MEDICAL STAFF BYLAWS, POLICIES, AND

RULES AND REGULATIONS

OF

THE CHRIST HOSPITAL

MEDICAL STAFF ORGANIZATION MANUAL

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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 is to be carried out by a member of Hospital management, 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 one or more designees.

(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:

Heart and Vascular

Cardiology

Cardiovascular & Thoracic Surgery

Vascular Surgery

Medicine (Comprehensive Integrated Medical Care)

Allergy & Immunology

Dermatology

Endocrinology

Emergency Medicine

Family Medicine

Gastroenterology

Geriatric Medicine

Palliative Care

Infectious Disease

Internal Medicine

Nephrology

Neurology

Psychiatry

Pulmonary Disease

Rheumatology

Musculoskeletal

Neurosurgery

Orthopedics

Physical Medicine & Rehabilitation

Podiatry

Spine

Sports Medicine

Oncology

Hematology

Oncology

Radiation Oncology

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 EXECUTIVE MEDICAL DIRECTORS

The functions and responsibilities of the service lines and service line executive 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.

3.B. MEETINGS, REPORTS, AND RECOMMENDATIONS

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

3.C. BYLAWS COMMITTEE

3.C.1. Composition:

(a) The Bylaws Committee shall consist of the Medical Staff Officers and a minimum of at least one Past President of the Medical Staff.

(b) The VP & Chief Medical Officer and Manager of Medical Staff Services shall be *ex officio* members, without vote.

3.C.2. Duties:

The Bylaws Committee shall:

(a) review the Medical Staff Bylaws and associated documents, including the Medical Staff Rules and Regulations, at least every other year, and recommend amendments to the Medical Executive Committee; and

(b) receive and consider all recommendations for changes to these documents made by any committee or service line of the Medical Staff, any individual appointed to the Medical Staff, the VP & Chief Medical Officer, and/or the President & Chief Executive Officer and provide a report to the Medical Executive Committee regarding them.

3.C.3. Meetings and Reports:

The Bylaws Committee shall meet every other year, and otherwise as necessary, and provide regular reports to the Medical Staff and Medical Executive Committee.

3.D. CANCER COMMITTEE

3.D.1. Composition:

(a) The Cancer Committee shall consist of at least one physician member from each of the following specialties, with the goal of representing each of the five major cancer sites (i.e., breast, prostate, lung, colon/rectum, and skin): diagnostic radiology, pathology, surgery (general surgery or a specialty involved in cancer care), medical oncology, and radiation oncology. The committee shall also include at least one member from clinical research and one member from rehabilitation. The Chair of the committee shall be a member of the Active Staff who may also fulfill the role of one of the required physician specialties.

(b) Representatives from administration (with administrative or financial control over the Hospital's cancer program), oncology nursing, social services, cancer registry, palliative care, and quality improvement shall be *ex officio* members, without vote.

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 Executive 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 Medical Officer, and other Hospital staff 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 the Hospital 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 the Hospital'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) The VP & Chief Medical Officer, the Chief Nursing Officer or CHO/Chair of the Allied Health Professionals Committee, and Manager of Medical Staff Services 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 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) establish the FPPE policy and ensure compliance of the policy through monitoring of FPPE activities;

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

(e) investigate any breach of ethics reported; and

(f) 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.F.4. Subcommittee:

The Allied Health Professionals Committee shall function as a subcommittee of the Credentials Committee. The Allied Health Professionals Committee shall consist of the Chief Nursing Officer, a minimum of two AHPs, and such others as the Credentials Committee shall designate. The Manager of Medical Staff Services shall attend the committee meetings as an *ex officio* member, without vote. The Allied Health Professionals Committee shall review and consider applications for the granting of clinical privileges or scope of practice to AHPs and make a recommendation to the Credentials Committee on the same. The Allied Health Professionals Committee shall meet monthly or as often as necessary to accomplish its duties and report to the Credentials 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 Medical Officer, the Director of Graduate Medical Education, residents training at the Hospital, residency program coordinators and peer-selected resident/fellow representatives as required by the ACGME or other accrediting body from each of the Hospital-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 in the Hospital.

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. MEDICAL ETHICS COMMITTEE

3.H.1. Composition:

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

3.H.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, the Hospital'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 Hospital policies and procedures that involve issues of medical ethics.

3.H.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.I. 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.J. MEDICAL STAFF QUALITY COMMITTEE ("MSQC")

3.J.1. Composition:

(a) The MSQC shall consist of the Medical Director of Quality and Patient Safety and no less than six Active Staff appointees, who will be appointed in such a way as to ensure broad representation of the service lines.

(b) The VP & Chief Medical Officer, Vice President/Chief Hospital Officer or Chief Nursing Officer, and the Director of Quality and Patient Safety shall be *ex officio* members, without vote.

3.J.2. Duties:

The MSQC shall:

(a) coordinate and standardize the use of indicators and studies by the Medical Staff, the review of all cases of sufficient complexity of management or seriousness of outcome requiring physician peer review identified by indicators;

(b) develop and monitor the follow-up action plans for identified improvement opportunities;

(c) coordinate feedback of OPPE information to Service Line Executive Medical Directors, Division Chiefs and to practitioners, and regularly update Medical Staff expectations in all dimensions of practitioner performance;

(d) ensure that all medical records meet appropriate standards of patient care, usefulness, and historical validity, and review records of discharged patients to determine promptness, pertinence, adequacy and completeness;

(e) review and evaluate blood ordering, distribution, handling and dispensing of blood products, and administration of blood products, including transfusion reaction and the effect of blood products on patients; and

(f) have its own Utilization Review Subcommittee.

3.J.3. Meetings and Reports:

The MSQC shall meet as often as necessary to accomplish its duties, but at least bimonthly, receive the peer review committee reports, maintain a permanent record of proceedings and actions, and report to the Medical Executive Committee on a regular basis.

3.J.4. Subcommittees:

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

(a) Tissue and Transfusion Subcommittee. The Tissue and Transfusion Subcommittee shall consist of such members as the MSQC shall designate, including representatives of the Hospital who may serve as *ex officio* members, without vote. The Tissue and Transfusion Subcommittee shall establish broad policies for blood transfusion therapy and the biologics implantation program; perform quality assessments; develop criteria audits of transfusion practice; enhance quality of patient care through objective assessments; review and analyze the statistical reports of the transfusion and biologics implantation services; audit blood use; and promote continuing education in transfusion practices and regulatory requirements for the biologics implantation program for the Hospital staff.

(b) Conscious Sedation Subcommittee. The Conscious Sedation Subcommittee shall consist of such members as the MSQC shall designate, including representatives of the Hospital who may serve as *ex officio* members, without vote. The Conscious Sedation Subcommittee shall assure compliance with Joint Commission standards; monitor compliance with applicable regulatory bodies; report and evaluate annual data related to the use of conscious sedation; implement regulatory changes in a timely manner; assure quality outcomes; and serve as an educational and compliance resource for the Medical Staff.

(c) Medical Records Subcommittee. The Medical Records Subcommittee shall consist of such members as the MSQC shall designate, including representatives of the Hospital who may serve as *ex officio* members, without vote. The Medical Records Subcommittee shall ensure that all medical records meet the highest standards of patient care, usefulness, and historical validity; ensure that medical records reflect realistic documentation of medical events; review discharge records to determine the promptness, appropriateness, adequacy and completeness thereof; evaluate the confidentiality of the medical records; and provide an annual data report to the MSQC.

(d) Utilization Review Subcommittee. The Utilization Review Subcommittee shall consist of at least two physicians representing the major clinical service lines, as designated by the MSQC. 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 oversee the Hospital's utilization review plan to assure the Hospital 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; make determinations regarding medical necessity; 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 make referrals to Peer Review and/or the MSQC as necessary. The committee will meet at least quarterly.

(e) Infection Control Subcommittee. The Infection Control Subcommittee shall consist of such members as the MSQC shall designate, including representatives of the Hospital who may serve as *ex officio* members, without vote. The Infection Control Subcommittee shall 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; reduce the risks of acquiring a healthcare associated infection ("HAI"); and provide infection control and prevention support to all service lines. The Infection Control and Prevention program's prevention and control methodology shall be selected on the basis of scientific data that demonstrates it to be effective and efficient. The Infection Control Subcommittee shall report to the MSQC at least annually and to the service lines as needed.

3.K. NOMINATING COMMITTEE

The composition and duties of the Nominating Committee are set forth in Section 3.D of the Medical Staff Bylaws.

3.L. PERIOPERATIVE EXECUTIVE COMMITTEE

3.L.1. Composition:

(a) The Perioperative Executive Committee shall consist of the following Service Line Physician Leaders (or their designee): Orthopedics, Spine, General Surgery, Gynecology, ENT, Cardiac Surgery, Urology, and Anesthesia.

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

3.L.2. Duties:

The Perioperative Executive Committee shall:

(a) oversee and be responsible for all areas of perioperative services within the Hospital, including pre-admission testing, Same Day Surgery, all Hospital operating rooms, cystoscopy, endoscopy, 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.L.3. Meetings and Reports:

The Perioperative Executive Committee shall meet as often as needed, maintain minutes of its activities, and report regularly to the Medical Executive Committee.

3.M. PHARMACY AND THERAPEUTICS COMMITTEE

3.M.1. Composition:

(a) The Pharmacy and Therapeutics Committee shall consist of at least three physicians appointed by the President of the Medical Staff.

(b) The Director of Pharmacy Services and Vice President/Chief Hospital Officer or Chief Nursing Officer shall be *ex officio*, non-voting members. Additional members of the committee shall include the Pharmacy Clinical Coordinator and the Pharmacy Assistant Director.

(c) The co-chair of the committee is the Pharmacy Clinical Coordinator.

3.M.2. Duties:

The Pharmacy and Therapeutics Committee shall:

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

(b) 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 the Hospital;

(c) manage a medication formulary;

(d) 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

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

3.M.3. Meetings and Reports:

The Pharmacy and Therapeutics Committee shall meet monthly, at least 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 at least six physician members of the Active Staff representing each of the following specialty areas: Heart and Vascular, Musculoskeletal, Comprehensive Medicine, Oncology, Surgery, and Women's Health.

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

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. PRACTITIONERS AID COMMITTEE

3.O.1. Composition:

The Practitioners Aid Committee shall consist of members of the Medical Staff and other appropriate professionals appointed for their knowledge about and/or expertise in impairment issues, including age impairment, substance abuse, or other health issues that might impact the ability of a practitioner to exercise privileges at the Hospital.

3.O.2. Duties:

The Practitioners Aid Committee shall carry out the functions outlined in Article 10 of the Credentials Policy.

3.O.3. Meetings and Reports:

The Practitioners Aid Committee shall meet as needed, maintain a permanent record of its activities and report, regarding specific practitioner issues, to the Medical Executive Committee. The Committee shall also report to the Medical Executive Committee as needed.

3.P. TRANSITION OF CARE COMMITTEE

3.P.1. Composition:

The Transition of Care Committee shall consist of internal key stakeholders at The Christ Hospital Health Network who have a keen interest in focusing on the continuum of care for the purpose of providing safe and quality care for our patients. This is an enterprisewide, interdisciplinary committee composed of representatives from our physicians, nurses, case management, social work, Family Advisory Committee, and administration. Information technology, pharmacy, Data Center, and representatives from post-acute providers will be included as members of work groups as needed. Post-acute providers include Nursing Facility, LTAC, Acute Rehab, Oxygen/DME, Infusion, Home Care, Hospice, and Ambulance Companies.

3.P.2. Duties:

The Transition of Care Committee shall:

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

(b) develop strategies and protocols to protect patients from suffering adverse outcomes related to disjointed and/or ineffective communication of medical information across the continuum;

(c) engage caregivers (physicians, facilities and agencies) who send us patients, and to whom we send patients, in designing work processes that provide prompt, efficient flows of clinical information. This may include providing education to post-acute providers about care paths and protocols to ensure coordination and continuity of care;

(d) remove obstacles to safe, quality care across the continuum. Provide ongoing assessment of the quality of care of post-acute providers;

(e) improve communication among caregivers across the continuum of care, by leveraging our EMR;

(f) evaluate the discharge planning process and identify areas of improvement to ensure quality of care and to ensure that Joint Commission standards and CMS Conditions of Participation are met; and

(g) monitor readmission rates, evaluate factors contributing to readmissions, and facilitate action within service line structure to reduce the Hospital readmission rate.

3.P.3. Meetings and Reports:

The Transition of Care Committee meets 10 times per year and will report its accomplishments to the Medical Executive Committee regularly and to the MSQC and the Board Quality Committee of The Christ Hospital Health Network (at least annually). This Committee is responsible to keep the work of the Committee and work groups visible in the organization and to bring recommendations from the project teams to administration, Medical Staff and Hospital staff as appropriate.

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.

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