACTITIONER/APP 46

SECTION 4.14 COPYING OF PRACTITIONER/APP PEER REVIEW FILES 47

SECTION 4.15 RAPE EXAMINATIONS 47

SECTION 4.16 RESTRAINTS OR SECLUSION 47

SECTION 4.17 PRONOUNCEMENT OF DEATH 48

SECTION 4.18 USE OF INVESTIGATIONAL/EXPERIMENTAL DRUGS OR 48

SECTION 4.19 CANCER STAGING 50

SECTION 4.20 FOCUSED PROFESSIONAL PRACTICE EVALUATION 50

SECTION 4.21 ONGOING PROFESSIONAL PRACTICE EVALUATION 50

ARTICLE 5. ADOPTION, AMENDMENT OR REPEAL 51

ARTICLE 1. FUNCTIONS OF THE MEDICAL STAFF

SECTION 1.1 GENERAL

The Medical Staff is Departmentalized. Departments shall be organized according to the Medical Staff Bylaws.

This Organization Manual adopts and incorporates by reference the definitions contained in the Medical Staff Bylaws unless otherwise provided herein.

SECTION 1.2 POSITION DESCRIPTIONS

1.2.1. Medical Staff Officers

(a) Chief of Staff

Reports to: Board of Directors and Medical Executive Committee, as needed to the President/CEO.

Position Purpose: The purpose of this position is to provide overall leadership and guidance to the Medical Staff. Additionally, it is essential that the Chief of Staff promote effective communication among the Medical Staff, Medical Executive Committee, Hospital administration, and the Board. The Appointee occupying this position will serve as the elected representative of the Medical Staff and will be responsible for Bylaws implementation, Medical Staff involvement in securing and maintaining accreditation, providing information to the Board concerning matters that pertain to the care and treatment of patients, and generally facilitating positive relationships among administration, the Medical Staff, and other support services of the Hospital.

Clinical policies and procedures must be written in accordance with acceptable standards of medical practice and patient care. Such are reviewed and revised to reflect required changes consistent with current practice, problem resolution and standards changes. The process for review, revisions, approvals, implementation, and monitoring of compliance of such are as established in the medical staff bylaws and governing documents; clinical quality and performance improvement plans, policies, and/or manuals; and/or hospital and medical staff policies, flowcharts, etc. The Chief of Staff shall sign off clinical policies and procedures as needed, but at least every three years, or as otherwise required by state regulations, hospital or medical staff policy, and/or accreditation standards.

Accountabilities and Functions: Coordinates the activities and concerns of Hospital administration, nursing service, and other patient care services with those of the Medical Staff.

- Communicates and represents the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Board, the President/CEO, and other Medical Staff leaders.

- Calls, presides at, and is responsible for the agenda of all general and special meetings of the Medical Staff.

- Serves as Chair of the Medical Executive Committee, a member of the Professional Practice Committee of the Board, an Ex-Officio attendee to the Board of Directors meetings, and an Ex-Officio invitee of all other Medical Staff committees.

- Consults with the Vice President Medical Affairs/Chief Medical Officer on matters of special concern to Appointees and maintains medical liaison with the Vice President Medical Affairs to assist in settling grievances and problems of the Medical Staff.

Responsibilities: Responsible for the enforcement of the Medical Staff Bylaws, Organization Manual, and Credentials Policy Manual, for implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been recommended against an Appointee.

Responsible for all administratively related activities of the Medical Staff, unless otherwise provided for by the Hospital.

Responsible, in conjunction with the Medical Executive Committee, for assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Medical Staff or the Hospital.

Responsible, in conjunction with the Medical Executive Committee, for the development and implementation of policies and procedures that guide and support the provision of services.

Responsible, in conjunction with the Department Chiefs, for the recommendations for a sufficient number of qualified and competent persons to provide care or service.

Responsible, in conjunction with the Department Chiefs, for the determination of the qualifications and competence of Clinical Service personnel who are not Practitioners and who provide patient care services.

Responsible for participating in the evaluation of existing programs, services, and facilities of the Hospital and Medical Staff and recommending continuation, expansion, abridgment, or termination of each.

Responsible, in conjunction with the Medical Executive Committee, for participating in evaluating financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, for acquiring new or replacement capital equipment, and for assessing the relative priorities of services and needs and allocation of present and future resources.

Responsible for appointing Practitioners to Medical Staff and Hospital committees, subject to approval of by the Bylaws to the extent the Bylaws so provide.

Position Requirements: The Appointee occupying this position must be a physician, MD or DO, and meet the qualifications of officers as outlined in the Medical Staff Bylaws. Prior experience within the KHN Hospital system as a Department Chief, Credentials Committee member, Board member, Medical Executive Committee member, or other similar Medical Staff leadership position is preferred. The Appointee occupying this position should have received education and training concerning medical administrative activities and Medical Staff leadership.

(b) Vice Chief of Staff

Reports to: Chief of Staff and Medical Executive Committee

Position Purpose: The purpose of this position is to provide continuity in leadership during times when the Chief of Staff is absent or otherwise unable to perform his/her assigned functions and to provide the Appointee with experience prior to assuming the Chief of Staff position. The Vice Chief of Staff will be expected to remain knowledgeable about all Medical Staff issues of current Medical Staff interest. At the conclusion of the term of the Chief of Staff, the Vice Chief of Staff will succeed as Chief of Staff.

Accountabilities and Functions: Assists the Chief of Staff with any functions specified by the Chief of Staff and the Medical Executive Committee. Is an Ex Officio invitee to the Board of Directors meetings and the Professional Practice Committee. Is a member of the Medical Executive Committee and any other committee as provided in the Bylaws or Organization Manual. Is Co-Chair of the Performance Improvement Council. As such, this Appointee will be expected to represent the findings and recommendations of the Performance Improvement Council to the Medical Executive Committee.

Responsibilities: Responsible, in conjunction with the Medical Executive Committee, for continuing surveillance of the professional performance of all Practitioners and APPs who have delineated Clinical Privileges.

Responsible, in conjunction with the Medical Executive Committee, for the continuous assessment and improvement of the quality of care, treatment, and services provided, and for the maintenance of quality assessment and performance improvement programs as appropriate.

Co-Chairs the Bylaws Committee, when enacted, in conjunction with the immediate past Chief of Staff to foster open communication of Bylaws changes between the Hospital Board, administration, and the Medical Staff.

Position Requirements: The Appointee occupying this position must be a physician, MD or DO, and meet the qualifications of officers as outlined in the Medical Staff Bylaws. Prior successful service as a Department Chair, Credentials Committee member, Board member, Medical Executive Committee member or other similar Medical Staff leadership position is preferred. Individuals occupying this position should have received education and training concerning medical administrative activities and Medical Staff leadership.

(c) Secretary /Treasurer Reports to: Chief of Staff and the Medical Executive Committee

Position Purpose: To provide additional leadership to the Medical Staff, perform the functions of Secretary/Treasurer, and promote effective communication between Practitioners, Hospital administration, and other members of Medical Staff leadership.

Accountabilities and Functions: Assists the Chief of Staff as directed by the Chief of Staff and the Medical Executive Committee. Meets regularly with the officers of the Medical Staff to discuss current concerns and develop plans and goals for the Hospital system.

Is a member of the Medical Executive Committee and attends quarterly Medical Staff Meetings.

Assists the Chief of Staff with corrective action issues, including medical records and behavioral concerns, when requested.

Position Requirements: Must be a physician, MD or DO, and meet the qualifications of officers as outlined in the Medical Staff Bylaws. Prior successful service as a Department Chief, Medical Staff committee member, Board member or similar leadership experience is preferred.

(d) Immediate Past Chief of Staff Reports to: Chief of Staff and Medical Executive Committee. Recommendations from the Credentials Committee are carried forward by the Immediate Past Chief of Staff to the MEC. Recommendations from the MEC are carried forward by the Chief of Staff to the Professional Practice Committee and then to the Board of Directors for final approval.

Position Purpose: To provide oversight for the Credentials Program of the Hospital and direction to the Board of Directors in the credentialing, appointment, and privileging of Medical Staff Appointees and APPs. To maintain compliance with the credentialing policies of the Hospital, the Hospital's accrediting agency standards, and applicable law.

The goal of the credentials program is to minimize potential liability; clearly define granted Privileges; ascertain the Practitioner's/APP's qualifications for Medical Staff appointment and/or to perform requested Privileges; periodically review information from legal and ethical sources and performance data that impact the Practitioner's/APP's appointment and/or Privileges; and minimize the effect of social, economic, political and other non-medical factors on credentialing.

Accountabilities and Functions: Together with the Vice President Medical Affairs/Chief Medical Officer, develop, edit and maintain, on behalf of the Board, a fully documented Credentials Policy Manual, criteria for appointment/reappointment and granting/regranting of Clinical Privileges, and associated policies and procedures that are utilized in the credentials process.

Appointment/reappointment and Clinical Privileges for the purpose of assuring that existing Medical Staff policies, accreditation standards, and State requirements are followed.

Will oversee processing of requests for all appointments to the Medical Staff and/or Privileges, and will specifically review those applications that fall outside of guidelines for a "clean" application.

The Immediate Past Chief of Staff, in conjunction with the Medical Staff Services Department, is responsible for the maintenance of accurate and complete documentation concerning the entire credentialing process. This includes the maintenance, security, storage, and retrievability of credentials' files, minutes, and other documents pertaining to the overall credentials program within the Hospital and the processing of individual applications for appointment and/or Clinical Privileges.

Position Requirements: The Immediate Past Chief of Staff will assume Credentials Chair and must be a physician, MD or DO, and meet the qualifications of officers as outlined in the Medical Staff Bylaws. Prior

service as a Department Chair, Board member, Medical Executive Committee member, or other similar Medical Staff leadership position is preferred. Past participation on the Credentials Committee is highly recommended. Specific training is necessary for performance and will be recommended by the Immediate Past Chief of Staff.

1.2.2. Medical Staff Department Chair

Reports to: Chief of Staff

Position Purpose: The purpose of this position is to provide leadership to those organized Department to discuss policies, service needs, programs, and other issues affecting the provision of patient care by providers in the Clinical Service.

Reporting Relationship: Department Chair reports directly to the Chief of Staff, Medical Executive Committee and, through written communication, to the Credentials Committee.

Accountabilities and Functions: Are members of the Medical Executive Committee and provide formal and informal positions on issues affecting the provision of patient care by providers in the Clinical Service.

Responsibilities: As outlined in the Medical Staff Bylaws.

Position Requirements: Must be a physician, MD or DO, and meet the qualifications as outlined in the applicable Article in the Medical Staff Bylaws.

1.2.3. Vice Chair

Reports to: Medical Staff Department Chair

Position Purpose: The purpose of this position is to assist the respective Department Chair to provide leadership to those Departments that choose to organize to discuss policies, service needs, programs, and other issues affecting the provision of patient care by Practitioners/APPs in the Department.

Reporting Relationship: The Vice Chair reports directly to the respective Department Chair and, if so directed, to the Chief of Staff, Medical Executive Committee, and/or other appropriate committees.

Accountabilities and Functions: Regularly attends the peer review committee and other committees, as appointed, in order to provide formal and informal positions on issues affecting the provision of patient care by providers in the Department.

Responsibilities: As outlined in the Medical Staff Bylaws.

Position Requirements: Must meet the qualifications as outlined in the Medical Staff Bylaws.

ARTICLE 2. COMMITTEES OF THE MEDICAL STAFF

There are standing committees/councils and/or functions of the Medical Staff as set forth in the Network Medical Staff Bylaws under Article 8, which are the following: there will be a Medical Executive Committee (MEC) and also the following required Hospital committees: Utilization Review Committee and an Osteopathic Practice Committee (Utilization of Osteopathic Methods and Concepts) if required by accreditation standards based on the number of osteopathic physicians on staff with admitting privileges at Hospital Required committees must report to the Medical Executive Committee regularly throughout the year according to the Bylaws and Organization and Functions Manual. The following committees serve required functions: Quality Assessment and Performance Improvement Committee (includes Infection Control, Transfusion, and Surgical and Tissue Case Review), Joint Advisory Council/Function, and Credentials Committee.

SECTION 2.1. Designation

There will be a Medical Executive Committee (MEC) and the following standing committees/councils shall report to the MEC: Credentials Committee, Performance Improvement Council, and Wellness Committee. The following committees will submit minutes to the Chief of Staff who will submit these reports to MEC as appropriate: the Performance Improvement Council, Pharmacy & Therapeutics, Utilization Review Committee, Clinical Quality Review, Perioperative Services Governance Council, Osteopathic Methods & Concepts, and the Infection Prevention & Control Committee (to the extent such committees are established), Ethics Committee. The Chief of Staff shall provide Medical Staff oversight for these committees and/or functions and will report to the MEC on an as needed basis regarding issues identified that directly affect the Medical Staff. The Chief of Staff shall appoint the chair (except for Credentials Committee, which is an elected position) and members of Medical Staff committees/councils and recommend Appointees for membership in Hospital and joint Medical Staff/Hospital committees/councils. Nothing in these Bylaws shall preclude joint meetings of Affiliate Hospitals Medical Staff committees to the extent that such meetings will assist in assuring quality patient care and effective peer review.

SECTION 2.2. MEDICAL EXECUTIVE COMMITTEE

2.2.1. Purpose and Composition. The Medical Executive Committee (MEC) supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its Departments as well as conducts periodic review of Medical Staff Bylaws, Manuals, and policies, and makes recommendations for changes to the

Medical Staff and to the Board of Directors as outlined in the Medical Staff Bylaws.

It is the responsibility of the MEC to initiate, investigate, review, and report on corrective action, and on any other matters involving clinical, ethical, or professional conduct of any individual Practitioner. This responsibility may be delegated to the Clinical Quality Review Committee or a focused professional practice quality improvement panel selected by the Chief of Staff with the intent to improve the Practitioner's performance. The panel shall conduct the review as peers following the time frames set for that focused review by the MEC.

The MEC consists of the Chief of Staff, Chief of Staff-Elect, immediate past Chief of Staff, Vice-Chief of Credentials, Vice-Chief at Large, and the Department Chiefs for a two (2) year term). The President/CEO, Vice President Medical Affairs/Chief Medical Officer, Vice President/Patient Care Services, Director of Medical Education, and a member representing the Board of Directors will be members Ex Officio. The Chief of Staff serves as chair of the committee. All active Appointees, of any discipline or specialty, are eligible for membership on the MEC; provided, however, that, at all times, Physician Appointees of the active Medical Staff shall comprise at least a majority of the voting members of the MEC.

2.2.2. Duties. The duties of the Medical Executive Committee shall be to:

a. Represent and to act on behalf of the Medical Staff, in the intervals between general Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.

b. Receive and act upon reports and recommendations from Medical Staff committees, joint Hospital/Medical Staff committees, Departments, and assigned activities groups, and to make recommendation to the Board regarding the same, including the following Quality Assurance Performance Improvement ("QAPI") functions which flow from the assigned committee and report to PIC/MEC for action and dissemination of information to clinical providers and Board.

- Medication therapy, including antibiotic and non-antibiotics for all service types (inpatient, outpatient, ambulatory, and emergency care) of patients;
- Infection control, including community acquired and healthcare acquired infections in patients and health care workers;

- Surgical/invasive and manipulative procedures, including tissues and non-tissue producing cases, with and without anesthesia and/or moderate sedation;

- Blood (including component) product usage;

- Data management (accuracy, currency, transferability) with emphasis on medical record pertinence and timeliness;

- Discharge planning and utilization review;

- Complaints regarding medical staff related issues;

- Restraint/seclusion usage; and

- Mortality review. Coordinate, provide leadership, and implement the professional, clinical, performance improvement (including customer satisfaction and patient safety), and organization activities and policies of the Medical Staff including peer review, which helps to create and maintain a culture of safety and quality throughout the Hospital.

c. Act as liaison between the Medical Staff and the Chief of Staff.

d. Recommend action to the Chief of Staff on matters of a medico-administrative nature and to recommend the Medical Staff organization structure to the Board.

e. Make recommendations on Hospital management matters to the Board through its Professional Practice Committee.

f. Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation and licensure status of the Hospital.

g. Fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients in the Hospital.

h. Design a mechanism to ensure that the same level of appropriate quality of patient care is provided by all Practitioners and AHP with Privileges, within and across the Departments and/or Sections, and between Practitioners and AHPs who have Privileges during the patient's entire stay at the Hospital.

i. Oversee the quality of patient care, treatment, and services provided by Practitioners and AHPs.

j. Review the qualifications, credentials, performance, professional competence, and character of applicants, Appointees, Practitioners, and AHPs, and to make recommendations to the Board regarding, appointment, reappointment, termination, assignments to Departments and Sections, Privileges, and corrective action.

k. Request evaluations of a Practitioner's or AHP’s Privileges through the Medical Staff process in instances where there is doubt as to an applicant's, Appointee’s, or AHP’s ability to perform the Privileges requested.

l. Take all reasonable steps to ensure ethical professional conduct and competent clinical performance on the part of Practitioners and AHPs with Privileges.

m. Conduct such other functions as are necessary for the effective operation of the Medical Staff.

n. Direct mechanisms for corrective action, including indications and procedures for automatic and summary suspension of a Practitioner’s appointment and/or privileges.

o. Establish mechanisms to provide effective communications among the Medical Staff, Hospital administration, Board, and all levels of governance involved in policy decisions affecting patient care services in the Hospital.

p. Report at each general Medical Staff meeting.

q. Access and recommend to the relevant Hospital authority off-site sources for needed patient care services not provided by the Hospital.

r. Make recommendations for the position of Vice President Medical Affairs/Chief Medical Officer to the Board of Directors from among nominees.

s. Provide oversight with respect to appropriate completion of medical records including implementation of action plans to repair deficiencies and assisting in the development of policies regarding (i) maintenance and proper recording of sufficient data to evaluate patients; (ii) confidentiality; (iii) access; and (iv) as otherwise necessary to the appropriate completion and maintenance of such documents.

2.2.3. Meetings. The Medical Executive Committee shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

2.2.4. Audience. Any active Appointee has the right to an audience with the Medical Executive Committee. In the event a Practitioner is unable to resolve an issue

by working with his/her Department Chief, the Appointee may, upon presentation of at least two (2) week written notice, meet with the Medical Executive Committee at its next regularly scheduled meeting to discuss any unresolved issues.

SECTION 2.3 Credentials Committee

2.3.1. Composition. The Credentials Committee shall be composed of the Credentials Chair (the immediate past Chief of Staff), Chief of Staff, the Vice President /Chief Medical Officer, a Board member/administrative representative (Ex Officio). In addition, reasonable efforts should be made to have Practitioners from the various Departments to reflect appropriate representation. The immediate Past Chief of Staff will advance to the Credentials Chair position. The officers will be ratified in a bi-annually election process outlined in the Bylaws. Member appointments shall be for a term of two (2) years and may be for unlimited consecutive terms. The Chief of Staff shall appoint new Department representatives after receipt of nominations from the Department Chiefs.

2.3.2 Duties. The Credentials Committee shall investigate the qualifications of all applicants for appointment and/or Privileges, and shall review the Departments assignments and the Medical Staff category and/or Privileges requested.

At an interval no greater than every twenty-four (24) months, the committee shall review all information available on each Practitioner and privileged AHP, including recommendation from the Department Chiefs. This information shall be used for the purpose of determining its recommendations for appointment/reappointment to the Medical Staff, assignment/reassignment to the Department, and the granting/regranting of Clinical Privileges. The committee shall transmit its recommendations in writing, which may be reflected by its minutes, to the Medical Executive Committee. Where non-appointment/reappointment/grant/regrant of Privileges, or a change in appointment category, Department, or Privileges is recommended, the reason(s) for such recommendation shall be stated and documented.

The Credentials Committee shall review qualifications of all privileged AHPs, subject to recommendation of the AHP Committee and Department Chief. The committee shall establish processes as necessary to accomplish this review.

The Credentials Committee shall establish criteria for new procedures provided such procedures are approved to be performed at the Hospital. The committee shall also evaluate the qualifications of any Practitioner applying for these Privileges.

The Credentials Chair shall be available to meet with the Board or its applicable committee on all recommendations that the Credentials Committee makes. The

Credentials Committee may also create an ad hoc committee to deal with specific concerns.

2.3.3 Meetings, Reports and Recommendations. The Credentials Committee shall meet as often as necessary to accomplish its duties but at least six (6) times a year. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Medical Executive Committee with a copy to the Board.

SECTION 2.4 WELLNESS COMMITTEE

2.4.1 Purpose. The Wellness Committee is a Medical Staff oversight committee whose primary purpose is not to discipline, but rather, to identify, assist, and foster rehabilitation of impaired Medical Staff Appointees and AHPs. The Wellness Committee's processes are separate from the Medical Staff corrective action function. An impaired Practitioner/AHP is one who is unable, or potentially unable, to exercise his/her Privileges with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skills, or excessive use or abuse of drugs including alcohol.

The committee serves to educate the Medical Staff and Hospital staff about health, addressing prevention of physical, psychiatric or emotional illness, and impairment recognition issues specific to Practitioners and AHPS including facilitation of confidential diagnosis, treatment and rehabilitation from potentially impairing conditions.

The committee will encourage self-referral and referral by other Practitioners, AHPs, and Hospital staff.

The committee will examine the evidence for impairment of Practitioners and AHPS including evaluation of the credibility of a complaint, allegation, or concern.

The committee will facilitate referral of the affected Practitioner/AHP, if indicated, to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern.

Committee members will seek to maintain confidentiality of the Practitioner/AHP seeking referral or referred for assistance, except as limited by law, ethical obligation, or when safety of a patient or other is threatened.

The committee will provide support to Practitioners/AHPs with an impairment while monitoring recovery, including safety of patients, until the rehabilitation or corrective action process is completed.

The committee will report to the Medical Staff leadership instances in which a recovering Practitioner/AHP is providing unsafe treatment to patients.

The functions of the committee include: (i) reviewing concerns in an orderly and expeditious fashion that have been received by the Chief of Staff or otherwise referred to the committee in accordance with the Practitioner Wellness Policy; (ii) monitoring current cases of impairment of Practitioners/AHPs; and (iii) fulfilling its responsibilities under the Practitioner Wellness Policy which is incorporated herein. Concerns about impairment of Practitioners/AHPs will be taken to the next scheduled meeting, or addressed sooner at the discretion of the chair or as otherwise stated in the Practitioner Wellness Policy. When problems are presented, documentation will be obtained in a timely fashion. Suggestions or allegations of impairment of Practitioners/AHPs will be investigated in a thorough manner.

When the committee finds that a formal, professional evaluation is necessary to determine whether a problem exists, the committee will carry out an intervention in confidence, encouraging the suspected impaired Practitioner/AHP ital to voluntarily submit to the evaluation. If necessary, the committee may seek the help of the Greene County Medical Society Physician's Effectiveness Committee, if any, and/or the Ohio State Medical Association Physician's Effectiveness Program to do an intervention. The Chief of Staff will attend all interventions and will make an executive decision as to action to be taken (e.g., requirement of a formal evaluation). The impaired Practitioner/AHP will be encouraged to take a voluntary leave of absence and advised of the potential of a suspension of Privileges if he/she does not do so. The immediacy of response for evaluation will depend on the magnitude of the perceived problem. If the Practitioner/AHP declines to voluntarily participate in the process, the Practitioner/AHP will be reported to the Ohio State Medical Board, or other applicable licensing entity, and to the MEC.

When Practitioner/AHP is acutely impaired, the Chief of Staff and Department or Section Chief will be notified promptly and, if appropriate, will take the necessary actions to prevent risk to patient safety or care. The Wellness Committee will be notified of this action and shall investigate and determine whether additional action is required.

The committee is delegated the responsibility of establishing protocols for the evaluation and treatment of Practitioners/AHP whose physical or mental capacity is questioned. Any physical or mental condition, that would reasonably be expected to impair the Practitioner/AHP could subject the Practitioner/AHP to investigation. Such investigations are to be conducted in a confidential and impartial manner.

2.4.2. Composition. The membership of the committee shall consist of not less than three (3) members. One (1) of the members shall be the Chief of Staff. At least two (2) of the remaining members shall be Appointees and preferably not a Clinical Department or Section Chief or MEC member.

2.4.3 Meetings, Reports and Recommendations. The Wellness Committee shall meet as often as necessary to accomplish its duties but at least annually. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the MEC.

SECTION 2.5. PERFORMANCE IMPROVEMENT COUNCIL

2.5.1 Purpose. The Performance Improvement Council ("PIC") is a joint committee of the Hospital and Medical Staff that establishes the quality assessment and performance improvement ("QAPI") priorities and receives and provides formal information sharing between the Clinical Quality Department and the leadership of the Hospital and Medical Staff. The PIC has the responsibility to charter, oversee, and regularly evaluate QAPI programs and activities of the Hospital and its Medical Staff. The PIC receives and acts on summary reports from clinical and administrative committees as well as functions that track and trend information on clinical and other monitoring activities. The PIC makes recommendations for QAPI and effectively communicates those recommendations to the Medical Staff and Hospital groups with related responsibilities as specified in the Hospital's Performance Improvement Plan ("PI Plan").

The PIC oversees organization efforts to measure, assess, and improve clinical activities outcomes, the quality and appropriateness of selected service, and identify problem in care and performance at the various levels of organization leadership, functional areas, and Departments. The PIC is responsible for coordinating efforts to evaluate and monitor resource consumption and utilization management. Clinical review activities include appropriates of selected services/activities and management of the same in the following processes: (i) medication therapy; (ii) infection prevention and control; (iii) surgical management; (iv) blood products; (v) data management; (vi) discharge planning and utilization review; (vii) utilization management; (viii) complaints regarding Medical Staff related issues; (ix) restraint/seclusion usage; (x) mortality review; and (xi) "Never" events promulgated by CMS. Clinical review activities may be delegated to other committees and subcommittees that report through the PIC.

The PIC coordinates, prioritizes, and monitors the Medical Staff, Hospital, and medical education data gathering and analysis components of the quality review program, of QAPI activities using "Plan, Do, Check Act ("PDCA") methodology, or such other methodology as is adopted from time to time, and coordinates the Medical Staff activities in these areas with those of the other professional and support services in the Hospital. Individualized Practitioner/AHP/resident data identified through QAPI processes will be delegated for handling to the Chief of Staff and/or Clinical Quality Review Committee, as needed, for further evaluation according to Medical Staff peer review process.

The PIC annually evaluates the Hospital's overall QAPI program for its

comprehensiveness, integration, effectiveness and cost efficiency, and revises the PI Plan as needed. The PI Plan includes evaluation mechanisms for every contracted patient care service and ensures that the list of all contracted services is maintained inclusive of the scope and nature of the services provided.

The PIC reviews clinical risk management events, including root cause analyses of sentinel events, morbidity concerns, and aggregate data on significant high risk events to identify possible patterns and communicate that information to the Medical Staff and Hospital groups with related responsibilities.

The PIC periodically oversees the development and implementation of Hospital safety programs and an emergency preparedness plan that addresses disasters, both Hospital and community.

The PIC annually reviews the Hospital Hazard Vulnerability Analysis ("HVA") objectives and scope of the Emergency Operations Plan, Environment of Care, Staffing Effectiveness, Plan for Patient Care, Patient Safety Plan, and the PI Plan.

The PIC establishes formats for the aggregation, display, and reporting of data and findings, as well as a system of follow-up to determine that recommended actions are implemented. The PIC formats and schedules submissions of data and findings, committee minutes, and special reports such that the entire clinical performance of the Hospital is monitored, the data is reported in a structured and comprehensive manner, and appropriate recommendations can be made based on that data to provide care within the Hospital of the highest quality.

The PIC oversees quality assessment, performance improvement, and peer review functions.

2.5.2. Composition. The composition of the PIC will include the Medical Director of Quality (co-chair), the Chief of Staff (co-chair), the Chief of Staff-elect, the Hospital Vice- Presidents, and such other Practitioners and members of Administration (in equal numbers) as are deemed necessary to accomplish the council's objectives. Practitioners shall be chosen by the Chief of Staff. Members of Hospital administration shall be chosen by the President/CEO.

2.5.3 Meetings, Reports and Recommendations. The PIC shall meet as often as necessary to accomplish its duties but at least quarterly. Medical Staff QAPI reviews that focus on clinical assessments, diagnostic procedures, and therapeutic interventions are reported at least semi-annually. The council shall maintain a permanent record of its proceedings and actions, and report its recommendations and findings to the Medical Executive Committee and the Board, as deemed appropriate. QAPI data and findings are used to develop continuing education activities, provide annual evaluations of improvement in clinical care, and assist in the credentialing process.

SECTION 2.6. UTILIZATION REVIEW COMMITTEE

2.6.1. Purpose. The Utilization Review Council is a joint committee of the Hospital and Medical Staff that develops and annually amends a utilization review plan for approval by the MEC, Hospital Executive Council and, ultimately, the Board. The plan applies to all patients regardless of payment source, outlines the confidentiality and conflict of interest policy, and includes provision for:

a. Reviewing admissions and medical necessity of admissions, continued hospitalization, and extended stays;

b. Discharge planning, including referral for appropriate post-hospitalization care and Practitioner follow-up;

(c) Reviewing medical necessity of professional services, such as, but not limited to, high cost procedures, drugs and biologicals, data collection and reporting requirements;

(d) Identifying Practitioner/case variations from evidence-based care.

The council engages in review of ongoing issues, including case-specific utilization, Practitioner and Practitioner group profiling, and department and clinical service line trending to insure high quality medical care and effective utilization of resources.

The council assists the Hospital with decision-making and tracking of high volume, high risk, high cost, and/or problem prone diseases or DRGs and recommending measures to improve outcomes. The council reviews cost and quality trends on a continuous basis as a means to improve clinical effectiveness and resource allocation.

The council reviews, approves, and recommends to the MEC all new Practitioner order sets and protocols and significant revisions to existing orders/protocols, as the need arises.

2.6.2. Composition. The composition of the council will include the Medical Director of Quality, a Physician, two (2) additional Practitioners (one (1) of whom may be the Chief of Staff), and two (2) additional members of administration. Practitioners shall be chosen by the Chief of Staff. Members of Hospital administration shall be chosen by the President/CEO.

Members should be experienced in utilization review functions. No council member may participate in the review of any case in which he/she was professionally involved in the care of the patient. No person serving on the council may hold any financial interest in any hospital.

2.6.3. Meetings, Reports and Recommendations. The council shall meet as often as necessary to accomplish its duties but at least quarterly. The council shall maintain a permanent record of its proceedings and actions, and report its recommendations to the MEC and the PIC as deemed appropriate.

SECTION 2.7. CLINICAL QUALITY REVIEW COMMITTEE

2.7.1. Purpose. Clinical Quality Review Committee (CQRC) is a subcommittee of the MEC responsible for receiving and/or identifying and determining initial peer review issues and coordinating, tracking, and trending clinical quality patterns and/or concerns as well as death reviews at the Hospital. The Leadership Committee may delegate certain peer review activities to the Departments but their activities must be reported to the CQRC. See Article 4, Section 4.4, Peer Review for procedure.

The Clinical Quality Review Committee:

(a) Conducts review of surgical/invasive and manipulative procedures including tissue and non-tissue producing cases, with and without anesthesia and/or moderate sedation, and cases that fail to meet predetermined criteria. These criteria may include: documentation, tissue examination, indications for surgery, and post-operative care. Define the scope and types of cases to be reviewed and provide tissue and audit review including cases with minimum or no pathology to determine the justification for all surgical procedures performed, scrutinize the relationship between preoperative diagnosis, and the final postoperative diagnoses.

(b) Reviews and evaluates internal and external data as necessary to understand the care that is being examined by the committee.

(c) Monitors and assesses utilization of blood and blood components for all types of patients, including evaluation of appropriateness of all blood component transfusions; reviews all confirmed transfusion reactions in a timely manner; reviews ordering practices for, and distributing, handling, dispensing, and administering of, blood and blood products; and, monitors blood and blood component effects on patients. The committee establishes policies governing all transfusions of blood and blood derivations, systems for reporting transfusion reactions, and evaluates such policies and practices at regular intervals. Transfusion reactions will be considered adverse medical events and will be reported through the QAPI process. The committee investigates all transfusion reactions occurring in the Hospital and recommends improvement in transfusion procedures. The committee develops policies and procedures regarding transfusions of potentially HIV/HCV infectious blood and blood products and defines the relationship and responsibilities of outside blood banks with appropriate notification procedures.

(d) Monitors mortality review and complaints with quality concerns regarding Medical Staff related issues. Mortality review considers the awareness of the critical nature of the cases, analyzes opportunities for early recognition of clinical deterioration, correct diagnosis, and educational reporting of interesting cases for potential instructional use by the Medical Staff and Hospital staff.

Reports will uphold confidentiality by using Hospital case numbers and Practitioner numbers.

2.7.2. Composition. The members of the Clinical Quality Review Committee will be appointed by the Chief of Staff and include, among others, appropriate Clinical Department Chiefs.

No committee members may participate in the review of any case in which he/she was professionally involved in the care of the patient.

2.7.3 Meetings, Reports, and Recommendations. The committee shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to either the appropriate surgical clinical service and the Medical Executive Committee as deemed appropriate.

SECTION 2.8. PHARMACY & THERAPEUTICS COUNCIL

2.8.1. Purpose. The Pharmacy and Therapeutics (P&T) Council is a joint committee of the Hospital and Medical Staff that serves as a regulatory and advisory committee in all matters pertaining to the evaluation, selection, and utilization of medications, including equipment used to prepare and administer medications.

The P& T Council:

a. Recommends and/or assists in the formulation of education programs designed to meet the needs of Practitioners, AHPs, nurses, pharmacists, and other health care providers on matters related to the selection, administration, and monitoring of medication use.

b. Develops and maintains a formulary of drugs accepted for use in the Hospital and provides for its appropriate revisions. The selection and review of these drugs is based on objective evaluation of their relative merit, safety and cost.

c. Establishes programs and procedures that help ensure cost effective drug therapy using indicators of patient outcome in their assessment.

d. Reviews adverse drug reactions and errors and develops programs and policies to minimize their occurrence and formulates procedures for reporting such reactions and errors; and assists the Medical Staff in investigating such issues and implementing corrective actions.

e. Collects data and monitors and recommends process improvement to the Hospital and the Medical Staff regarding procurement, storage and distribution; prescribing or ordering; preparing and dispensing; administering and monitoring the effects on patients of medications used in the Hospital and enteral nutrition products in the Hospital.

f. Reviews medication errors and determine actions that should be taken to minimize their occurrence.

g. Develops a medication safety program for the Hospital that promotes safe medication administration and reduces preventable medication errors.

h. Recommends to the Medical Staff and Hospital policies regarding nutrition care issues.

i. Establishes priorities for ongoing assessment of medication used in the Hospital.

j. Monitors the anticoagulation management program for efficiency and effectiveness.

k. Recommends drugs that are stocked on nursing units.

l. Evaluates clinical data concerning new drugs requested for use in the Hospital, and advises the Medical Staff and pharmacists on the choice or use of drugs.

(m) Reviews P&T related policies at least every three (3) years and updates more frequently as necessary.

2.8.2. Composition. The P&T Council consists of representatives from the Medical Staff, nursing, pharmacy, nutrition services, and other health care providers. Members are appointed jointly by the Chief of Staff and the Hospital executive committee. The chair shall be appointed by the Chief of Staff. The number of members may not exceed twenty (20).

2.8.3 Meetings, Reports and Recommendations. The council shall meet as often as necessary to accomplish its duties but at least quarterly. The council shall maintain a permanent record of its proceedings and actions, and report its recommendations to the PIC and the MEC as deemed appropriate.

SECTION 2.9. PERI-OPERATIVE SERVICES GOVERNANCE COUNCIL

2.9.1 Purpose. The Peri-operative Services Governance Council is a joint committee of the Hospital and Medical Staff for the following: the Operating Rooms ("OR"), the Post Anesthesia Care Units ("PACU"), the Ambulatory Surgery Center ("ASC") (pre and post-operative care) (if any), and the Pre-Admission Testing ("PAT") services (including the Pre-Operative Clinic, Endoscopy Services ('.'GI") Outpatient Surgery Center, and Central Sterile Processing).

The Council:

a. Reviews, revises, and develops policies and procedures for Peri-operative Services.

b. Recommends policy revisions to the MEC for approval.

c. Monitors compliance with Peri-operative services policies.

d. Monitors and evaluates effectiveness of Peri-operative Services, including patient safety issues and performance improvement activities.

e. Upon request, provides comments to the Credentials Committee or other appropriate Medical Staff committee regarding Practitioners' use of Peri-operative Services.

f. Reviews and prioritizes requests for capital equipment, instruments, and medical supplies.

g. Reviews and complies with regulatory and accrediting agency requirements.

h. In urgent situations, the co-chairs of the Peri-operative Services Committee may:

(i) Discuss team interactions.

(ii) Interpret and enforce Peri-operative Services policies, if necessary, between meetings of the Peri-operative Services Committee.

2.9.2. Composition. The council consists of the Chair of the Department of Surgery, the Administrative Director of Peri-operative Services (co-chair), and additional Practitioners and members of Hospital administration as necessary to accomplish the council's purposes. Practitioners shall be chosen by the Chief of Staff. Members of Hospital administration shall be chosen by the President/CEO.

2.9.3. Meetings, Reports and Recommendations. The council shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall

maintain a permanent record of its proceedings and actions, and report its recommendations to the PIC, the Hospital Executive Council, and to the MEC as deemed appropriate.

SECTION 2.10. OSTEOPATHIC METHODS & CONCEPTS COMMITTEE

2.10.1. Purpose

The committee:

(a) Makes recommendations to improve utilization of osteopathic principles and practice; records osteopathic findings, describes osteopathic manipulative treatment, and applies such modalities as part of the comprehensive care received by patients.

(b) Establishes and records retrospective and current audits of patient charts relating the application of osteopathic principles and practice to patient diagnosis and treatment.

(c) Inform osteopathic Physicians of the evaluations of patient charts reviewed by the committee to improve utilization of osteopathic principles and practices.

2.10.2. Composition. The committee shall consist of at least two (2) osteopathic Physicians on the active Medical Staff. The committee does not need to be established unless and until there are ten (10) osteopathic Physicians on the active Medical Staff.

2.10.3. Meetings, Reports and Recommendations. The committee shall meet as often as necessary to accomplish its duties but at least annually. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the PIC and the MEC as deemed appropriate.

SECTION 2.11. MEDICAL RECORDS COMMITTEE

2.11.1. Purpose

The Committee:

2.11.1.1. Using the Kettering Health Network definition for a complete medical record as standard for comparison, will review reporting of record reviews that substantiates compliance with the standard. Assures implementation of actions plans to repair such deficiencies as are identified.

2.11.1.3 Addresses concerns regarding records completions as brought forth to the committee from the administration or the medical staff.

2.11.1.4. Recommends any new use or any changes in the format of medical records.

2.11.1.5. Reports quarterly to the MEC and Performance Improvement Committee its findings and process evaluations.

2.11.1.6. Recommends policies regarding maintenance and proper recording of sufficient data to evaluate patient care, as well as matters of confidentiality, access, and legal release of information.

2.11.2. Composition

The Vice Chief at Large will serve as the Co-chair of the Medical Records Committee along with the Network Medical Records Administrator. It shall include as members the Vice President Medical Affairs/Chief Medical Officer, the Director of Medical Records for the hospital, the Medical Director of Clinical Quality, at least one additional medical staff member, as appointed by the Chief of Staff and one additional member from the medical records department.

2.11.3. Meetings, Reports and Recommendations

The Medical Records Committee shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Performance Improvement Committee and to the Medical Executive Committee as deemed appropriate.

SECTION 2.12. JOINT CONFERENCE COMMITTEE

2.12.1. Purpose. The Joint Conference Committee is an ad hoc committee of officers of the Medical Staff and officers of the Board of Director whose function is to address issues of direct or potential conflict between the Hospital Board and the Medical Staff and to facilitate communication between the Board and the Medical Staff.

The Joint Conference Committee shall:

(a) Be a forum for the discussion of matters involving Hospital Policy and Practice, especially those pertaining to patient care and shall provide medical administrative liaison with the Board.

(b) Monitor the correction of any cited deficiencies resulting from inspection by Hospital accrediting bodies and compliance with their directives.

(c) Perform such other duties as shall be delegated to it by the Board.

2.12.2. Composition

The Joint Conference Committee shall be a Board committee. The chair of the committee shall be a member of the Board appointed, by the Chair of the Board. Membership shall include three (3) members of the Board nominated by the committee Chair and approved by the Chair of the Board, and three (3) active Medical Staff Appointees, usually the Chief of Staff, the Chief Elect, and one additional member appointed by the Chief of Staff.

2.12.3. Meetings, Reports and Recommendations

The Joint Conference Committee shall meet as soften as necessary to accomplish its duties but at least Quarterly. The Committee shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the MEC, the Hospital CEO and the Board.

SECTION 2.13. ETHICS COMMITTEE

2.13.1. Purpose. The Soin Medical Center and Greene Memorial Hospital Ethics Committee is a committee of under dual appointment by the Medical Staff and Soin Medical Center and Greene Memorial Hospital. The purpose of the Ethics Committee shall be advisory in nature. The Committee may participate in development of guidelines for review of cases having ethical implications; development and implementation of procedures for such review; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of ethical policies; consultation with concerned parties to facility communication and aid conflict resolution; and education of the hospital staff on ethical matters.

The Ethics Committee shall:

(a) Review procedures and protocols to assist on ethical issues to patients and their families and to those engaged in patient care, particularly the physicians and nurses.

(b) Provide counsel with respect to the operation of the medical center and to any other corporate ethical issues that it may be assigned by the administrators.

(c) Review issues to help ensure that the treatment of patients and their families is consistent with the established principles of ethics and the values of the institution.

(d) To provide direction to medical center leadership on clinical ethical issues, specifically areas that address:

i. Personnel behavior

b. Clinical practices

c. Allegations of violations of ethical conduct

(e) To provide the services of a hospital ethics committee (HEC) for education, for policy creation or revision and for case consults when requested or needed.

(f) To provide medical-ethical education for physicians, medical residents and students, nurses and other care-givers at Soin Medical Center and Greene Memorial Hospital through grand rounds, ethics forums, lectures, meetings and consults when requested.

(g) Inform physicians and staff of the availability of Palliative care and use as appropriate.

2.13.2. Composition

The Ethics Committee shall be Co-Chaired by the Chief of Staff and the Vice President Medical Affairs/Chief Medical Officer. It shall consist of members as the medical executive committee may deem appropriate. Members may include:

- Co-Chair – Vice President Medical Affairs/Chief Medical Officer
- Co-Chair – Chief of Staff
- Patient Relations
- Palliative Care
- Legal counsel, as needed
- Hospital Chaplain
- Nursing Representative
- Quality Medical Director
- Ethicist, as needed
- Recorder – Medical Staff Manager
- Social Worker
- Physician Representative – OB/GYN Chief
- Physician Representative – ICU Director
- Physician Representative – Emergency Medicine Chief

2.13.3. Meetings, Reports and Recommendations

The Ethics Committee shall meet as necessary. An established quorum will include one Co-Chair and three committee members. The Committee shall maintain a permanent record of its proceedings and actions and shall report its recommendations to the MEC, the Hospital CEO and the Board.

ARTICLE 3 MEDICAL STAFF MEETINGS AND PROCEDURES

SECTION 3.1 NOTICE OF COMMITTEE/COUNCIL MEETINGS

Written notice of any regular or special committee meeting not held pursuant to resolution will be provided to all persons entitled to be present not less than ten (10) days before the date of such meeting. Personal attendance at a meeting constitutes a waiver of notice of such meeting, except when a person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting was not duly called or convened.

SECTION 3.2 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present is the action of the group. In unusual circumstances, action may be taken without a meeting by the Medical Staff, Department, or committee/council by presentation of the question to each member eligible to vote, in person or by mail, and their vote returned to the Chair of the group, Department Chair, or to the Chief of Staff in the case of a Medical Staff vote. Such vote shall be binding so long as the question is voted on by at least the number of voting members of the group that could constitute a quorum.

SECTION 3.3 MINUTES

Minutes of all meetings, except as noted in the Bylaws, shall be prepared and include a record of attendance and the vote taken on each matter. Minutes are to be signed by the presiding Chair or officer, forwarded to the Medical Executive Committee (or the parent committee in the case of a subcommittee), and presented to the attendees at a subsequent meeting for acceptance. Minutes shall be made available, upon request to and at the discretion of the Chief of Staff, to any Appointee who functions in an official capacity within the Hospital so as to have a legitimate interest in them. When access is approved, it shall be afforded in a manner consistent with the confidentiality policies of the Hospital concerning Medical Staff minutes and activities. A permanent file of the minutes of each meeting shall be maintained.

SECTION 3.4 PARTICIPATION BY CHIEF OF STAFF

The Chief of Staff may attend any committee or Department meeting of the Medical Staff.

SECTION 3.5 VOTING AND MEETING OPTIONS

3.5.1. Voting. Unless otherwise specified in these Bylaws or Manuals, voting may occur in any of the following ways as determined by the Chair of the respective

committee/council; the Department Chair; or, for voting by the Medical Staff, as determined by the Chief of Staff:

(a) By hand or voice ballot at a meeting at which a quorum is present.

(b) By written ballot at a meeting at which a quorum is present.

(c) Without a meeting, by written ballot or electronic ballot provided such ballots are received prior to the deadline date set forth in the notice advising of the purpose for which the vote is to be taken.

(d) Absentee written ballot, provided the ballots are received prior to the deadline set forth in the notice advising of the purpose for which a vote is to be taken.

3.5.2. Meeting Options. Unless otherwise specified in the Bylaws or Manuals, Practitioners may participate in and act at any meeting by conference call or other communication equipment through which all persons participating in the meeting can communicate with each other. Participation by such means shall constitute attendance and presence in person at the meeting.

ARTICLE 4 RULES AND REGULATIONS

SECTION 4.1 OUTPATIENT (AMBULATORY), OBSERVATION AND ADMISSION STATUS

4.1.1 Provisional Diagnosis and Status: No patient shall be admitted to the Hospital until a provisional diagnosis has been documented in the medical record and an admission order from the admitting Practitioner (or his/her alternate) secured. Justification for the assignment of status shall reflect Medical Staff approved criteria.

4.1.2 Patients: The Hospital shall accept patients suffering from all types of diseases except those whose medical needs are beyond the scope of care provided at the Hospital. Patients presenting to the Hospital for treatment outside the Hospital's scope of service will be stabilized and transferred to another appropriate health care entity.

4.1.3 Protection of Other Persons: Practitioners admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients and personnel from those who are a source of danger from any cause whatever or to assure the protection of the patient from self-harm.

This Hospital has the obligation of minimizing the risk of hazards and safeguarding all patients, visitors, and personnel. Therefore, when any patient

whose mental or physical condition causes him/her to be disturbing and/or unsafe to himself/herself, other patients, and personnel of this Hospital, the patient may be transferred to a private room. This transfer will be discussed with and approved by the attending Practitioner. In case of disagreement, the appropriate Service Chief will be contacted and, if a mutual decision with the attending Practitioner cannot be reached, a Medical Staff officer shall be consulted to make a final disposition.

4.1.4 Transfer of Service: Patient transfer from the admitting Practitioner's care to another Practitioner is arranged by agreement of the current attending Practitioner and receiving Practitioner whether the transfer is requested by the patient or patient's appropriate legal representative or by the attending Practitioner.

To complete a patient transfer of service, the attending Practitioner must order a transfer of service with appropriate documentation of reasons for transfer in the Practitioner's progress notes. In addition, the receiving Practitioner must document acceptance of the patient transfer in the receiving Practitioner's progress notes and orders.

Assignment of Cases:

1. Unattached patients shall be attended by Practitioners with appropriate Privileges and shall be assigned by the Department concerned in the treatment of the disease that necessitated admission.

2. It is expected that private patients shall be attended by their own Practitioner. All Practitioners with Clinical Privileges are required to provide continuity of care to all patients in their practice for whom they are responsible, and to provide care that is effective, safe, patient and family centered, efficient, timely, and within the parameters of granted Privileges. In the event that a Practitioner plans to be away from the Hospital for a scheduled absence (e.g. vacation or absences for personal reasons but not including a leave of absence as defined in the Credentials Policy Manual), the Practitioner must make adequate arrangements prior to departure for coverage of his/her private patients who are inpatients or who may present to the Emergency Department while the Practitioner is away on such planned absence. The Practitioner (unless in a group practice in which all Practitioners have common Privileges or in a designated call coverage group made known in advance to the Medical Staff Services Department) shall notify the Medical Staff Services Department and the Emergency Department of such period of scheduled absence, and shall identify the covering Practitioner. The covering Practitioner must have similar Privileges at the Hospital, have agreed in writing to provide the coverage, and be located within the Hospital's geographic service area close enough to provide timely care for the private Practitioner's inpatients and/or Emergency Department patients. If

the Practitioner is also scheduled to be on-call during the scheduled absence, he/she must also arrange for backup on-call coverage with another Practitioner who meets the above criteria, and must notify the Departments identified above and other Hospital areas/Departments as may be required in the Manuals and/or Medical Staff/Hospital policies.

In the case of a patient requiring admission who has no attending Practitioner on the Medical Staff and who does not elect or is unable to choose one, he/she shall be referred to the appropriate Department on-call Practitioner.

3. Practitioners to whom unattached patients are referred have a responsibility to provide care to the patient at least once for the problem for which the patient was referred, regardless of ability to pay, and to provide continued care or secure referral to another appropriate available care provider.

4. Practitioners who assume responsibility for unattached patients are expected to respond to a request from the Emergency Department to provide consultative or in-hospital care in a timely fashion to meet patient care needs.

5. All patients who are placed in a Hospital bed as an inpatient or in observation status are required to be seen by the admitting or consulting Practitioner (who is privileged to admit patients to the Hospital) in a timely fashion with documentation of that visit in the medical record. Medicare patients must be under the care of a MD/DO.

   Patients transferred or admitted to an ICU shall be seen by the attending or consulting Physician within a time frame consistent with the clinical condition of the patient, usually no longer than twelve (12) hours.

   Patients placed in a non-ICU bed as an outpatient (ambulatory), observation status or admission, shall be seen by the admitting or consulting Practitioner within a time frame consistent with the clinical condition of the patient, but within twenty-four (24) hours.

   All patients, require daily patient visits by the attending Practitioner or his/her covering Practitioner. These visits must be documented in the patient's progress notes as a part of usual care. Medical student progress notes will not be a part of the medical record until they are signed by a supervising resident or Practitioner. To provide appropriate continuity of care for patients who are hospitalized by Practitioners other than the patient's primary care Practitioner, the attending Practitioner is responsible to communicate, when appropriate, with the primary care Practitioner regarding the patient's Hospital course and the plan of care post-hospitalization.

SECTION 4.2 PATIENT SAFETY

The Hospital and its Medical Staff have a responsibility to promote patient safety and medical error reduction. This is accomplished through the identification and prevention of medical errors through the prospective analysis and re-design of vulnerable patient systems, the promotion of a culture of non-punitive reporting, and the responsibility to tell a patient if he/she has been harmed by the care provided. Each Practitioner is expected to participate in the patient safety program at the Hospital by actively supporting and following the Hospital policies and procedures related to providing safe medical care, including the Hospital's Patient Safety Performance Improvement initiatives and informing patients and their families about unanticipated outcomes of care.

SECTION 4.3 UTILIZATION

The history and physical and progress notes must document the patient's clinical course in sufficient detail to provide a reasonable understanding of the patient's evolving condition, diagnoses, treatment, and plan of care. In addition, the notes must provide sufficient information regarding the severity of illness and/or intensity of service that requires continued use of Hospital resources. The medical history and physical examination requires a co-signature in all circumstances when not completed by a Physician or other appropriately qualified and licensed individual as permitted by clinical privileges in compliance with then-current accreditation standards, federal and state law, and Medical Staff/Hospital policies. An Emergency Department evaluation may be accepted as a history and physical examination for purpose of emergency procedures provided that the entry documenting and examination is complete, including any changes in the patient’s condition and all must be co-signed.

Practitioners are required to provide appropriate diagnoses or clinical indications to justify diagnostic tests and therapeutic interventions performed by Hospital Departments.

Admissions prior to the day of surgery will be permitted if the medical condition warrants Hospital admission criteria. If prior approval for non-emergency surgery or admission is required by the payor, the Practitioner is responsible (whenever possible) for obtaining such approval prior to surgery or admission.

If approval for performance of any non-emergency procedures is required by the third party payor, such approval must be obtained prior to performance of that procedure.

It is the Practitioner's responsibility to abide by the stipulations made by the payor for patient services as long as these requirements are consistent with the Bylaws and Manuals of the Medical Staff and consistent with appropriate standards of care.

Periodic review of the appropriateness of patient care may be made by the Hospital's Clinical Quality Department. Deviations from Medical Staff approved criteria will be referred to the appropriate utilization reviewer.

SECTION 4.4 PEER REVIEW

The peer review function for Practitioners and APPs with delineated Clinical Privileges will be performed with intention to safeguard Practitioner confidentiality to the greatest extent and to promote objective and unbiased considerations. The purpose of all peer review is to promote excellent clinical outcomes and the safety of patients and staff. Peer review is to be done with the intention to identify and improve processes which may impair the ideal delivery of clinical care. Its intent is performance improvement and not indictment of individuals. Issues of disruptive behavior are not addressed via peer review (refer to Disruptive Practitioner Section of this Manual). Peer review is a necessary element of professionalism and all Practitioners and APPs are expected to actively participate in the process, when requested.

Situations may arise when practitioners outside of the Medical Staff may be asked to participate in the peer review process. In this event, the Practitioner subject to peer review will be apprised of this need and will be invited to nominate unbiased external Practitioners for consideration. The decision as to whether to utilize the services of any such nominated Practitioner will be at the committee's sole discretion. When a determination is made by the appointed peer review committee of a significant issue, the Practitioner will be given written notification by Special Notice within thirty (30) days.

If a subcommittee is appointed to investigate a peer review matter by the MEC or the Chief of Staff, the subcommittee members will follow the following guidelines:

1. Any predetermined review by which criteria are established to evaluate a diagnosis, treatment outcome, procedure or other parameter must not be exclusively directed at one (1) Practitioner and should include all Practitioners involved in the same. This procedure does not preclude an investigation of an individual Practitioner based upon a specific complaint.

2. Once the initial chart review indicates further inquiry is necessary, the Practitioner involved should be notified in writing, by Special Notice, that a review will take place.

3. The Medical Executive Committee will maintain a file for each investigation containing the written complaint, if any, and all relevant correspondence, clinical records, and committee minutes. The Practitioner who is the subject of investigation will be provided with a summary of the complaint and the nature of the supporting evidence. The file documents are confidential and are protected peer review documents.

4. Minutes shall be maintained by the investigating committee and shall identify any deviation from the appropriate standard of care or violation of Hospital and/or Medical Staff Bylaws, Manuals, policies, rules, and/or regulations. When such is the case, the Practitioner will be notified by Special Notice, and asked to respond. When a Practitioner's response

satisfies the committee or if, for other reasons, the committee feels that no action is appropriate, the investigation will be terminated with a positive comment and an appropriate letter shall be sent by Special Notice to the Practitioner.

5. When the investigation reveals a significant deviation or violation as aforementioned; or, if for other reasons the investigating committee feels that further action is necessary, the affected Practitioner shall be invited to meet with the committee to discuss the case(s). The Chair of the committee shall make efforts to see that each member of the committee reviews the complete file so they are well informed before the meeting. This shall include comparing any internal reviewer's report with any patient charts in question. If the matter is resolved at this level, the review will be terminated with a positive comment and a letter to that effect shall be sent by Special Notice to the Practitioner.

6. If the majority of the committee is still not satisfied after meeting with the Practitioner, it can refer the matter and the complete file back to the Medical Executive Committee with or without recommendation. The Medical Executive Committee will act at that point, based on the recommendation, or otherwise send the file to an outside reviewer. External peer review shall be initiated by request, if approved by the Medical Executive Committee, from any one of the following:

   Department Peer Review Committee Medical Executive Committee
   Department Chief
   Chairman of the Peer Review Committee Chief of Staff
   President of the Hospital
   Board of Directors

   Indications for an external review include, but are not limited to, the following:

   Ambiguity when dealing with vague or conflicting recommendations from committee review(s) where conclusions from the review could impact a Practitioner's appointment and/or Privileges.

   Lack of internal expertise, when no one on the Medical Staff has adequate expertise in the clinical procedure or area under review.

   When the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credentials file, or for assistance in developing a benchmark for quality monitoring.

   To promote impartiality in peer review.

   In any other circumstance deemed appropriate by the MEC or the Board.

In the event of an external review, and provided the MEC is satisfied with the external reviewer's findings, the MEC may terminate the review with a positive comment. In such case, an appropriate letter shall be sent by Special Notice to the Practitioner (unless the Board has required such review in which event the Board will act on the external reviewer's report). If not satisfied with the external review or if the external review raises quality of care concerns, the MEC will decide on an appropriate action as set forth in the Bylaws and make its recommendation to the Board for final action.

Cases presented to committee will be reviewed and a type assignment/variance will be assigned in one of the following categories:

No quality variance: Care rendered was appropriate, however, cases may still be tracked to determine and developing trends.

Major variance from expected practice: care rendered is deemed to be substantially outside of benchmarks/established standards/standard of care.

Minor variance from expected practice: Care rendered is deemed to be outside of benchmarks/established standards/standard of care, however, the variance was minor or standards of care for the case are controversial.

Type/Variance Levels assigned to physicians are totaled on a rolling 12 month basis.

If 3 or more total minor plus major variances occur in a rolling 12 month period then that provider/physician is notified and is brought up for review by the executive CQRC committee (which consists of the CQRC chair, vice president medical affairs/chief medical officer, chief quality officer, department chair, vice president of medical affairs, and the COS). The executive review committee may recommend a focused professional practice evaluation (FPPE) for that provider.

Identification of potential minor variance issues may be from case managers, health information services personnel, Medical Director of Quality, Vice President Medical Affairs/Chief Medical Officer, or by a member of the Medical Executive Committee.

Identification of potential minor variance or major variance issues may arise from any of the following: complaints by patients, written complaints by Hospital or Medical Staff, routine chart and outcome reviews by Hospital's Quality Department, routine chart review by appropriate Hospital staff and/or committees, routine review of clinical outcomes and documentation statistics, or by focused professional practice evaluation as

requested by a Department Chief, the Medical Executive Committee, or the Professional Practice Committee of the Board.

A Practitioner who has received a minor variance or major variance determination will be notified in writing by Special Notice and given the opportunity to appeal the decision. This appeal may be in writing or in person. Appeals shall be directed to the Chair of the peer review committee, the Department Chief, or the Chief of Staff.

The aggregate data from minor variance or major variance issues will be reviewed as indicated and during the biennial reappointment/regrant of Privileges and recredentialing process of the Medical Staff.

SECTION 4.5 ORDERS

4.5.1. Admission Orders. Any practitioner with appropriate clinical privileges at our facility may give orders for inpatients in their care or for provision of the outpatient services where provided. This includes physicians, dentists, podiatrists, APP's and other practitioners authorized by the governing body to request such services.

Outpatient orders may be accepted from licensed practitioners no on staff at the hospital for tests within the scope of their practice. If necessary, the Medical Staff Office can be asked to review unknown providers to verify CMS participation and licensure.

For outpatient testing requests that involve procedures which pose some immediate risk to the patient, a provider with privileges at our facility is required. If the ordering provider does not have privileges at the Hospital that provider must find an Active Medical Staff physician who will take the responsibility of the patient. We encourage providers who refer to our facility regularly to apply for refer and follow privileges without the responsibilities of regular membership.

Orders for outpatient services (as well as patient referrals for hospital outpatient services) may be made by any practitioner who satisfies the Hospital's written policy for ordering certain or all types of outpatient services and for referring patients for such applicable Hospital outpatient services, so long as such policy has been authorized by the particular Hospital's Medical Staff, approved by the Board, and complies with applicable Medicare Conditions of Participation and accreditation standards requiring that any such practitioner must be:

(a) Responsible for the care of the patient;

(b) Licensed in, or holds a license recognized in the jurisdiction where he/she sees the patient; and

(c) Acting within his/her scope of practice under State law.

Such policy may include both Practitioners who are on the Hospital Medical Staff and who hold Privileges that include ordering the services, as well as other practitioners who are unaffiliated with and/or are not on the Hospital Medical Staff, but who satisfy the particular Hospital's policies for ordering applicable outpatient services and for referring for Hospital outpatient services.

Hospital personnel may accept such orders within the scope of their licensure, certification, or registration.

4.5.2. Written Orders. All orders for diagnostic procedures, treatment, or medication shall be in writing or directly entered into the electronic medical record or physician order entry system. All orders, including telephone and verbal orders, must be dated, timed and authenticated within forty-eight (48) hours by the ordering Practitioner or another Practitioner responsible for the care of the patient.

4.5.3. Telephone and Verbal Orders. Telephone and verbal orders shall be accepted, recorded, and carried out when dictated to Hospital personnel within the scope of their licensure, certification, or registration. Telephone and verbal orders are to be written down by authorized Hospital staff and then read back to the ordering Practitioner (except in an emergency or during a procedure when repeating back the order is adequate). Documentation of verbal orders includes the time the verbal order was received; and the date and names of individuals who gave, received, recorded, and implemented the orders.

4.5.4. Telefaxed Orders. Telefaxed orders may be accepted if the telefax is signed by the ordering Practitioner, and the sending telefax site is identified.

Orders may be accepted via email or two-way pager services if sent through a Hospital-approved site or another secure site, and the ordering Practitioner is clearly identified. Orders received from Practitioners via any of the above means will be transcribed into the record and dated, timed, and authenticated by signature or electronic verification.

For purposes of this 4.5, the term Practitioner includes an APP with Privileges.

SECTION 4.6 RECORDS

4.6.1. Content, Review and Evaluation

(a) Content: The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. A complete medical record of a patient in admission, observation, or ambulatory status shall, as applicable, include identification data; chief complaint(s); history of present illness; relevant past history; social history; family history;

review of systems; relevant physical examination; admitting/provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; multidisciplinary notes and flow sheets; medication administration records; special reports such as consultations, clinical laboratory reports, radiology/imaging reports, and a discharge summary including outcome of hospitalization, discharge./final diagnoses, disposition of the case, and provisions for follow-up care. The record must also reflect evidence of appropriate findings by clinical and other staff involved in the care of the patient; documentation of complications, hospital- acquired infections, and unfavorable reactions to drugs and anesthesia; properly executed informed consent forms; all Practitioners'/APPs' orders; nursing notes; reports of treatment; medication records; vital signs, and other information necessary to monitor the patient's condition.

(b) Legibility: Practitioners and APPs have a responsibility to make legible entries into the medical record. The Medical Staff has a legibility policy to assure all individuals having access to patient medical records can read information contained within the medical record. Non-compliance may result in progressive corrective action including notification, education (including possible remedial handwriting programs), suspension(s), or termination for incomplete medical records.

(c) Non-Medical Comments: Criticism, impertinent and inappropriate comments, drawings or language, or personal attacks against Practitioners/APPs, Hospital personnel, or the Hospital and its policies shall not appear in the medical record. Any alleged violation of this rule shall be referred to the Chief of Staff and/or the Vice President of Medical Affairs/ CMO for interpretation, judgment, and action. If warranted, they may refer the incident to the Medical Executive Committee for review and recommendation.

(d) History and Physical: A current complete history and physical examination (H&P) consists of the following required elements: chief complaint, history of present illness, relevant past history, social history, family history, review of systems, relevant physical examination, impression, and plan of care. For those patients for whom a surgery/procedure is to be performed, the H&P must include indications for the surgery/procedure as documented by the Practitioner performing the procedure. A complete H&P, documented for each patient no more than 30 days prior to hospital admission or registration, and any updates thereto, shall be placed on the patient's chart within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

An Emergency Room provider note is not considered an “H&P”.

An osteopathic musculoskeletal examination is required as an integral part of the history and physical performed by osteopathic physician on their admitted patients unless contraindicated. The reason for omitting the musculoskeletal examination is documented in those cases where this examination is contraindicated.

The H&P records are the responsibility of the attending Practitioner. H&Ps shall be properly documented, authenticated, dated, and timed. Medical student H&P's will not be part of the medical record unless they are written and signed by a supervising resident or the attending Practitioner. Medical student dictation will not be transcribed by the Hospital.

The H&P must be completed and documented by one of the following:

Doctor of allopathy or osteopathy

Doctor of podiatric medicine (in accordance with State law and as indicated in the Credentials Policy Manual)

Doctor of dental surgery or of dental medicine (in accordance with State law and as indicated in the Credentials Policy Manual)

Physician Assistants (if privileged to do so by the Hospital and in accordance with State law)

Advanced Practice Nurses (if privileged to do so by the Hospital and in accordance with State law)

NOTE: H&P's completed and documented by PAs and APNs must be authenticated by the attending Practitioner.

Should the H&P be provided by a practitioner without Privileges at the Hospital (e.g., patient's primary care practitioner), then an update meeting the required contents of the H&P as defined in this section must be completed and documented by a Practitioner who is privileged in accordance with the Medical Staff Bylaws and Manuals.

When an H&P is completed within the 30 days before admission or registration, an updated medical record entry is required. The update, if any, shall indicate the following: the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed. Any changes in the patient's condition must be documented in the update note and placed in the patient's medical record within twenty-four (24) hours of admission or registration, but prior to surgery or a procedure requiring anesthesia.

If the Practitioner finds that the H&P done before admission is incomplete, inaccurate, or otherwise unacceptable, the Practitioner reviewing the H&P,

examining the patient and completing the update may disregard the existing H&P and conduct and document in the medical record a new H&P within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia.

(e) Ambulatory/Outpatient H&P

Ambulatory patients who are undergoing procedures not requiring moderate sedation or anesthesia do not require a complete H&P on the chart. Only a pertinent note concerning the nature of the disease process leading to the procedure and the intended procedure is necessary in these cases. Other pertinent positive findings, such as drug allergies and serious pre-existing disease entities, should also be noted.

(f) Anesthesia/Procedural Sedation: Outpatients who are undergoing surgery or procedures under any anesthesia or moderate sedation (except local anesthesia) require an H&P.

(g) Pre-Operative/Pre-procedure Record: Except in an emergency situation, patients shall not be taken to the operating/procedure room unless the medical record contains a signed and witnessed informed consent form, a plan of care for the surgery/procedure and anesthesia/procedural sedation, and an acceptable current H&P. In emergency conditions, an acceptable H&P may be limited to major significant conditions requiring the immediate surgery/procedure. Surgery/procedure time may be forfeited on the authority of the multi-disciplinary surgery oversight committee (as outlined in the Operating/Procedure Room Policy, as such policy may be amended from time to time) when the start of the operation/procedure is delayed for more than fifteen (15) minutes.

(h) Pre-Operative Attestation Informed Consent: To assist the patient in providing informed consent, the Practitioner performing the surgery or procedures shall provide a plan of care for the patient including informing the patient and/or legal representative(s) regarding the need for, benefits, alternative options, risks, and potential complications associated with the surgery/procedure.

To assist the patient in providing informed consent, the Practitioner responsible for managing the patient's care, treatment, and services shall ensure that the patient and/or legal representative(s) is informed of the potential benefits, risks, and side effects of the patient's proposed care, treatment, and services, the likelihood of the patient achieving his or her goals, and any potential problems that might occur during recuperation. This informed consent process includes a discussion about reasonable alternatives to the patient's proposed care, treatment and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care,

treatment and services. Risks and benefits associated with blood transfusion, when blood or blood components may be needed with an operative procedure, are also discussed. Documentation of risks, benefits, and alternatives must be present in the patient record. The Hospital's Informed Consent Policy, as such policy may be amended from time to time, outlines the details of the informed consent process.

To assist the patient in providing informed consent, the Practitioner or CRNA providing anesthesia or procedural sedation shall provide an anesthesia or procedural sedation plan of care including documenting the patient's American Society of Anesthesiology ("ASA") classification and informing the patient and/or legal representative(s) of the need for, benefits, alternative options, risks, and potential complications associated with anesthesia or procedural sedation prior to administration of pre-operative medication.

d. Anesthesia Documentation: A pre-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia services.

An intra-operative anesthesia record shall be maintained.

A post-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia no later than forty-eight (48) hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery is completed in accordance with State law and regulation and Hospital policies and procedures that have been approved by the Medical Staff and that reflect current standards of anesthesia care Surgical Record: All operations or procedures performed in the Hospital shall be described in full through immediate dictation or by a hand-written report. The operative report must be in sufficient detail to provide necessary clinical and billing information, must be entered immediately into the patient's medical record upon completion of the operative or high-risk procedure and before the patient is transferred to the next level of care (unless an immediate progress note is entered—see below) and must include the following elements:

Name and hospital identification number of the patient.

Date/time of surgery.

Names(s) of the Practitioner(s) who performed the procedure and his/her assistant(s) (even when performing those tasks under supervision).

Name of the procedure.

Findings of the procedure (including complications, if any).

Description of the procedure/techniques (including the type of anesthesia administered).

Any estimated blood loss.

Any specimens/tissues removed or altered.

Pre-operative diagnosis.

Postoperative diagnosis.

Description of the specific significant surgical tasks that were conducted by Practitioners other than the primary Practitioner. Significant surgical procedures include prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

The report/note must be dated, timed, and signed by the Practitioner who performed the surgery/high risk procedure when the original or a hard copy of the full operative report is not placed in the medical record immediately after surgery or procedure, a progress note of the operation or procedure must be entered immediately. This immediate postoperative/procedure note, completed before the patient is transferred to the next level of care, includes the same elements outlined above.

All tissues and foreign material that are surgically removed must be processed in accordance with Hospital policy.

4.6.2. Daily Progress Notes

Progress notes must be documented in the record daily that justify hospital stay, describe significant changes in condition and delineate the plan of care. The daily note is a responsibility of the attending provider and fulfills the requirement that the physician see the patient daily. Notes may be provided by physician extenders but must be authenticated by the physician and do not substitute for the requirement that the attending physician see the patient each hospital day.

4.6.3 Discharge Summary

To facilitate continuity of care, a discharge summary must be included in the medical record containing, at a minimum, the reasons for and outcome of hospitalization; significant findings procedures performed and care, treatment, and services rendered; the final diagnoses; the patient's condition and disposition at discharge; instructions to the patient and/or legal representative(s); and provisions for follow-up care. Also, the discharge summary must be completed within 7 days of discharge.

For normal newborns, uncomplicated deliveries, or patients who's admitted Hospital stay is less than forty-eight (48) hours with uncomplicated care, a discharge progress note that includes the outcome of hospitalization, the patient's condition at discharge/disposition of the case, discharge instructions, and provisions for follow up care, may be substituted for a discharge summary. A discharge progress note may also be used to satisfy the discharge summary requirements for the initial hospitalization when a patient is transferred to another KHN Network facility.

Any multi-service patient (one (1) whose medical care is provided by more than one (1) specialist or attending Practitioner) shall have a single discharge summary that includes all areas of care. The attending Practitioner will be responsible for the discharge summary.

4.6.4 Completion of Records - Requirements:

(a) An H&P, discharge summary, consultation, and operative/procedure note shall be authenticated with a handwritten or electronic signature as well as timed and dated. Rubber stamp signatures are not acceptable for authentication. Electronic, verbal or telephone orders must be authenticated within forty-eight (48) hours.

(b) Charts must be accurately and legibly completed within twenty-one (21) days from allocation date. Charts are complete only after dictated reports and required entries are signed, dated, and timed within required timeframes; merely dictating before the deadline is not sufficient. Charts may be identified as incomplete prior to discharge if required elements are not performed as mandated by the stricter rules set forth in the Manuals, Hospital policy, or accrediting and/or regulatory standards/requirements. Examples of such incomplete records include lack of an immediate post-operative note and failure to authenticate electronic, verbal, or telephone orders within forty-eight (48) hours. A reminder notification will be electronically sent to the practitioner/Allied Health Practitioner at twenty-three (23) days.

(c) Notification of suspension of Privileges for incomplete or delinquent medical records will be given to the Practitioner/APP either verbally, by Special Notice, or by receipted facsimile. For records that are not able to be completed within the twenty-one (21) day period due to extenuating circumstances (e.g. illness, vacation) a prior waiver with time extension may be requested from the officers listed below.

(d) Automatic suspension of Privileges for incomplete or delinquent medical records results in the affected Practitioner not being able to admit or write orders for new patients, but it does not in any way remove the Practitioner's responsibilities for call coverage, for patients already under

his/her care in the Hospital, or for the provision of services that have been scheduled prior to the suspension and that cannot be appropriately rescheduled.

(e) Suspension of Practitioners who supervise APPs may result in the APP's Privileges being suspended as well if the APP has no other collaborating or supervising Practitioners.

(f) Any Practitioner/APP whose Privileges have been suspended because of incomplete or delinquent records, or portions thereof, may, in the event of unusual or extenuating circumstances, obtain authority to care for or admit a specific patient from the Chief of Staff, Chief of Staff-Elect, Immediate Past Chief of Staff/Credentials Chairman, Secretary/Treasurer, or the Vice President Medical Affairs/CMO. The approving officer and Practitioner shall both notify the Admissions Office of the nature of the special circumstances prior to the admission of the patient. For removal of the suspension prior to curing medical records deficiencies, Practitioners may submit a plan of compliance and petition for restoration to one of the above officers. Upon approval of the plan, the approving individual will contact the Health Information Management Department to restore such Practitioner's Privileges.

(g) Practitioners will be assessed a fine of $500.00 in addition to the imposition of an automatic suspension in the following cases: (i) A Practitioner who has received three (3) suspension letters during any consecutive twelve (12) month period and who subsequently has incomplete or delinquent medical records; or (ii) a Practitioner who has been under suspension for two (2) consecutive weeks without an excused waiver. Reinstatement of Privileges cannot occur until the Practitioner completes all delinquent and incomplete records and pays the fine to the Medical Staff Services Department.

If Privileges are reinstated, any single subsequent delinquency or failure to complete the medical records as required during the same consecutive twelve (12) month period will result in a fine of $1000.00 and an automatic suspension. In addition, the Practitioner will be required to present an acceptable corrective action plan, in person, to the Medical Executive Committee.

If Privileges are reinstated, any subsequent noncompliance with medical record requirements in the same consecutive twelve (12) month period will result in immediate termination of both Medical Staff appointment and Clinical Privileges. Notice of such termination will be sent by Special Notice, and reasonable attempts will be made to contact the Practitioner personally. Signature of receipt of the notice or documentation of the date of the personal contact will constitute completion of the notification process. A Practitioner who is so terminated will not be entitled to any

procedural due process rights as set forth in the Bylaws and will need to reapply to the Medical Staff for appointment and Clinical Privileges. The Practitioner may reapply at any time but, when so doing, will be treated as an initial applicant.

For patient safety reasons, and in order to not jeopardize the continuity of patient care, in the event of such imminent automatic termination, the Chief of Staff may intervene to permit the Practitioner to have a limited extension of Privileges restricted to caring for currently hospitalized patients and for patients previously scheduled for procedures or admission. Following the discharge of the last patient, the automatic termination will take effect.

(h) Practitioners who resign while under automatic suspension will be designated as "Resigned: NOT in Good Standing" status and will be so reported by the Medical Staff Services Department in any future queries to the Medical Staff regarding status.

(i) A suspension for failure to complete medical records lasting thirty-one (31) days or more may be reportable to the National Practitioner Data Bank and the State licensing board if such failure is determined through a Professional Review Action based upon professional competence or conduct that adversely affects or could adversely affect a patient's health or welfare.

4.6.5. Chart Review: Department Chiefs who are assigned utilization or quality issues for review will have charts made available to them. These charts shall be reviewed in a timely fashion and will be subject to addition to the Practitioner's incomplete medical record profile.

4.6.6. Denial Appeals Process: A Practitioner may appeal a third-party payor denial of payment for services rendered at the Hospital when, in the Practitioner's opinion, such services were medically necessary. It is preferable that these appeals occur while the patient is in- house or immediately following discharge. These appeals may be performed through direct verbal/written communication with the payer's medical director or through appropriate documentation in the medical record. Requests for appeals of denials post discharge will be placed in the medical record and will be a component of a Practitioner's incomplete medical records profile.

4.6.7. Ownership: All records, including medical images, are the property of the Hospital. Copies of the medical record may be removed from the Hospital's jurisdiction and safekeeping only in accordance with patient authorization, a court order/subpoena signed by a judge, or federal/state statute. In the case of readmission of a patient, all available records shall be provided, if requested, for the use of the attending Practitioner, whether the patient is being attended by the same Practitioner or another.

4.6.8 Access to Records: Access to medical records shall be afforded to Appointees in Good Standing for bona fide study and research (with appropriate Institutional Review Board ("IRB") authority) consistent with preserving confidentiality of personal information concerning individual patients. Subject to the discretion of the President/CEO, former Appointees shall be permitted free access to information from the medical records of their patients covering all periods in which they attended such patients in the Hospital. Review of medical records is limited to Medical Staff and Hospital professionals who are responsible for providing care to the patient. Practitioners performing peer review and utilization functions may review any chart assigned for review. Practitioners who have the permission of the attending Practitioner and the patient or patient's legal representative may review the medical record of a currently hospitalized patient. Practitioners not on the Medical Staff, with the permission of the attending Practitioner or his/her designee and with permission of the patient or patient's legal representative, may review the medical record of a currently hospitalized patient.

4.6.9 Electronic Medical Records and Other Clinical Documentation (EMR)

(a) All Practitioners/APPs who seek privileges for patient care activities at the time of initial Hospital appointment are required to complete training sessions on the use of the Hospital’s EMR system (currently EPIC, or its successor) for electronic medical record entry and other applicable clinical documentation that is available from time to time, and must provide appropriate documentation of successful completion of such training to Medical Staff Services prior to the initiation of any clinical activities.

(b) All Practitioners/APPs who provide ongoing patient care activities are expected to maintain current competencies in the use of the Hospital’s then-current EMR system applications as required to utilize the EMR for computerized order entry and all other applicable clinical documentation.

(c) Non-compliance with these requirements can result in suspension of patient care activities, including elective admissions, outpatient care activities, and non-emergency surgical cases.

(d) Enforcement of these requirements is the joint responsibility of the Chief of Staff and the Vice President of Medical Affairs/Chief Medical Officer. Hospital privileges will be reinstated upon documentation that the Practitioner/APP has agreed to utilize the EMR for all applicable patient care activities, including an agreed-upon plan to complete (and proof of successful completion) any necessary remedial training within a specified time period.

SECTION 4.7 CONSULTATION

The responsibility for patient care rests with the attending Practitioner but consultation is recommended when there is a reasonable doubt as to the diagnosis and/or treatment. Consultation is required when the patient needs care that is beyond the scope of the attending Practitioner's Privileges. If the attending physician and the consultant disagree on management of a patient, a second opinion must be ordered.

Appointees are expected to respond to requests for consultations in a timely fashion that meets patient care demands and the need for appropriate utilization of services. The Appointee requesting consultation will be responsible for providing appropriate clinical information and time-to-response expectations on the order sheet. Guidelines for time-to-response expectations are as follows:

- Emergent consultations: 30-60 minutes (e.g., immediate threat to life, limb or body organ).
- Urgent consultations: 4 hours (e.g., impending threat to life, limb or body organ).
- Routine consultations: 24 hours.

Practitioner to Practitioner contact is the preferred way of initiating all consultations but is required for emergent and urgent consultations.

Consultation with other Practitioners shall be sought as appropriate in order to provide the best possible care for the Hospital's patients. If circumstances are such as to render consultation undesirable or unnecessary, consultation shall not be performed and the reasons thereof shall be communicated with the Practitioner requesting the consult.

Hospital patients with substance abuse issues are encouraged to be referred to or consulted by a Practitioner with substance abuse expertise or referred to an external community based substance abuse service.

The consultant must be Practitioner well qualified to give an opinion in the field in which his/her opinion is sought. Privileges in the field concerned are the usual accepted evidence of qualifications.

A satisfactory consultation includes examination of the patient, review of the chart, and a written report of the findings and recommendations signed, dated, and timed by the consultant which is made a part of the record. Pre-surgical consultation reports, at least in brief form, shall be recorded prior to the operation.

In circumstances of grave urgency or when consultation is required by this Manual, the President/CEO shall, at all times, have the right to call in a consultant after conference with the Chief of Staff or an available member of the Medical Executive Committee.

SECTION 4.8 DISCHARGE

Patients shall be discharged only by order of the attending Practitioner or his/her covering Practitioner. APPs may discharge patients per the order of the attending physician.

SECTION 4.9 BASIC RULES FOR THE USE OF HOSPITAL FACILITIES

The exercise of Privileges is contingent upon the Practitioner/APP abiding by the Bylaws, Manuals, all applicable policies, and compliance with accreditation and regulatory requirements. Failure to do so may subject the Practitioner to corrective action in accordance with the process set forth in the Medical Staff Bylaws and Manuals.

SECTION 4.10 EMERGENCY DEPARTMENT ON-CALL PHYSICIANS

Appointees have an obligation to work with the Hospital administration to provide coverage of Emergency Medical Conditions arising within or presenting to the Hospital as required by law. The Emergency On-Call list is developed by the Medical Staff Services Department in conjunction with Hospital administration. Providers may be on-call at multiple KHN Network hospitals as long as there are plans to provide alternate coverage should more than one (1) hospital require emergent services at one time.

The Emergency On-Call list is intended to provide urgent and emergent consultation to patients either seeking care in the ED or within the Hospital and its affiliated units. The call lists will be available on the Hospital Intranet.

If there are discrepancies, administrative, or reimbursement concerns, it is the responsibility of the currently listed on call Practitioner to see to the emergent needs of the patient first and to deal with the non-clinical issues secondarily. If an on call Practitioner is unavailable for duty on the day that he/she is specified for call, it is the Practitioner's responsibility to find and report to the Medical Staff Services Department and/or the Emergency Department, a suitable on-call replacement Practitioner.

On-Call Practitioners must respond to emergency requests for evaluation in a timely fashion and provide stabilization and/or emergent definitive treatment as requested by the consulting Practitioner without regard to insurance status or payment capability. Emergency patients referred to a provider in the outpatient setting will also receive initial stabilizing care without regard to immediate payment capability.

If stabilization and/or definitive treatment of the patient's medical condition is not available within the current capabilities of the Hospital, the patient may be transferred to an appropriate facility upon certification by a Practitioner that the medical benefits of the transfer outweigh the risks and that the transfer is in the best interest of the patient.

An on-call Practitioner may not request that a patient be transferred to a second hospital for the Practitioner's convenience. In the circumstance where needed services exist at

the Hospital, a patient or patient's legal representative may still request a transfer to another hospital. In such event, transfer may occur only when that hospital has verified availability of services and an accepting Practitioner has been established. This process must be clearly documented in the medical record and on the appropriate COBRA transfer form.

SECTION 4.11 SOURCES OF PATIENT CARE PROVIDED OUTSIDE THE HOSPITAL

Hospital administration will seek input from the Medical Executive Committee regarding contractual sources of patient care provided by entities outside of the Hospital.

Written agreements should include at least the following:

(a) Nature and scope of patient care being provided.

(b) That such care must be provided in a timely fashion and consistent performance of patient care processes according to appropriate accreditation standards.

(c) That all Practitioners/APPs who will be providing patient care, treatment, and services pursuant to such contract must be appropriately credentials/privileged to do so.

(d) That the contracted organization will ensure that all contracted services provided by the Practitioners/APP will be within the scope of their Privileges/scope of practice.

SECTION 4.12 CONDUCT

Unprofessional and unethical conduct and the violation of this Organizational Manual or Hospital policy may be grounds for corrective action.

All Practitioners are required to abide by the Network’s Code of Conduct Policy and the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal Health Insurance Portability and Accountability Act of 1996 regulations.

It is the desired culture of the Medical Staff that all Practitioners and APPs conduct themselves in a professional manner at all times that promotes patient safety and the delivery of competent, quality care; that foster a congenial working environment; and that does not disrupt the operations of the Hospital.

Violations in conduct will be evaluated and acted upon as delineated in the Bylaws.

SECTION 4.13 DISRUPTIVE PRACTITIONER/APP

The stated goal of the Medical Staff is to ensure professional behavior at all times that promotes patient safety and the delivery of competent quality care, fosters a congenial working environment, and does not disrupt the operations of the Hospital. Any and all reports of disruptive behavior are taken seriously.

Disruptive behavior within the Hospital will be addressed in accordance with policies that are similar in goals for both Hospital employees and Practitioners/APPs. It is the intention of the Hospital administration and the Medical Staff that these policies are enforced in a firm, fair, and equitable manner. Any form of retaliation against the person(s) bringing complaint will not be tolerated.

Disruptive behavior by Practitioners/APPs will be dealt with by the Vice President Medical Affairs/ Chief Medical Officer, Department Chief, and/or Chief of Staff. The report of the behavior will be documented, the incident investigated, and appropriate actions will be taken. Collegial intervention is outlined in the Code of Conduct Policy, and the corrective action procedure is set forth in the Bylaws. Behavior that creates a risk for immediate harm may result in summary suspension of appointment and Privileges pending further investigation. As appropriate, the Vice President Medical Affairs/ Chief Medical Officer may choose to involve the Hospital executive team when disruptive behavior poses risk to the Hospital. Consultation with the Wellness Committee and outside resources may also be utilized.

SECTION 4.14 COPYING OF PRACTITIONER/APP PEER REVIEW FILES

All Medical Staff and APP peer review files are confidential including, but not limited to, the credentialing files and anything used in the credentialing process, committees, services, and Medical Staff meeting minutes, reports, and discussions and deliberations concerning this information. Such information shall be disclosed only to those persons and only for the purposes listed in the policy concerning Confidentiality of Practitioner/APP Records. Confidentiality must be maintained for subsequent use of the information, and it is the responsibility of the person requesting the information and anyone receiving the information.

SECTION 4.15 RAPE EXAMINATIONS

Rape examination is a formal legal collection of evidence when the allegation of sexual assault has occurred. Emergency Department Physicians and nurses are specifically trained in this procedure. Patients presenting to the Emergency Department from the outpatient environment or the inpatient setting with a request for rape examination will be evaluated, evidence collected, and medical treatment offered as dictated in the Emergency Department Policy Manual, as such Manual may be amended from time to time. If a Sexual Assault Nurse Examiner ("SANE") professional is available, the evidence collection and exam may be deferred to that person. Medical treatment of injury or infection is addressed by the Emergency Department Physician or may be assumed by the patient's private Physician in attendance at the time of the evaluation.

SECTION 4.16 RESTRAINTS OR SECLUSION

It is the desired culture of the Medical Staff to minimize the use of physical and chemical restraints with pro-active situation management. Should a need for short term restraint arise, the processes delineating their use are set forth in Network policy PC-KHN Restraints and Seclusions

SECTION 4.17 PRONOUNCEMENT OF DEATH

Only a licensed Physician may pronounce a patient dead in our hospitals. The Physician need not personally examine the body. A resident, nurse, paramedic, or other competent observer may report findings on the telephone for the Physician to make the death pronouncement. The Physician pronouncing the patient is responsible for completing the death/autopsy form on all Hospital deaths. The death certificate is a State form and must be signed by a fully licensed Physician or coroner. Ideally this should be a Physician with an established relationship with the patient or who is otherwise familiar with the patient's history. In general, this is the attending Physician for an admitted patient, the patient's primary Physician, or the Physician predominantly involved in the current care of the patient for outpatients.

Autopsies may be requested on admitted patients at the time of death by the attending physician or family for non-forensic purposes and as outlined in the facility autopsy policy. Autopsies are not performed at our facilities and are a contracted service. The Nursing Supervisor will assist the family in making arrangements at the families' expense after the proper consent from next of kin is obtained. At the time of disposition of the body, the hospital representative will request autopsy results be returned to the medical records department to be filed in the patient's final record.
The following deaths require reporting to the coroner: accidental deaths, homicidal deaths, suicidal deaths, occupational deaths; deaths while confined; therapeutic deaths; death during anesthesia induction or the immediate post-anesthesia period; death during or following diagnostic or therapeutic procedures; death due to administration of drug, vaccine or other substance; "medical malpractice"; abortion-related death; special circumstances ("delayed death"); any death about which there is doubt, question or suspicion; any unattended death at home or in a public or outdoor place. Any doubt regarding reportable cases should be referred to the coroner's office for clarification.

SECTION 4.18 USE OF INVESTIGATIONAL/EXPERIMENTAL DRUGS OR DEVICES

A Practitioner must obtain Kettering Health Network ("KHN") IRB approval prior to using any investigational/experimental drugs or devices for research studies or emergency use. Industry- sponsored research studies may be submitted to a Hospital-approved central IRB for review. All IRB submissions begin initially with the KHN Innovative Center who will assist with preparation and submission to the IRB. Investigational/experimental drugs or devices are defined as any non-FDA approved drug/device or a drug/device used in a research study. IRB approval is for protection of patients' rights and does not imply credentials beyond those approved by the Medical Staff and Board. Requests for Privileges to perform investigational procedures shall be processed through the Hospital's usual credentialing and privileging process.

The granting of Privileges for new procedures that are necessary to use investigational/experimental devices will follow the Medical Staff process for privileging described in the Credentials Policy Manual.

Research Studies: To obtain IRB approval of a research study of an investigational/experimental drug or device, contact KHN Innovative Center for assistance in preparing and submitting a protocol, informed consent form, and other required documents to the IRB Office for approval.

Emergency Use: Emergency use is defined as the use of an investigational/experimental drug or device on a human subject in a life-threatening situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval for its use. A written request, usually in letter form, that includes the risks, benefits, and consent, signed by the requesting Practitioner, stating the life-threatening situation or one-time need and, the absence of standard acceptable treatment, is submitted to the IRB Office with the assistance of the KHN Innovative Center. The IRB Chair or designee will review the request and approve or disapprove its use. In accordance with FDA Regulation 21 CFR 50.23 and CFR 56.104 (as that standard may be amended from time to time), the protocol and consent form are reviewed and approved by the IRB within five (5) working days of initial approval. The standard guidelines for obtaining informed consent apply.

Patients currently on research protocols from the Hospital or other institutions who are admitted, must follow Pharmacy Department Policy, as such policy may be amended from time to time, covering investigational drug procedures.

When the IRB receives a request from a Practitioner for an emergency use of an investigational/experimental drug or device, the IRB must examine each case to assure itself and the Hospital that the emergency use was justified and compliant with FDA regulations 21 CFR 50.23 and CFR 56.104, as that provision may be amended from time to time.

SECTION 4.19 CANCER STAGING

All newly diagnosed cancers will be staged by the managing Physician (defined as the treating Physician, usually the surgeon, medical oncologist, or radiation oncologist) using the American Joint Commission on Cancer-TMN staging format or a format approved by the KHN Network Cancer Committee. The staging will be entered on a form adopted by the Cancer Committee and the completion of the staging will be required to complete the medical record on the patient. Cases that cannot be staged will be so indicated on the staging form with a reason why it cannot be staged.

SECTION 4.20 FOCUSED PROFESSONAL PRACTICE EVALUATION

The focused evaluation of a physician of APP's competence in exercising a specific privilege. This process is implemented for all newly granted privileges (initial grants as

well as grants of additional privileges during the term of an existing grant period) and whenever a question arises regarding a physician or APP's ability to provide safe, quality care. This process is part of the Hospital's routine evaluation process and allows the Medical Staff to focus on a specific aspect of a physician of APP's performance.

SECTION 4.21 ONGOING PROFESSIONAL PRACTICE EVALUATION

The performance outcomes of each physician and APP holding clinical privileges shall be monitored per hospital policy on a routine basis to determine current competence relative to the clinical privileges held. Results of such evaluation shall be reported to the Medical Executive Committee on a routine basis with appropriate intervention occurring as needed.

ARTICLE 5 ADOPTION, AMENDMENT OR REPEAL

This Organization Manual may be adopted, amended, or repealed, in whole or in part, in accordance with the applicable provision set forth in the Medical Staff Bylaws.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee on September 13, 2018

Scott Arnold, MD

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Chief of Staff

Approved by the Board of Directors on November 08, 2018
after receipt of a recommendation by the Medical Executive Committee

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