Medical Staff Organization Policy

Bethesda Hospital

A Medical Staff Document

TABLE OF CONTENTS

ARTICLE I - DUTIES OF MEDICAL STAFF OFFICERS

1.1 MEDICAL STAFF PRESIDENT

1.1-1 The Medical Staff President shall:

(a) Act as the chief officer of the Medical Staff in coordination and cooperation with the System CEO in matters of mutual concern involving the Hospital.

(b) Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the Medical Executive Committee and report, as required, at such meetings.

(c) Appoint committee chairs and members to all Medical Staff committees except to the Medical Executive Committee and except as may be otherwise provided in the Medical Staff governing documents.

(d) Serve as chair of the Medical Executive Committee, with vote, and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as provided for in the Medical Staff governing documents.

(e) Represent the views, policies, needs, and concerns of the Medical Staff and report on the medical activities of the Medical Staff to the Board and to the System CEO.

(f) Serve as a day-to-day liaison on medical matters with the System CEO and the Board.

(g) Receive and interpret the policies of the Board to the Medical Staff.

(h) Report to the Board with respect to the delegated responsibility of the Medical Staff to oversee the delivery of quality medical care.

(i) Be the spokesperson for the Medical Staff in its external professional and public relations.

(j) Ensure, in cooperation with the Hospital, that an audit of the Medical Staff fund is conducted by a qualified accountant at the close of each Medical Staff Year, as applicable.

1.2 MEDICAL STAFF PRESIDENT-ELECT

1.2-1 The Medical Staff President-Elect shall:

(a) Assume the duties and have the authority of the Medical Staff President in the event of the President's temporary unavailability for any reason.

(b) Serve as a voting member of the Medical Executive Committee.

(c) Serve as chair or co-chair of the Joint Patient Care Committee, with vote.

(d) Serve as chair or co-chair of the Joint Medical Staff Peer Review Committee (MSPRC), with vote.

(e) Automatically succeed the Medical Staff President when the President fails to serve for any reason.

(f) Perform such other duties as are assigned by the Medical Staff President.

1.2-2 Should both the Medical Staff President and the President-Elect be unavailable in an emergency, the authority and duties of the Medical Staff President will be temporarily assumed in the following order of succession: Secretary/Treasurer, Immediate Past Medical Staff President (if available), the member-at-large of the Medical Executive Committee with the longest Medical Staff affiliation, and the member-at-large of the Medical Executive Committee with the second longest affiliation.

1.3 SECRETARY-TREASURER

1.3-1 The Secretary-Treasurer shall:

(a) Assume all of the duties and have the authority of the Medical Staff President in the event of the President's and the Medical Staff President-Elect's temporary unavailability for any reason.

(b) Assume all of the duties and have the authority of the Medical Staff President-Elect in the event of the President-Elect's temporary unavailability for any reason.

(c) Be a voting member of the Medical Executive Committee and the Medical Staff Bylaws Committee.

(d) Keep accurate and complete minutes of all Medical Staff and Medical Executive Committee meetings.

(e) Attend to all correspondence.

(f) Collect and be responsible for Medical Staff dues and funds.

(g) Make disbursements authorized by the Medical Executive Committee or its designees.

(h) Perform such other duties as are assigned by the Medical Staff President.

1.4 IMMEDIATE PAST MEDICAL STAFF PRESIDENT

1.4-1 The Immediate Past Medical Staff President shall:

(a) Serve as a voting member of the Medical Executive Committee

(b) Serve as chair or co-chair of the Joint Credentials Committee, with vote.

(c) Serve as chair of the Nominating Committee, with vote.

(d) Serve as a member of the Joint Practitioner Effectiveness (PEC) Committee, with vote.

(e) Perform such other duties as are assigned by the Medical Staff President.

1.5 OFFICER COMPENSATION

1.5-1 Medical Staff officers' compensation will be paid by the Hospital and the Medical Staff as mutually agreed upon by the Hospital and Medical Executive Committee and approved by the Board.

ARTICLE II - MEDICAL STAFF DEPARTMENTS & SECTIONS

2.1 DESIGNATION OF DEPARTMENTS/SECTIONS

2.1-1 Bethesda Hospital

(a) Department of Behavioral Health

(b) Department of Critical Care

(1) Stroke & Neurocritical Care Section

(2) Cardiac Critical Care & Mechanical Circulatory Support Section

(c) Department of Emergency Medicine

(d) Department of Family Medicine

(e) Department of Internal Medicine

(1) Cardiology Section

(2) Gastroenterology Section

(3) Hematology Section

(4) Inpatient Medicine Section

(5) Nephrology Section

(6) Neurology Section

(7) Occupational Medicine Section

(8) Medical Oncology Section

(9) Pulmonary Disease Section

(f) Department of Neonatal Pediatrics

(g) Department of Obstetrics/Gynecology

(1) Maternal/Fetal Medicine Section

(2) Gynecological Oncology Section

(3) Reproductive Endocrinology Section

(4) Female Pelvic Medicine and Reconstructive Surgery

(h) Department of Orthopedic Surgery

(1) Podiatry Section

(2) Physical Medicine Section

(i) Department of Pathology & Laboratory Medicine

(j) Department of Perioperative Medicine & Anesthesiology

(k) Department of Radiology

(1) Diagnostic Radiology Section

(2) Nuclear Radiology Section

(3) Radiation Oncology Section

(l) Department of Surgery

(1) Cardiothoracic Surgery Section

(2) Dentistry Section

(3) General Surgery Section

(4) Neurosurgery Section

(5) Ophthalmology Section

(6) Otolaryngology Section

(7) Plastic, Reconstructive & Hand Surgery Section

(8) Urology Section

(9) Vascular Surgery Section

2.2 ADDITIONAL INFORMATION

2.2-1 Additional information with respect to Medical Staff Departments and Sections is set forth in the Medical Staff Bylaws.

ARTICLE III - BOARD JOINT CONFERENCE COMMITTEE

3.1 JOINT CONFERENCE COMMITTEE

3.1-1 DOCUMENT CONFLICTS

(a) In the event that the Hospital's Code of Regulations is amended to provide for a standing Joint Conference Committee, then the information regarding the Joint Conference Committee set forth in the Hospital's Code of Regulations shall govern and this Article will be deemed to be likewise automatically amended.

3.1-2 COMPOSITION

(a) In the event that the Hospital's Code of Regulations is amended to provide for a standing Joint Conference Committee, the composition of such committee shall be as set forth in the Code of Regulations.

(b) In the event that the Hospital's Code of Regulations does not provide for a standing Joint Conference Committee, then there shall be an *ad hoc* Joint Conference Committee, as established by the Board, composed of an equal number of Board members selected by the Board (or Board chair) and Medical Staff representatives selected by the MEC (or MEC chair).

(c) Unless otherwise provided in the Hospital's Code of Regulations, a Board member selected by the Board (or Board chair) shall chair the *ad hoc* Joint Conference Committee.

3.1-3 DUTIES

(a) The Joint Conference Committee shall:

(1) Be consulted in those instances set forth in the Medical Staff governing documents.

(2) Be a forum for interaction between the Board and Medical Staff on such other matters as may be referred by the Medical Executive Committee, the Board, or the System CEO.

(3) Be a forum for the discussion of matters of Hospital policy and practice, especially those pertaining to patient care.

(4) Provide medico-management liaison with the Board.

(b) The Joint Conference Committee shall serve in an advisory capacity.

3.1-4 MEETINGS

(a) The Joint Conference Committee shall meet, as needed, to fulfill its duties and role.

ARTICLE IV - MEDICAL STAFF COMMITTEES

4.1 MEDICAL STAFF COMMITTEES

4.1-1 STANDING

The standing Medical Staff committees are as follows:

(a) Medical Executive Committee

(1) Nominating Committee

(2) Joint Bylaws Committee

(3) Joint Credentials Committee

(4) Joint Patient Care Committee

(5) Joint Practitioner Effectiveness Committee

(6) Joint Medical Staff Peer Review Committee (MSPRC)

(i) The Joint Quality Assurance Committees set forth in Addendum A shall each report to the Joint MSPRC.

(b) Creation of new standing Medical Staff committees, dissolution of standing Medical Staff committees, or changes to the composition, duties, or meeting requirements of standing Medical Staff committees require(s) amendment of the Medical Staff Bylaws (with respect to the MEC and Nominating Committee) or this Medical Staff Organization Policy (with respect to the standing Medical Staff committees addressed herein or as may hereinafter be otherwise created), as applicable.

(c) Any Medical Staff function required to be performed by the Medical Staff governing documents not otherwise assigned to a Medical Staff committee shall be performed by the Medical Executive Committee.

4.1-2 OTHER

(a) The Medical Executive Committee may, by resolution, without amendment of this Medical Staff Organization Policy, establish *ad hoc* Medical Staff committees for specific purposes. In the same manner, the MEC may, by resolution, dissolve an *ad hoc* Medical Staff committee or modify such committee's composition, duties, or meeting requirements, as needed to better perform the Medical Staff functions.

(b) The composition, duties, and meeting requirements of *ad hoc* Medical Staff committees may be set forth in the resolution creating each committee.

4.1-3 JOINT COMMITTEES

(a) Hospital and Affiliate Hospital Medical Staff committees may meet jointly as necessary to promote broad collaboration between the Hospital and Affiliate

Hospital medical staffs and further effective peer review and quality of care for patients.

(b) For purposes of this Policy, the term "Joint Committee" means a single committee with all Hospital and participating Affiliate Hospital committee members having the right to vote on all actionable items with one set of minutes distributed to the respective Hospital's or participating Affiliate Hospital's MECs (or to such other Medical Staff committee, as applicable).

4.2 MEDICAL STAFF COMMITTEE MEMBERS

4.2-1 Practitioners appointed to the active (with or without Privileges), courtesy, reciprocal, affiliate, emeritus, or retired Medical Staff category may serve as a voting member of a Medical Staff committee unless otherwise provided in the Medical Staff governing documents.

4.2-2 APPs are not Members of the Medical Staff but may serve on a Medical Staff committee, with or without the right to vote, as specified in the composition of the applicable Medical Staff committee set forth in this Policy. APPs shall not serve on the Medical Executive Committee, Nominating Committee, Patient Care Committee, or Medical Staff Peer Review Committee.

4.2-3 Unless otherwise provided in the Medical Staff governing documents, members of each Medical Staff committee shall be appointed yearly by the President of the Medical Staff with no limitation on the number of terms they may serve.

4.2-4 Unless otherwise provided in the Medical Staff governing documents, all appointed members of a Medical Staff committee may be removed and vacancies filled by the Medical Staff President at his or her discretion.

4.2-5 Unless otherwise provided in the Medical Staff governing documents, the System CEO and the Medical Staff President of the Hospital (and, for Joint Medical Staff committees, of those participating Affiliate Hospitals) shall be *Ex Officio* members of all Medical Staff committees, without vote.

4.3 MEDICAL STAFF COMMITTEE CHAIRS

4.3-1 Unless otherwise provided in the Medical Staff governing documents, the Medical Staff President shall annually appoint all Medical Staff committee chairs who shall be selected from among Practitioners appointed to the active, reciprocal, emeritus, or retired Medical Staff; provided, however, that a Practitioner who holds a courtesy appointment at this Hospital may chair a joint Medical Staff committee if the Practitioner holds active Medical Staff appointment at least one participating Affiliate Hospital.

4.3-2 Unless otherwise provided in the Medical Staff governing documents, Medical Staff committee chairs may be reappointed by the Medical Staff President for additional one-year terms with no limitation on the number of terms they may serve.

4.4 MEDICAL EXECUTIVE COMMITTEE

4.4-1 The composition, duties, and meeting requirements of the Hospital's Medical Executive Committee are set forth in the Medical Staff Bylaws.

4.5 NOMINATING COMMITTEE

4.5-1 The composition, duties, and meeting requirements of the Hospital's Nominating Committee are set forth in the Medical Staff Bylaws.

4.6 JOINT MEDICAL STAFF BYLAWS COMMITTEE

4.6-1 COMPOSITION

(a) The voting members of the Joint Medical Staff Bylaws Committee shall include:

(1) The Medical Staff Secretary-Treasurer from the Hospital and each of the participating Affiliate Hospital medical staffs.

(2) Such other qualified Practitioners from the Hospital and participating Affiliate Hospitals as jointly determined by the Medical Staff Presidents of the participating System hospitals.

(b) The *Ex Officio* (non-voting) members of the Joint Medical Staff Bylaws Committee shall include the:

(1) The positions set forth in Section 4.2-5.

(2) System CMO

(3) Associate CMOs

(4) APP(s) as jointly determined by the Medical Staff Presidents of the participating System hospitals.

(c) The Joint Medical Staff Bylaws Committee will be chaired or co-chaired by a qualified Practitioner(s) as jointly determined by the Medical Staff Presidents of the participating System hospitals.

4.6-2 DUTIES

The Joint Medical Staff Bylaws Committee shall:

(a) Review the Medical Staff governing documents of the Hospital and participating Affiliate Hospital Medical Staffs (to include the Medical Staff Bylaws, Policies, Rules & Regulations, and related Medical Staff applications) at least every three (3) years, or more often as necessary, and recommend amendments thereto to the Hospital and respective participating Affiliate Hospitals' Medical Executive Committees.

(b) Receive and consider all recommendations for changes to the Hospital and participating Affiliate Hospitals' Medical Staff governing documents and advise

the Hospital and respective participating Affiliate Hospitals' MECs regarding same.

4.6-3 MEETINGS

(a) The Joint Medical Staff Bylaws Committee shall meet as needed to accomplish its duties at the call of the committee chair.

(b) Minutes will be maintained of each meeting, copies of which will be provided to the Medical Executive Committee of the Hospital and each participating Affiliate Hospital.

4.7 JOINT CREDENTIALS COMMITTEE

4.7-1 COMPOSITION

(a) The Joint Credentials Committee shall consist of the following voting members:

(1) Immediate Past Medical Staff President from the Hospital and each participating Affiliate Hospital.

(2) Such other qualified Practitioners representative of the diverse specialties from the Hospital and the participating Affiliate Hospitals as jointly determined by the Medical Staff Presidents of the participating System hospitals.

(b) The *Ex-Officio* (non-voting) members of the Joint Credentials Committee shall include:

(1) The positions set forth in Section 4.2-5.

(2) System CMO

(3) Associate CMOs

(4) APP(s) as jointly determined by the Medical Staff Presidents of the participating System hospitals

(c) The chair and co-chair of the Joint Credentials Committee will alternate between the Immediate Past Medical Staff President of Bethesda Hospital and the Immediate Past Medical Staff President of Good Samaritan Hospital.

(d) Service on this committee shall be considered as the primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere.

4.7-2 DUTIES

The Joint Credentials Committee shall:

(a) Review the credentials of and completed applications from Practitioner applicants requesting Medical Staff appointment/reappointment and/or Privileges at this Hospital and/or a participating Affiliate Hospital(s).

(b) Review the credentials of and completed applications from APP applicants requesting Privileges at this Hospital and/or a participating Affiliate Hospital(s).

(c) Interview such applicants, at the committee's sole discretion, and make recommendations for, as applicable, Medical Staff appointment (for Practitioners) and/or Privileges (for Practitioners and APPs) in accordance with the procedures set forth in the Medical Staff Bylaws and Credentials Policy or APP Policy, as applicable.

(d) Report to the Hospital's or respective participating Affiliate Hospital's Medical Executive Committees on each applicant for, as applicable, Medical Staff appointment/reappointment and/or Clinical Privileges including specific consideration of the recommendations from the Chair(s) of the Medical Staff Department(s) in which each such applicant requests Privileges.

(e) Review reports concerning the conduct or clinical competence of Practitioners/APPs referred to the Joint Credentials Committee and make recommendations in accordance with the applicable procedure set forth in the Medical Staff governing documents.

(f) The chair of the Joint Credentials Committee or such other member(s) of the committee as deemed necessary shall be available to meet with the Board or its applicable committee(s) on all recommendations that the Joint Credentials Committee may make.

4.7-3 **MEETINGS**

(a) The Joint Credentials Committee shall meet at least ten (10) times per year and as otherwise needed to accomplish its duties at the call of the committee chair.

(b) Minutes will be maintained of each Joint Credentials Committee meeting, copies of which will be provided to the Hospital's and respective participating Affiliate Hospitals' Medical Executive Committees.

4.8 **JOINT PATIENT CARE COMMITTEE**

4.8-1 **COMPOSITION**

(a) The Joint Patient Care Committee shall consist of the following voting members:

(1) The Medical Staff President-Elect from the Hospital and each participating Affiliate Hospital.

(2) The following Department Chairs (or designee) at the Hospital and each participating Affiliate Hospital:

(i) Behavioral Health (attends on an *ad hoc* basis)

(ii) Critical Care Medicine

(iii) Emergency Medicine

(iv) Family Medicine

(v) Inpatient Medicine

(vi) Internal Medicine Specialties

(vii) Neonatal Pediatrics (attends on an *ad hoc* basis)

(viii) Obstetrics and Gynecology

(ix) Orthopedics/Orthopedic Surgery

(x) Pathology

(xi) Perioperative Medicine & Anesthesiology

(xii) Radiology

(xiii) Surgery

(3) One (1) elected at-large member from Good Samaritan Hospital and one (1) elected at-large member from Bethesda Hospital.

(b) The *Ex-Officio* (non-voting) members of the Patient Care Committee shall be:

(1) The positions set forth in Section 4.2-5.

(2) System CMO

(3) Associate CMOs

(4) System Senior Vice President/Chief Nursing Executive

(5) Vice President, Chief Nursing Officer

(6) Fellow (who holds a Medical Staff appointment at the Hospital)

(c) The chair and co-chair of the Joint Patient Care Committee will alternate between the Medical Staff President-Elect of Bethesda Hospital and the Medical Staff President-Elect of Good Samaritan Hospital.

(d) The Clinical Quality Resources Manager and the Clinical Quality Resources Operations Coordinator will provide administrative support to the Joint Patient Care Committee.

4.8-2 **DUTIES**

(a) The Joint Patient Care Committee shall:

(1) Provide Practitioner input to management on all systemic matters pertaining to patient care.

(2) Assist Hospital departments in formulating, improving, reviewing and recommending policies, procedures, rules, regulations, and budget requests regarding patient care.

4.8-3 **MEETINGS**

(a) The Joint Patient Care Committee shall:

(1) Meet as often as necessary, but at least quarterly, to accomplish its duties at the call of the committee chair.

(2) Report quarterly to the Hospital and respective participating Affiliate Hospitals' Medical Executive Committees and to the Safety, Quality, Service Committee.

4.9 JOINT MEDICAL STAFF PEER REVIEW COMMITTEE

4.9-1 COMPOSITION

(a) The Joint Medical Staff Peer Review Committee (MSPRC) shall be composed of the following voting members:

(1) The Medical Staff President-Elect from the Hospital and each participating Affiliate Hospital.

(2) Chair (or designee) of each Joint Medical Staff Quality Assurance Committee

(3) The following Department Chairs (or designee) at Hospital and each participating Affiliate Hospital:

(i) Behavioral Health (attends on an *ad hoc* basis)

(ii) Critical Care Medicine

(iii) Emergency Medicine

(iv) Family Medicine

(v) Inpatient Medicine

(vi) Internal Medicine Specialties

(vii) Neonatal Pediatrics (attends on an *ad hoc* basis)

(viii) Obstetrics and Gynecology

(ix) Orthopedics/Orthopedic Surgery

(x) Pathology

(xi) Perioperative Medicine & Anesthesiology

(xii) Radiology

(xiii) Surgery

(4) Anatomic Pathology Director

(5) System Chief, Gastrointestinal Service Line

(6) System Chief, Cardiovascular Service Line

(7) System Chief, Oncology Service Line

(b) The *Ex Officio* (non-voting) members of the MSPRC shall include the:

(1) The positions set forth in Section 4.2-5.

(2) Associate CMOs

(3) Fellow (who holds a Medical Staff appointment at the Hospital)

(c) Residents may not attend Joint MSPRC meetings other than as invited guests, for the purpose of answering questions related to a particular case, after which such guest will be excused.

(d) The chair and co-chair of the Joint MSPRC will alternate between the Medical Staff President-Elect of Bethesda Hospital and the Medical Staff President-Elect of Good Samaritan Hospital.

(e) The Clinical Quality Resources Manager and the Clinical Quality Resources Operations Coordinator will provide administrative support to the Joint MSPRC.

4.9-2 **DUTIES**

(a) The Joint MSPRC shall fulfill the duties set forth in the Medical Staff Peer Review/Professional Practice Evaluation Policy, as such policy may be amended from time to time.

4.9-3 **MEETINGS**

(a) The Joint MSPRC shall meet monthly, at the call of the committee chair, as needed to fulfill the duties set forth in the Medical Staff Peer Review/Professional Practice Evaluation Policy.

(b) The Joint MSPRC shall report to the Hospital's and each participating Affiliate Hospitals' respective Medical Executive Committee.

(c) Minutes will be maintained of each meeting, copies of which will be provided to the Hospital's and each participating Affiliate Hospitals' respective Medical Executive Committee.

4.10 JOINT MEDICAL STAFF QUALITY ASSURANCE COMMITTEES

4.10-1 DESIGNATION

(a) The Joint Medical Staff Quality Assurance (QA) Committees that report to the Joint MSPRC are set forth on Addendum A.

4.10-2 COMPOSITION

(a) The composition of each Joint Medical Staff Quality Assurance Committee is set forth in the applicable committee charter attached hereto as Addendum B.

4.10-3 DUTIES

(a) The duties of each Joint Medical Staff Quality Assurance Committee is set forth in the applicable committee charter attached hereto as Addendum B.

4.10-4 MEETINGS

(a) The meeting requirements with respect to each Joint Medical Staff Quality Assurance Committee are set forth in the applicable committee charter attached hereto as Addendum B.

4.11 JOINT PRACTITIONER EFFECTIVENESS COMMITTEE

4.11-1 COMPOSITION

(a) The voting members of the Joint Practitioner Effectiveness Committee (PEC) shall include:

(1) A Psychiatrist

(2) Immediate Past Medical Staff President from the Hospital and each participating Affiliate Hospital.

(3) Associate Chief Medical Officer from each of the participating System hospitals.

(4) Such other qualified Practitioners from the Hospital and each participating Affiliate Hospital as jointly determined by the Medical Staff Presidents of the participating System hospitals.

(5) A qualified APP(s) who shall serve on an *ad hoc* basis, with vote, for the limited purpose of assisting with APP impairment matters.

(b) The *Ex Officio* (non-voting) members of the PEC shall include the:

(1) The positions set forth in Section 4.2-5.

(c) The Joint PEC will be chaired or co-chaired by a qualified Practitioner(s) as jointly determined by the Medical Staff Presidents of each participating System hospital. The position of chair/co-chair requires history of membership on the Practitioner Effectiveness Committee.

(d) Appointment to this committee generally requires a minimum of a two (2) year commitment.

4.11-2 **DUTIES**

(a) The duties of the Joint PEC shall be as set forth in the Practitioner/APP Conduct Policy and the Practitioner/APP Impairment Policy, as such policies may be amended from time to time.

4.11-3 **MEETINGS**

(a) The Joint PEC shall meet, as needed, at the call of the committee chair to fulfill the duties set forth in the Practitioner/APP Conduct Policy and the Practitioner/APP Impairment Policy.

(b) The Joint PEC shall report to the respective Medical Executive Committee at the Hospital and each participating Affiliate Hospital.

(c) Minutes will be maintained of each meeting, copies of which will be provided to the Hospital's and participating Affiliate Hospitals' Medical Executive Committees.

4.12 **PEER REVIEW PRIVILEGE**

4.12-1 Each Medical Staff committee provided for in the Medical Staff governing documents is hereby designated as a peer review committee as that term is defined in Ohio Revised Code §2305.25 *et seq*. The Medical Staff, through its committees, shall be responsible for evaluating, maintaining, and monitoring the quality and utilization of the Hospital's health care services.

4.12-2 In carrying out his/her duties under the Medical Staff governing documents, whether as a committee member, Department Chair, Section Chair, Medical Staff officer, or otherwise, each Practitioner (and APP, to the extent applicable) shall be acting in his/her capacity as a designated agent of a peer review committee.

4.12-3 Such peer review committees and their designated agents may, from time to time and/or as specifically provided in the Medical Staff governing documents, appoint Hospital administrative personnel as their agents in carrying out such peer review duties.

ARTICLE V - MEDICAL STAFF MEETINGS

5.1 MEETINGS OF THE MEDICAL STAFF

5.1-1 REGULAR MEETINGS

The Medical Staff shall meet at least once each calendar year, on dates set at the beginning of the year by the Medical Staff President, for the purpose of reviewing and evaluating Medical Staff Department and Medical Staff committee reports and recommendations, and acting on any other matters placed on the agenda by the President. The Medical Staff shall be notified of regular Medical Staff meetings in the manner set forth in Section 7.1-1.

5.1-2 SPECIAL MEETINGS

Special meetings of the Medical Staff may be called at any time by the Medical Staff President, a majority of the Medical Executive Committee, or a petition signed by not less than one-fourth of the voting Members of the Medical Staff. The business to be transacted at any special meeting shall be limited to those items of business set forth in the notice of the meeting. The Medical Staff shall be notified of special Medical Staff meetings in the manner set forth in Section 7.1-1.

5.2 AGENDA

5.2-1 The agenda for all regular meetings of the Medical Staff shall be as follows:

(a) Call to order

(b) Acceptance of the minutes of the last regular meeting and of any intervening special meetings

(c) Unfinished business

(d) Clinical review activities

(e) New business

(f) Adjournment

5.2-2 The agenda shall be prepared in advance and approved by the Medical Staff President.

5.2-3 The agenda and minutes of the previous meeting shall be provided to voting Medical Staff Members in advance of the meeting.

5.2-4 Reports should be prepared in advance and submitted in writing to preserve as much time as possible for matters/issues requiring discussion or action.

5.3 QUORUM

5.3-1 The presence of at least 35 Medical Staff Members eligible to vote shall constitute a quorum for any regular or special meeting of the Medical Staff.

5.3-2 The required quorum must be present in order for any action (*i.e.*, a vote) to be taken at a Medical Staff meeting.

5.3-3 All actions taken at a Medical Staff meeting at which a quorum is present at the time of the vote shall be binding even though less than a quorum exists at a later time in the meeting.

5.4 MINUTES

5.4-1 Minutes of each meeting of the Medical Staff shall be prepared and include a record of the attendance of Members, recommendations made, and the vote taken on each matter. The minutes shall be reviewed and approved by the voting Members of the Medical Staff.

5.4-2 Copies of Medical Staff meeting minutes shall be provided to the Board.

5.4-3 Medical Staff meeting minutes shall be retained in accordance with the System record retention policy as such policy may be amended from time to time.

ARTICLE VI - DEPARTMENT, SECTION, AND MEDICAL STAFF COMMITTEE MEETINGS

6.1 DEPARTMENT AND SECTION MEETINGS

6.1-1 Members of Medical Staff Departments shall meet as a Department as often as necessary at the discretion of the Department Chair, but at least quarterly, at a time set by the Department Chair to review and evaluate the clinical work of the Department and to discuss any other matters concerning the Department. Department members shall be notified of regular Department meetings in the manner set forth in Section 7.1-1.

6.1-2 Members of Medical Staff Sections shall meet as a Section as often as necessary, at the discretion of the Section Chair, at a time set by the Section Chair to review and evaluate the clinical work of the Section and to discuss any other matters concerning the Section. Section members shall be notified of regular Section meetings in the manner set forth in Section 7.1-1.

6.1-3 The agenda for a Department or Section meeting shall be set by the Department or Section Chair.

6.2 MEDICAL STAFF COMMITTEE MEETINGS

6.2-1 Unless otherwise specified in the Medical Staff governing documents, all Medical Staff committees shall meet at least quarterly at a time set by the committee chair. Medical Staff committee members shall be notified of regular Medical Staff committee meetings in the manner set forth in Section 7.1-1

6.2-2 The agenda for a Medical Staff committee meeting shall be set by the committee chair.

6.3 SPECIAL MEETINGS OF MEDICAL STAFF DEPARTMENTS, SECTIONS, AND COMMITTEES

6.3-1 A special meeting of any Medical Staff Department, Section, or committee may be called by or at the request of its chair, by the Medical Staff President, or by a petition signed by not less than one-fourth of the voting members of the respective Department, Section, or committee. Notice of special meetings of Medical Staff Departments, Sections, and committees shall be provided pursuant to Section 7.1-1.

6.4 QUORUM

6.4-1 Medical Staff Departments: Unless otherwise set forth in the Medical Staff governing documents, the presence of at least one-fourth (*i.e.*, 25%) of the Medical Staff Department members eligible to vote at any regular or special Department meeting shall constitute a quorum for all actions.

6.4-2 Medical Staff Sections: Unless otherwise set forth in the Medical Staff governing documents, the presence of at least one-fourth (*i.e.*, 25%) of the Medical Staff Section members eligible to vote at any regular or special Section meeting shall constitute a quorum for all actions.

6.4-3 Medical Executive Committee: The presence of at least seven (7) voting members of the Medical Executive Committee shall constitute a quorum at meetings of the MEC.

6.4-4 Joint Credentials Committee: The presence of at least eight (8) voting members of the Joint Credentials Committees shall constitute a quorum at meetings of the Joint Credentials Committee.

6.4-5 Other Medical Staff Committees: Unless otherwise set forth in the Medical Staff governing documents, the presence of at least one-fourth (*i.e.* 25%) of the Medical Staff committee members eligible to vote at any regular or special committee meeting shall constitute a quorum for all actions.

6.4-6 The required quorum must be present in order for any action (*i.e.*, a vote) to be taken at a Medical Staff Department, Section, or committee meeting.

(a) *Ex Officio* committee members may not vote and are not counted for purposes of determining quorum unless otherwise specified in the Medical Staff governing documents.

(b) *Ex Officio* committee members are entitled to stay for the entire meeting.

(c) Guests may attend a meeting in order to make a requested presentation or provide requested information after which such guests will be excused.

6.4-7 All actions taken at a Medical Staff Department, Section, or committee meeting at which a quorum is present at the time of the vote shall be binding even though less than a quorum exists at a later time in the meeting.

6.5 MINUTES

6.5-1 Minutes of each meeting of a Medical Staff Department, Section, and committee shall be prepared and shall include a record of the attendance of members, recommendations made, and the vote taken on each matter. The minutes shall be reviewed and approved by the voting members of the Medical Staff Department, Section, or committee.

(a) Copies of Section minutes shall be provided to the applicable Medical Staff Department/Department Chair and to the MEC.

(b) Copies of Department minutes shall be provided to the MEC.

(c) Copies of Nominating Committee minutes shall be provided to the MEC.

(d) Copies of MEC minutes shall be provided to the Board.

(e) Copies of minutes of the Joint Credentials Committee, the Joint Bylaws Committee, the Joint Practitioner Effectiveness Committee, and the Joint Medical Staff Peer Review Committee shall be provided to the Hospital's and participating Affiliate Hospitals' MECs.

(f) Copies of minutes of a Joint Medical Staff Specialty Quality Assurance Committee shall be provided to the Joint MSPRC.

6.5-2 Medical Staff Department, Section, and committee meeting minutes shall be retained in accordance with the System record retention policy as such policy may be amended from time to time.

ARTICLE VII - PROVISIONS COMMON TO ALL MEETINGS OF THE MEDICAL STAFF OR A MEDICAL STAFF DEPARTMENT, SECTION, OR COMMITTEE

7.1 POSTING NOTICE OF MEETINGS

7.1-1 Notice of all regular and special meetings of the Medical Staff and of Medical Staff Departments, Medical Staff Sections, and Medical Staff committees shall be communicated at least five (5) business days in advance of such meetings in such manner as determined by (as applicable) the Medical Staff President, Department Chair, Section Chair, or the chair of the Medical Staff committee. Such communication shall be deemed to constitute actual notice to the persons concerned. The attendance of an individual at a meeting shall constitute a waiver of that individual's notice of said meeting.

7.2 ATTENDANCE REQUIREMENTS

7.2-1 Each Practitioner appointed **to the active Medical Staff with Privileges or to the active Medical Staff without Privileges** shall demonstrate his or her interest in the activities of the Medical Staff by accumulating a minimum of three (3) attendance points annually in accordance with the procedure set forth in Section 7.2.2 through Section 7.2-4.

7.2-2 Practitioners must attend (as evidenced by the Practitioner's signature on the applicable meeting attendance log) **at least one** (1) of the following meetings **annually**:

(a) Medical Staff meeting.

(b) Department or Section meeting.

(c) Standing Medical Staff committee meeting

7.2-3 The **two (2) additional annual attendance points** may either be earned by attending two (2) additional meetings, on an annual basis, from the list set forth in Section 7.2.2 above; **OR,** by attending two (2) additional meetings, on an annual basis, from the list below:

(a) Other meetings/activities as approved by the MEC including, but not limited to:

- Organized patient/provider experience and/or safety related meetings:
    - SOAR councils
    - Wellness meetings
- Practitioner leadership meetings:
    - Integrated leadership team meetings
    - Leadership development institute
    - Practitioner leadership development institute
    - Practice of medicine leadership team meetings
    - TPP associate medical director meetings

- Outpatient quality and population health committee meetings
- Other outpatient department meetings

- High reliability and safety training and related committees/meetings
- Volunteer activities related to the Medical Staff:
  - Development and foundation committees
  - Price Hill Free Clinic
  - Cradle Cincinnati/Healthy Moms and Babies
- Board of Director meetings and Board committee meetings
- PHO activities and committee meetings

(b) A Department Chair may award points to Department members for providing continuing or graduate medical education; or, for participation in meetings of the graduate medical education faculty or clinical competency committees.

7.2-4 At the time of reappointment/regrant of Privileges, a Practitioner who seeks reappointment to the active Medical Staff category with Privileges or to the active Medical Staff category without Privileges shall attest, in writing, that he/she has earned a total of six (6) attendance points (3 points annually) in accordance with the procedure set forth in Section 7.2-1 through Section 7.2-3 above. In the event that a Practitioner fails to satisfy the applicable attendance requirements, then he/she shall not be eligible for reappointment to the active Medical Staff with or without Privileges but may request transfer to another Medical Staff category, if any, for which such Practitioner is qualified.

7.2-5 Practitioners appointed to categories **other than** the active Medical Staff category with or without Privileges are expected to attend and participate in meetings of the Medical Staff, Departments, Sections, and committees (to the extent each such Practitioner is permitted to do so) but shall not be required to do so as a condition of continued Medical Staff appointment.

7.3 MEETING CONDUCT

7.3-1 Common sense, as determined by the Medical Staff President or the chair of the Department, Section, or Medical Staff committee, as applicable, shall be applied in the conduct of meetings.

7.3-2 To the extent there is a disagreement as to procedure, the latest edition of Robert's Rules of Order may be consulted for guidance.

7.4 MANNER OF ACTION AT A MEETING

7.4-1 Unless otherwise specified in the Medical Staff governing documents, individuals may participate in and act at any meeting by conference call, video conferencing, or other forms of telecommunication through which all persons participating in the meeting can

communicate with each other in real-time. Participation by such means shall constitute attendance and presence in person at the meeting.

7.4-2 Unless otherwise provided in the Medical Staff governing documents:

(a) The action of a majority of those Members eligible to vote who are present and voting at a Medical Staff meeting at which a quorum is present is the action of the Medical Staff.

(b) The action of a majority of those members eligible to vote who are present and voting at a Department, Section, or Medical Staff committee meeting at which a quorum is present is the action of that Department, Section, or Medical Staff committee.

7.5 MANNER OF ACTION WITHOUT A MEETING

7.5-1 Unless otherwise provided in the Medical Staff governing documents:

(a) The Medical Staff and any Department, Section, or committee of the Medical Staff may act on a matter by ballot without a meeting.

(b) In such event, ballots shall be distributed, as applicable, to each Medical Staff Member or Medical Staff Department, Section, or committee member eligible to vote. Completed ballots shall be returned within the time period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. A majority vote of the total votes returned by the stipulated date shall be the action of the Medical Staff or a Medical Staff Department, Section, or committee, as applicable.

(c) Notwithstanding the above, a recommendation by the MEC with respect to a summary suspension or formal corrective action investigation cannot be made by the MEC without a meeting.

7.6 VOTING

7.6-1 Unless otherwise specified in the Medical Staff governing documents, voting may occur in any of the following ways as determined by the chair of the Department, Section, or the applicable Medical Staff committee; or, for voting by the Medical Staff, as determined by the Medical Staff President.

(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 votes are received prior to the deadline date set forth in the notice advising of the purpose for which the vote is to be taken.

7.6-2 Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote provided that such individual is eligible to vote.

ARTICLE VIII - MISCELLANEOUS

8.1 DEFINITIONS

8.1-1 The definitions set forth in the Medical Staff Bylaws shall apply to this Medical Staff Organization Policy unless otherwise specifically provided herein.

8.2 ADOPTION & AMENDMENT

8.2-1 This Medical Staff Organization Policy may be adopted and amended in accordance with the procedure set forth in the Medical Staff Bylaws for adoption and amendment of Medical Staff Policies.

CERTIFICATION OF ADOPTION & APPROVAL

Adopted by the Medical Executive Committee on:

Approved by the Board on:

ADDENDUM A
Joint Medical Staff Quality Assurance Committees

Behavioral Health Quality Assurance Committee

Cardiology Quality Assurance Committee

Cardiothoracic Quality Assurance Committee

Critical Care Quality Assurance Committee

Emergency Medicine Quality Assurance Committee

Gastroenterology Quality Assurance Committee

Medicine Quality Assurance Committee

Neonatal Pediatrics Quality Assurance Committee

OB/GYN Quality Assurance Committee

Oncology/Blood Quality Assurance Committee

Orthopedics Quality Assurance Committee

Perioperative Medicine & Anesthesiology Quality Assurance Committee

Radiology Quality Assurance Committee

Surgery Quality Assurance Committee

- Trauma Performance Improvement Committee (reports to the Surgery Quality Assurance Committee)

Additional Joint Medical Staff Quality Assurance Committees may only be created in accordance with the procedure set forth in Section 4.1-1 (b) of this Policy.

ADDENDUM B

MEDICAL STAFF QUALITY ASSURANCE COMMITTEE CHARTER

Medical Staff Quality Assurance (QA) Committees are established and subject to the provisions governing Medical Staff committees set forth in the Medical Staff Bylaws and Medical Staff Organization Policy. The QA Committees overall responsibilities include the review and evaluation of clinical work performed by Practitioners and Advanced Practice Providers (APPs) within the designated specialty (Specialty), as well as discussion and/or action regarding other matters impacting patient care delivery involving the Specialty.

References to positions shall include the position's designee.

Section 1 - Composition

- The Joint Medical Staff Peer Review Committee (MSPRC) may make recommendations with respect to members of a Specialty QA Committee.

- Each Specialty QA Committee shall consist of the following voting members:

    - Practitioners with Privileges in the Specialty and may include Practitioners from other specialties deemed applicable and appropriate by the Medical Staff Presidents of the participating System hospitals in consultation with the QA Committee chair provided inclusion of such Practitioners supports enhancement of quality review.

- The *Ex-Officio* (non-voting) members of each Specialty QA Committee shall be:

    - The designated Associate Chief Medical Officer.

    - The applicable System Chief.

    - Additional individuals as the Medical Staff Presidents of the participating System hospitals may appoint in consultation with the QA Committee chair.

- APPs with Privileges may, as deemed applicable and appropriate by the Medical Staff Presidents of the participating System hospitals in consultation with the QA Committee chair, serve as a voting or non-voting member of a Specialty QA Committee provided inclusion of such APPs supports enhancement of quality review.

- Residents may not attend QA Committee meetings other than as invited guests for the purpose of answering questions related to a particular case, after which such guests will be excused.

- The QA Committee will be chaired or co-chaired by a qualified Practitioner(s) as jointly determined by the Medical Staff Presidents of the participating System hospitals.

Section 2 - Duties

Each Specialty QA Committee shall:

- Conduct Practitioner/APP peer review and professional practice evaluation in accordance with the Medical Staff Peer Review/Professional Practice Evaluation Policy, as such policy may be changed from time to time.

- Provide input to management on matters pertaining to patient care relevant to the Specialty.

- Assist in the evaluation of Practitioners and APPs whose performance has been identified as a result of clinical monitoring and assessment activities.

- Be responsible for performance measurement, assessment, and improvement relative to clinical processes and outcomes for Practitioner and APPs.

- Identify and refer systemic peer review issues for process improvement opportunities to the appropriate responsible party(ies) or committee for action.

- Designate individual Practitioners/APPs to act as agents of the QA Committee for purposes of case review and/or professional practice evaluation, as needed.

Section 3 - Meetings

- Each Specialty QA Committee shall meet as needed to perform its designated duties. It is expected that a Specialty QA Committee will meet not less than every other month. If a Specialty QA Committee's oversight is such that meetings are needed less than six (6) times per year, consideration will be given to combining it with another Specialty QA Committee.

- Agendas should be prepared in advance of the meeting and approved by the QA Committee chair.

- Quorum shall be as set forth in the Medical Staff Organization Policy.

- Minutes shall be taken and maintained by the Clinical Quality Specialist supporting the QA Committee. Minutes of the prior meeting will be provided to all committee members in advance of the next meeting. Following approval by committee members, minutes shall be signed by the QA Committee chair with a copy provided to the MSPRC.

Section 4 – Reporting Structure

The QA Committee shall report to the MSPRC which, in turn, reports to the Medical Executive Committee of each participating System hospital.

Designated QA cases will be highlighted in QA Committee minutes for review by the MSPRC.

The applicable Department Chair(s) may receive copies of applicable QA Committee minutes as a QA Committee member and agent of the peer review process.

Section 5 - Confidentiality Agreement

Each member of a Specialty QA Committee, and each Practitioner/APP requested to perform a case review on behalf of a Specialty QA Committee must sign a Confidentiality Agreement (attached hereto), in the form set forth in the Medical Staff Peer Review/Professional Practice Evaluation Policy, annually (or in advance of the case review for agents) agreeing to maintain the confidentiality of all peer review activities within the scope of the QA Committee.

ADDENDUM C
PEER REVIEW PROGRAM
MEMORANDUM OF UNDERSTANDING
AND STATEMENT OF CONFIDENTIALITY

Thank you for agreeing to serve as a member of a Peer Review Committee (PRC) or otherwise participate in the Peer Review process at Good Samaritan Hospital and its provider-based locations (Hospital). Practitioners and Advanced Practice Providers (APPs) who participate in Peer Review must be viewed by their colleagues as fair, collegial, confidential, clinically competent, and professional. Peer Review is ultimately the responsibility of the Hospital Board as part of evaluating, maintaining, and monitoring the quality of health care services provided by Practitioners and APPs granted Clinical Privileges at the Hospital. The Board delegates this responsibility to the Medical Staff through its PRCs and those committees' members/agents. As a member of a PRC or participant in the Peer Review process, it is your shared responsibility, in return, to make sure that the Peer Review program is effective.

The ultimate goal of Peer Review is to continuously improve the skills of Practitioners and APPs with Privileges at the Hospital through identification, analysis, and practice improvement recommendations for problematic events. In order for these interventions to successfully improve patient care, the process of Peer Review has to be just and fair. This leads to a number of behavior expectations for members of PRCs and other Peer Review participants, as follows:

- Have a professional and collegial demeanor in all activities.

- Keep deliberations frank, honest, accurate, unbiased, and non-inflammatory.

- Be trustworthy. Keep the deliberations confidential the way you would expect if your case was under review.

- Seek additional input if the issue is outside the expertise of the PRC members. Sometimes determining whether or not a particular action was within the standard of care requires detailed knowledge of current practice that only a group of Peers from within the involved specialty can provide.

- Do not use the Peer Review process to discredit, embarrass, undermine, discourage, or unseat a colleague. Cases should be selected without bias.

- Do not protect a colleague or friend from Peer Review. If you perceive that this needs to be done, you are indicating that you believe the Peer Review process is either not fair; or, is being used to do something other than improve the Quality of Care. It is your obligation to bring these concerns to the PRC chair.

- If you have a conflict of interest with the Practitioner/APP being discussed (*e.g.*, competitor, partner, refers patients to you or vice-versa, financial relationship, employed in the same group, *etc.*), you are expected to disclose that conflict to the PRC. The PRC is responsible for determining whether the conflict rises to the level of precluding you from participating in the pending Peer Review matter. For purposes of the Peer Review Program Policy, the fact that Practitioners/APPs are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners/APPs from participating in the Peer Review process with respect to his/her colleagues.

All Peer Review information is privileged and confidential in accordance with the Medical Staff governing documents, Hospital policies, and state and federal laws, rules, and regulations pertaining to confidentiality and non-discoverability. In Ohio, Peer Review discussions and documents are protected from discovery by Ohio law. As long as the Hospital has a prescribed process for Peer Review and follows that process, efforts to protect patients and improve Practitioner/APP performance cannot be used as evidence in a state civil lawsuit.

To preserve the confidentiality of Peer Review information and quality data, it is imperative that Practitioners and APPs involved in the Peer Review process observe the following instructions in the performance of Peer Review:

- The case review form should never be shared with individuals who are not authorized to access this information. When the review is completed, please submit the form (either in hard copy or electronically) to the designated Medical Staff/Hospital personnel or office. The form is not to be part of the patient's medical record.

- Once the case review form is completed, making additional copies of the form is prohibited.

- Discussing Peer Review cases or data with other Practitioners or APPs outside of the PRC meeting is prohibited unless specifically requested by the PRC.

- Discussing any Peer Review case or data with anyone in a public setting is prohibited.

- Discussing PRC reviews with Hospital employees other than those involved in the Peer review or quality/performance improvement process is prohibited.

I understand the expectations for a member of a PRC/participant in the Peer Review process and I agree to comply with these expectations. I further understand and agree to comply with the requirements for confidentiality of Peer Review deliberations. I also understand and acknowledge that failure to comply with these expectations and requirements may result in my removal as a member of a PRC/participant in the Peer Review process and/or may be grounds for corrective action pursuant to the Medical Staff Bylaws or APP Policy, as applicable.

NAME (Print)	SIGNATURE	DATE SIGNED