MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF THE CHRIST HOSPITAL HEALTH NETWORK

MEDICAL STAFF ORGANIZATION MANUAL

Adopted: July 16, 2014

Last Revised: October 31, 2018

TABLE OF CONTENTS

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function under this Manual is to be carried out by a member of TCHHN Administration, by a Medical Staff Leader, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or TCHHN employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. The delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee is a record of the committee that is ultimately responsible for the review in a particular matter.

(2) When a Medical Staff Leader is unavailable or unable to perform an assigned function, a Medical Staff Officer may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

SERVICE LINES

2.A. SERVICE LINES

The Medical Staff shall be organized into the following service lines and specialty divisions:

HVSL

Cardiac Imaging

Cardiac Rehab

Cardiothoracic Surgery

Clinical Service

Electrophysiology

Heart Failure

Intervention/Cath Lab

Structural Heart

Vascular

Medicine (Comprehensive Integrated Medical Care)

Allergy & Immunology

Dermatology

Endocrinology

Emergency Medicine

Family Medicine

Gastroenterology

Geriatric Medicine

Hospital Medicine

Palliative Care

Infectious Disease

Internal Medicine

Nephrology

Neurology

Psychiatry

Pulmonary Disease

Rheumatology

Musculoskeletal

Neurosurgery

Orthopedics

Physical Medicine & Rehabilitation

Podiatry

Shoulder and Upper Extremity

Spine

Sports Medicine

Oncology

Hematology

Oncology

Radiation Oncology

Primary Care

Surgery (Specialized Surgical Services)

Anesthesiology

Colon/Rectal Surgery

General Dentistry/Oral and Maxillofacial Surgery

General Surgery

Ophthalmology

Otolaryngology

Pain Management

Pathology

Plastic Surgery

Radiology

Urology

Women's Health

Gynecologic Oncology

Maternal and Fetal Medicine

Obstetrics

Gynecology

Pediatrics

Reproductive Endocrinology

Urogynecology

2.B. FUNCTIONS AND RESPONSIBILITIES OF SERVICE LINES AND SERVICE LINE MEDICAL DIRECTORS

The functions and responsibilities of the service lines and Service Line Medical Directors are set forth in Article 4 of the Medical Staff Bylaws.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Each committee may also be assigned duties within the scope of its subject matter area by the Medical Executive Committee.

(3) Procedures for the appointment of committee chairs and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

(4) All committees in this document shall be chaired by a member of the Medical Staff.

3.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical Staff committee, members must acknowledge and agree to the following:

(1) have the willingness and ability to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent upon the full participation of its members;

(2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;

(3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee's functions may be performed in an informed, efficient, and effective manner;

(4) attend meetings on a regular basis to promote consistency and good group dynamics;

(5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid off-topic or sidebar conversations;

(6) voice disagreements in a respectful manner and strive for "consensus" decision-making, thereby avoiding the majority vote, whenever possible;

(7) express reasonable dissenting opinions but support the actions and decisions made (even if they were not the individual's first choice);

(8) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

(9) bring any conflicts of interest to the attention of the Committee Chair, in advance of the committee meeting, when possible;

(10) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the Committee Chair outside of committee meetings; and

(11) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

3.C. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely report after each meeting to the Medical Executive Committee and to other committees and individuals as may be indicated in this Manual.

3.D. CANCER COMMITTEE

3.D.1. Composition:

(a) The Cancer Committee will consist of Medical Staff members from the diagnostic and therapeutic specialties who are involved in the care of cancer patients. There will be at least one physician from each of the following clinical specialties:

(1) diagnostic radiology;

(2) medical oncology;

(3) pathology;

(4) radiation oncology;

(5) surgery; and

(6) urology.

(b) The Cancer Committee must be chaired by a physician (of any specialty) who shall be responsible for overseeing compliance with the requirements of the American College of Surgeons Commission on Cancer.

(c) Allied Health Professionals who work with cancer patients may also be appointed as members of the Cancer Committee.

(d) The Cancer Liaison Physician will also serve as a member of this committee.

(e) The Cancer Committee will also include:

(1) the cancer program administrator (responsible for the administrative oversight or who has budget authority for the cancer program);

(2) the certified tumor registrar;

(3) an oncology nurse;

(4) a palliative care team member;

(5) a genetics professional;

(6) a performance improvement or quality management representative;

(7) a social worker or case manager; and

(8) at least one representative from TCHHN Administration, Clinical Education, Home Care/Hospice, Pharmacy, and Rehabilitation.

(f) The Leadership Council will have the authority to appoint other individuals to serve on the Committee and may select representatives from both the community and from within TCHHN. The Leadership Council will appoint any other individuals as needed to comply with the accreditation requirements of the American College of Surgeons.

(g) Members of the Cancer Committee must be aware of all applicable attendance requirements set by the American College of Surgeons Commission on Cancer, and must be willing and able to meet those requirements that apply to their particular position.

3.D.2. Duties:

The Cancer Committee shall:

(a) monitor and improve the quality of cancer care programs and services and programmatic goals of the Cancer Committee;

(b) develop and evaluate the annual goals and objectives for the clinical, educational, research, and programmatic activities related to cancer care, and evaluate those goals at least mid-year and year-end;

(c) supervise the cancer registry, implement a Quality Control Plan to annually evaluate the registry data, and ensure accurate and timely abstracting, staging and follow-up reporting;

(d) establish the cancer conference frequency, format, and multidisciplinary attendance requirements;

(e) monitor community outreach activities;

(f) establish and offer cancer educational activities, at least annually;

(g) facilitate clinical research in cancer evaluation and treatment; and

(h) develop and implement policies and procedures to ensure compliance with the American College of Surgeons Commission on Cancer Standards.

3.D.3. Meetings and Reports:

The Cancer Committee shall meet at least once every calendar quarter, more often when needed, shall maintain records of its activities and attendance at each meeting, and regularly report to the Oncology Service Line Medical Director.

3.E. CONTINUING MEDICAL EDUCATION COMMITTEE

3.E.1. Composition:

(a) The Continuing Medical Education Committee shall consist of physician representatives who will be appointed in such a way as to ensure broad representation of the service lines.

(b) The Continuing Medical Education Coordinator, the VP & Chief Clinical Officer, and other TCHHN representatives from supporting departments shall be *ex officio* members, without vote.

3.E.2. Duties:

The Continuing Medical Education Committee shall:

(a) identify and assess the educational needs of TCHHN's Medical Staff members and other health professionals in surrounding communities;

(b) facilitate professional development in the wide range of competencies needed to practice quality medicine in the multidisciplinary context of patient care;

(c) ensure the continuing medical education program's compliance with the Accreditation Council for Continuing Medical Education's ("ACCME") Essential Areas and their Elements and the Ohio State Medical Association ("OSMA") accreditation requirements;

(d) monitor the CME activity planning and implementation processes, ensuring the activities comply with all ACCME and OSMA guidelines; and

(e) assess the effectiveness of CME activities to assist in the development and implementation of strategies needed to improve TCHHN's overall CME program.

3.E.3. Meetings and Reports:

The Continuing Medical Education Committee shall meet quarterly, more often when needed, maintain records of its activities, and report to the Medical Executive Committee.

3.F. CREDENTIALS COMMITTEE

3.F.1. Composition:

(a) The Credentials Committee shall consist of at least five voting members of the Active Staff selected to ensure adequate representation of the Medical Staff, two of whom shall be the President-Elect of the Staff, who shall serve as Chairman, and the Secretary-Treasurer, who will serve as a member.

(b) A member of the Allied Health Professional Staff will also be appointed as an ad hoc non-voting member.

(c) The VP & Chief Clinical Officer, the Chief Nursing Officer, Manager of Medical Staff Services, and others, as determined by the Leadership Council, shall be *ex officio* members, without vote.

3.F.2. Duties:

The Credentials Committee shall:

(a) in accordance with the Credentials Policy, review the credentials of all applicants for Medical Staff and Allied Health Professional Staff appointment, reappointment, and clinical privileges or scope of practice, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) review all information available regarding the current clinical competence of individuals currently appointed to the Medical Staff, including OPPE information, and, as a result of such review, make recommendations for the granting of privileges, reappointment, and assignment of practitioners to various services in accordance with the Bylaws;

(c) carry out the functions outlined in the FPPE Policy to Confirm Practitioner Competence and Professionalism;

(d) develop and approve delineation of privilege forms for different specialties; and

(e) carry out such other functions as outlined in the Credentials Policy, including developing the criteria for clinical privileges that cross specialty lines.

3.F.3. Meetings and Reports:

The Credentials Committee shall meet monthly, maintain a permanent record of its proceedings and actions, and report to the Medical Executive Committee.

3.G. GRADUATE MEDICAL EDUCATION COMMITTEE

3.G.1. Composition:

The Graduate Medical Education Committee shall consist of at least five voting Medical Staff members, including program directors of Hospital-sponsored residency and fellowship programs, the Designated Institutional Official ("DIO"), the VP & Chief Clinical Officer, the Director of Graduate Medical Education, residency program coordinators and peer-selected resident/fellow representatives as required by the ACGME or other accrediting body from each of the TCHHN-sponsored programs.

3.G.2. Duties:

The Graduate Medical Education Committee shall:

(a) provide and maintain liaison with the residency and fellowship directors and other affiliated institutions;

(b) establish institutional policies for graduate medical education and procedures for the selection, evaluation, promotion and dismissal of residents;

(c) review all residency and fellowship training programs and ensure compliance with institutional policies and requirements of the relevant ACGME review committee;

(d) establish and implement policies, which accord fairness and due process, for discipline and adjudication of complaints and grievances related to the graduate medical programs;

(e) assure appropriate and equitable funding for resident positions, including benefits and support services;

(f) review ethical, socio-economic, medical/legal and cost containment issues that affect graduate medical education;

(g) review medical student activities; and

(h) establish quality and patient safety guidelines for credentialing of residents and fellows, including approval of schedules of resident and fellow activities within TCHHN.

3.G.3. Meetings and Reports:

The Graduate Medical Education Committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions. The Committee shall report not less than annually to the Medical Executive Committee and the Board of Directors.

3.H. LEADERSHIP COUNCIL

3.H.1. Composition:

(a) The Leadership Council shall be comprised of the following voting members:

(1) the President of the Medical Staff, who shall serve as Chair;

(2) the President-Elect of the Medical Staff (in recognition of his or her role as Chair of the Credentials Committee);

(3) the Secretary-Treasurer; and

(4) the Immediate Past President of the Medical Staff (in recognition of his or her role as Chair of the PPEC).

(b) The following individuals shall serve as non-voting members to facilitate the Leadership Council's activities:

(1) the VP & Chief Clinical Officer; and

(2) PPE Specialists.

(c) Other Medical Staff members or TCHHN personnel may be invited to attend a particular Leadership Council meeting (as guests, without vote) in order to assist the Leadership Council in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the Leadership Council review process and are bound by the same confidentiality requirements as the standing members of the Leadership Council.

3.H.2. Duties:

The Leadership Council shall perform the following functions:

(a) review and address concerns about practitioners' professional conduct as outlined in the Medical Staff Professionalism Policy;

(b) review and address possible health and wellness issues that may affect a practitioner's ability to practice safely as outlined in the Practitioner Health Policy;

(c) identify and make available education and resources related to practitioner wellness issues;

(d) review and address issues regarding practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy (PPE);

(e) meet, as necessary, to consider and address any situation involving a practitioner that may require immediate action;

(f) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within TCHHN;

(g) as set forth in Section 3.D of the Medical Staff Bylaws, identify and nominate a slate of qualified individuals to serve as the Medical Staff Officers, to be presented to and elected by the Medical Staff;

(h) appoint the chairs and members of all Medical Staff committees, except for the Medical Executive Committee;

(i) cultivate a physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future;

(j) review and consider all recommendations for changes to the Medical Staff Bylaws and associated documents, including the Medical Staff Rules and Regulations, at least every three years, and recommend amendments to the Medical Executive Committee; and

(k) perform any additional functions as may be requested by the PPEC, the Medical Executive Committee, or the Board.

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

The Leadership Council shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The Leadership Council shall report to the Medical Executive Committee and others as described in the Policies noted above. The Leadership Council's reports to the Medical Executive Committee will provide summary and aggregate information regarding the committee's activities. These reports will generally not include the details of any reviews or findings regarding specific practitioners.

3.I. MEDICAL ETHICS COMMITTEE

3.I.1. Composition:

The Medical Ethics Committee shall consist of a minimum of two voting members of the Medical Staff, and at least one representative from pastoral care, nursing, and administration.

3.I.2. Duties:

The Medical Ethics Committee shall:

(a) consult and advise on ethical questions raised by the President of the Medical Staff, the Medical Executive Committee, the Board, TCHHN's legal department, or patients, their representatives and families, and health care providers;

(b) educate the Medical Staff, Allied Health Professionals, administrators, hospital staff, patients, their representatives and families, and the community about ethical issues that arise in health care and resolution strategies; and

(c) provide assistance with the development of TCHHN policies and procedures that involve issues of medical ethics.

3.I.3. Meetings and Reports:

The Medical Ethics Committee shall meet on short notice and render recommendations in a timely and prompt fashion. The Medical Ethics Committee shall meet at least quarterly, but more often due to the nature and urgency of ethical issues, and shall maintain records of its activities. The Committee shall report to the Medical Executive Committee at least annually or whenever it is called upon to render a recommendation on an urgent issue.

3.J. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the Medical Executive Committee are set forth in Section 5.B of the Medical Staff Bylaws.

3.K. MEDICAL RECORDS COMMITTEE

3.K.1. Composition:

The Medical Records Committee shall consist of members appointed by the Leadership Council, including representatives of TCHHN who may serve as *ex officio* members, without vote.

3.K.2. Duties:

The Medical Records Committee shall:

(a) ensure that all medical records meet the highest standards of patient care, usefulness, and historical validity;

(b) ensure that medical records reflect realistic documentation of medical events;

(c) review discharge records to determine the promptness, appropriateness, adequacy and completeness thereof;

(d) evaluate the confidentiality of the medical records and provide an annual data report to the NQAPI; and

(e) determine what is officially part of the TCHHN-designated medical record.

3.L. NQAPI COMMITTEE

3.L.1. Composition:

The Network Quality Assessment/Safety & Performance Improvement Committee ("NQAPI") shall consist of Medical Staff members representing each of the service lines, in addition to representatives from quality, nursing, and administration and others as deemed appropriate. The VP & Chief Clinical Officer shall serve as chair of the committee.

3.L.2. Duties:

The NQAPI shall:

(a) prioritize annual performance improvement metrics and priority objectives in the Network PI Plan;

(b) re-prioritize annual objectives in the case of urgent or unexpected needs;

(c) provide oversight to performance improvement activities, including evaluation of priority status and ongoing and/or annual reports from assigned committees as indicated in the Network PI Plan;

(d) make assignments of priorities and measurement activities and evaluate plans for duplication avoidance;

(e) coordinate The Joint Commission compliance by establishing and overseeing preparation efforts with administration; and

(f) perform such other functions as outlined in the Network PI Plan.

3.L.3. Meetings and Reports:

The NQAPI shall meet at least ten times per year and will make reports to the Board Quality and Patient Safety Committee and the MEC.

3.L.4. Subcommittees:

The NQAPI shall consist of the following subcommittees. Unless otherwise indicated, each subcommittee shall report to the NQAPI at least annually:

(a) Blood Utilization, Laboratory, and Tissue Subcommittee. The Blood Utilization, Laboratory, and Tissue Subcommittee shall consist of members appointed by the Leadership Council, including representatives of TCHHN who may serve as *ex officio*

members, without vote. The Blood Utilization, Laboratory, and Tissue Subcommittee shall:

(1) establish broad policies for blood transfusion therapy and the biologics implantation program;

(2) perform quality assessments;

(3) develop criteria audits of transfusion practice; enhance quality of patient care through objective assessments;

(4) review and analyze the statistical reports of the transfusion and biologics implantation services;

(5) audit blood use; and

(6) promote continuing education in transfusion practices and regulatory requirements for the biologics implantation program for TCHHN staff.

The Blood Utilization, Laboratory, and Tissue Subcommittee will report its activities to the NQAPI along with overall Laboratory performance.

(b) Conscious Sedation Subcommittee. The Conscious Sedation Subcommittee shall consist of members appointed by the Leadership Council, including representatives of TCHHN who may serve as *ex officio* members, without vote. The Conscious Sedation Subcommittee shall:

(1) assure compliance with Joint Commission standards;

(2) monitor compliance with applicable regulatory bodies;

(3) report and evaluate annual data related to the use of conscious sedation;

(4) implement regulatory changes in a timely manner;

(5) assure quality outcomes; and

(6) serve as an educational and compliance resource for the Medical Staff.

(c) Infection Control Subcommittee. The Infection Control Subcommittee shall consist of members appointed by the Leadership Council, including representatives of TCHHN who may serve as *ex officio* members, without vote. The Infection Control Subcommittee shall:

(1) develop and implement the Infection Control and Prevention program in order to minimize the risk of infection for patients, hospital personnel, medical and dental staff, students and visitors;

(2) reduce the risks of acquiring a healthcare associated infection ("HAI"); and

(3) provide infection control and prevention support to all service lines.

The Infection Control Subcommittee shall report to the NQAPI at least annually and to the service lines as needed.

(d) Pharmacy and Therapeutics Subcommittee. The Pharmacy and Therapeutics Subcommittee shall consist of at least three physicians appointed by the Leadership Council. The Director of Pharmacy Services and Vice President/Chief Operating Officer shall be *ex officio,* non-voting members. Additional members of the committee shall include the Pharmacy Clinical Coordinator and the Pharmacy Assistant Director. The co-chair of the committee is the Pharmacy Clinical Coordinator. The Pharmacy and Therapeutics Subcommittee shall:

(1) develop and survey all medication utilization criteria and outcomes within TCHHN in order to assure optimum clinical results and a minimum potential for hazard;

(2) assist in the formulation of broad policies regarding the evaluation, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in TCHHN;

(3) manage a medication formulary;

(4) evaluate and improve performance of ordering practices, preparing and dispensing of medications, administration of medications, and monitoring the effects of medications on patients, including adverse drug reactions; and

(5) oversee efforts to prevent food and drug interactions, and nutritional support services.

The Pharmacy and Therapeutics Subcommittee shall meet monthly, at least ten times a year, maintain minutes of its activities, and report regularly to the Medical Executive Committee and at least annually to the NQAPI Committee.

(e) Transition of Care Subcommittee. The Transition of Care Subcommittee shall consist of representatives from nursing, case management, social work, pharmacy, the family advisory committee, and administration, as well as physician representatives from geriatrics and hospitalist services. The Transition of Care Subcommittee shall:

(1) improve communication among caregivers across the continuum of care by leveraging TCHHN's electronic medical record;

(2) ensure safe and effective hand-offs for patients across the continuum of care;

(3) develop strategy and protocols to identify patients at high risk of suffering adverse outcomes related to disjointed and/or ineffective communication of medical information across the continuum;

(4) seek ways to reduce unplanned readmissions;

(5) explore the development of TCHHN nursing home practice;

(6) remove obstacles to safe and quality care across the continuum; and

(7) bring recommendations to administration, the Medical Staff, and hospitalist staff, as appropriate.

The Transition of Care Subcommittee meets ten times per year and will report its accomplishments to the Medical Executive Committee regularly and to the NQAPI at least annually.

(f) Utilization Review Subcommittee. The Utilization Review Subcommittee shall consist of at least two physicians representing the major clinical service lines, as appointed by the Leadership Council. Representatives from Administration and clinical and ancillary support services shall attend the committee meetings as *ex officio* members, without vote. The Utilization Review Subcommittee shall:

(1) oversee the Hospital's Utilization Review Plan to assure TCHHN provides for review of services furnished by the institution and by members of the Medical Staff to patients entitled to benefits under the Medicare and Medicaid programs;

(2) make determinations regarding medical necessity;

(3) track and trend the utilization and availability of hospital and patient care resources, length of stay and physician practice patterns and make recommendations on the same; and

(4) make referrals to the PPEC and/or the NQAPI Committee annually.

The Utilization Review Subcommittee will meet at least quarterly.

3.M. PERIOPERATIVE EXECUTIVE COMMITTEE

3.M.1. Composition:

(a) The Perioperative Executive Committee shall consist of at least seven voting members of the Medical Staff representing each of the following specialty areas: Heart and Vascular, Musculoskeletal, Comprehensive Medicine, Oncology, Surgery, and Women's Health and other members as deemed appropriate by the Committee Chair (who shall be a member of the Medical Staff with procedural clinical privileges).

(b) The Service Line Medical Director, OR Manager, PACU Manager, SDS Manager, and Administrative Directors shall be *ex officio* members, without vote.

3.M.2. Duties:

The Perioperative Executive Committee shall:

(a) oversee and be responsible for all areas of perioperative services within TCHHN, including pre-admission testing, Same Day Surgery, all hospital operating rooms, cystoscopy, endoscopy, JSC, Montgomery, Liberty, Redbank and PACU;

(b) be responsible for establishing all policies and procedures for perioperative services;

(c) oversee scheduling and utilization and may recommend actions required for efficient and proper utilization of surgical and perioperative services; and

(d) review and advise on allocation of supply and equipment, capital and noncapital resource needs, space utilization, personnel and human resource allocations, and other matters relating to the safety and efficiency of perioperative services.

3.M.3. Meetings and Reports:

The Perioperative Executive Committee shall meet a minimum of ten times a year, maintain minutes of its activities, and report regularly to the Medical Executive Committee.

3.N. PHYSICIAN INFORMATION TECHNOLOGY COMMITTEE

3.N.1. Composition:

(a) The Physician Information Technology Committee shall consist of Medical Staff members representing each of the service lines.

(b) The Chief Information Officer, Clinical IT Solutions Director, Infrastructure Services Director, Information Services Director, Manager of Medical Staff Services (or designee), and the IT Service Line Leaders shall be *ex officio* members, without vote.

(c) The Chief Medical Information Officer shall serve as Chair.

3.N.2. Duties:

The Physician Information Technology Committee shall:

(a) make recommendations regarding educational and training needs around the use of the electronic medical records system;

(b) make policy recommendations regarding adoption and propose use of the electronic medical record system by members of the Medical Staff;

(c) provide physician input to IT services on enterprise IT initiatives, projects and issues; and

(d) make recommendations for strategic planning regarding IT systems and services supporting the clinical environment.

3.N.3. Meetings and Reports:

The Physician Information Technology Committee shall meet no less than bi-monthly, but more often when needed, maintain records of its activities, and report regularly to the Medical Executive Committee.

3.O. PROVIDER PERFORMANCE ENHANCEMENT COMMITTEE ("PPEC")

3.O.1. Composition:

(a) The PPEC shall consist of the following voting members:

(1) the Immediate Past President of the Medical Staff (who shall serve as Chair);

(2) at least one Medical Staff President (current or past) other than the Immediate Past President of the Medical Staff; and

(3) additional Medical Staff members who are:

(i) broadly representative of the clinical specialties on the Medical Staff, including at least one primary care physician and possibly service line PEC members or chairs;

(ii) interested or experienced in credentialing, privileging, PPE/peer review, or other Medical Staff affairs; and

(iii) supportive of evidence-based medicine protocols.

(b) The following individuals shall serve as non-voting members to facilitate the PPEC's activities:

(1) VP & Chief Clinical Officer;

(2) PPE Specialists;

(3) the Medical Director for Ambulatory Quality and Patient Safety; and

(4) a member of the Allied Health Professional Staff as an ad hoc non-voting member.

(c) If a Past President of the Medical Staff is unwilling or unable to serve, the Leadership Council shall appoint another former physician leader (e.g., Medical Staff Officer, Service Line Medical Director, Division Chief, or committee chair) who is experienced in credentialing, privileging, PPE/peer review, or Medical Staff matters.

(d) To the fullest extent possible, PPEC members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.

(e) Before any PPEC member begins serving, the member must review the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on professional practice evaluation.

(f) Other Medical Staff members or TCHHN personnel may be invited to attend a particular PPEC meeting (as guests, without vote) in order to assist the PPEC in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the PPEC.

3.O.2. Duties:

The PPEC shall perform the following functions:

(a) oversee the implementation of the Professional Practice Evaluation Policy (Peer Review) ("PPE Policy") and ensure that all components of the process receive appropriate training and support;

(b) review reports showing the number of cases being reviewed through the PPE Policy, by service line or specialty, in order to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;

(c) review, approve, and periodically update Ongoing Professional Practice Evaluation ("OPPE") data elements that are identified by individual service lines and divisions, and adopt Medical Staff-wide data elements;

(d) review, approve, and periodically update the specialty-specific quality indicators identified by the service lines/divisions that will trigger the professional practice evaluation/peer review process;

(e) identify those variances from rules, regulations, policies, or protocols which do not require physician review, but for which an Informational Letter may be sent to the practitioner involved in the case;

(f) review cases referred to it as outlined in the PPE Policy;

(g) develop, when appropriate, Performance Improvement Plans for practitioners, as described in the PPE Policy;

(h) monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully addressed and report on those results to the applicable committees and service lines of the Medical Staff (if such an issue is identified but the PPEC is unable to obtain resolution, the matter will be forwarded to the Medical Executive Committee);

(i) work with Service Line Medical Directors and Division Chiefs to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through educational sessions in the service line/division or through some other mechanism; and

(j) perform any additional functions as may be set forth in applicable policy or as requested by the Medical Executive Committee or the Board.

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

The PPEC shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The PPEC shall submit reports of its activities to the Medical Executive Committee on a regular basis. The PPEC's reports will provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by service lines; types and numbers of dispositions for the cases; listing of education initiatives based on reviews; listing of system issues identified). These reports will generally not include the details of any reviews or findings regarding specific practitioners.

ARTICLE 4

AMENDMENTS

This Manual may be amended in accordance with Article 8 of the Medical Staff Bylaws.

ARTICLE 5

ADOPTION

This Medical Staff Organization Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein.

Originally adopted by the Medical Staff on June 24, 2014 and approved by the Board on July 16, 2014.

Revised: Medical Executive Committee – November 24, 2015

Board – April 27, 2016.

Revised: Medical Executive Committee – October 30, 2018

Board – October 31, 2018.