

**NATIONWIDE CHILDREN'S HOSPITAL
COLUMBUS, OHIO**

MEDICAL STAFF

**PRACTITIONER/ADVANCED PRACTICE
PROVIDER EFFECTIVENESS POLICY**

**MEDICAL STAFF OFFICE
Ross Hall 1st Floor
700 Children's Drive
Columbus, Ohio 43205
(614) 722-3040**

ARTICLE 1: PROFESSIONAL PRACTICE EVALUATION

1.1. Purpose

The Hospital's Board of Directors ("Board"), by delegation to its Medical Staff, collects and/or analyzes and reviews credentials and performance data for the evaluation of each Practitioner's and Advanced Practice Provider's (APP) (Practitioners and APPs hereinafter collectively referred to, for purposes of this Section, as "Practitioners") current clinical competency in order to determine the Practitioner's eligibility for requested Clinical Privileges and assure high quality, safe patient care in the Hospital.

1.2. Professional Practice Evaluation (PPE)

- A. The Hospital performance improvement program initiatives are designed to: (1) continuously improve the quality of care to patients; and (2) provide for PPE that consistently determines the current competency of privileged Practitioners. Such activities are peer review protected activities.
- B. A Practitioner's performance evaluation shall be conducted in a uniform and consistent manner by the Practitioner's peers (or selected consultants to the Medical Staff) during:
 - 1. The appointment/reappointment and privileging processes.
 - 2. On an ongoing basis.
 - 3. On a focused basis whenever a quality of care concern arises. In such reviews, all concerns as well as results of tracking and trending of peer review activity shall be considered.
- C. Practitioner competency is evaluated via PPE initiatives. Results of these activities will be aggregated, trended, and maintained as needed in each Practitioner's individual credentials or quality file retained in the Medical Staff Office.
- D. Initiation and monitoring of PPE will be coordinated by an applicable Section/Department Chief with coordination/assistance by Quality Improvement Services ("QIS") and/or the Medical Staff Office.
- E. The results of a PPE may be used to implement change or to improve performance of a Practitioner, a medical specialty, or care practices while fully safe-guarding the confidentiality of the protected peer review process. Should a PPE result in a determination that patient safety is in jeopardy, the provisions of the Medical Staff Bylaws or APP Policy are to be initiated, as applicable.
- F. Exhibit A-1, attached hereto and incorporated by reference herein, sets forth the process for periodic review of PPE data evaluation forms.

1.3. Ongoing Professional Practice Evaluation Process ("OPPE")

- A. Continuous OPPE by the Medical Staff of the medical/clinical care provided by privileged Practitioners is conducted to ensure the consistent and continuous

delivery of high quality safe patient care. OPPE applies to all Practitioners who have been granted Clinical Privileges. The Department Chief, in consultation with the applicable Section Chief, is responsible for establishing specific OPPE criteria that will be regularly monitored. Such criteria may include the following categories: activity data (e.g., inpatient admissions, consults, procedures, length of stay, etc.) and performance data including clinical care, medical/clinical knowledge, practice-based learning and improvement, communication skills, and professionalism.

- B. Information used in OPPE may be acquired through multiple resources including the following:
 - 1. Record review.
 - 2. Direct observation.
 - 3. Patient and/or family feedback.
 - 4. Monitoring of diagnostic and treatment techniques.
 - 5. Discussion with other individuals involved in the care of each patient including consulting Practitioners, assistants at surgery, nursing, and administrative personnel. The Departments shall, from time to time, review, revise, and create criteria directing the type of data to be collected.
- C. All OPPE activities are conducted continuously and reported periodically (usually quarterly or semi-annually) to determine if generally accepted standards of care have been met and to determine if opportunities to improve care and care processes exist within the Hospital. Relevant information gleaned from an OPPE will be integrated into performance improvement activities as applicable. OPPE derived data may be used to assign a period of FPPE monitoring for quality of care concerns to assess the Practitioner's current competence, practice behavior, and/or the ability to perform a requested Privilege(s).
- D. OPPE activity is under the direction and guidance of the relevant Section/Department Chief in conjunction with the Hospital QIS Department. Data pertaining to the Practitioner and Department/Section specific metrics will be gathered by QIS and reported to the Section/Department Chief. It is the responsibility of the Department/Section Chief to periodically review this OPPE-specific data and make recommendations, if necessary, to the appropriate Medical Staff committee regarding the need for initiation of FPPE for quality of care concerns. Information regarding Practitioner specific OPPE will be maintained in each Practitioner's quality file and retained in the Medical Staff Office.

1.4. Focused Professional Practice Evaluation ("FPPE")

- A. FPPE is a targeted, focused monitoring of competency associated with the exercise of Clinical Privileges. PPE of Practitioners using the FPPE process is initiated for:

1. New Privileges: all initial (new) Privileges (whether a new Practitioner to the Hospital or an established Practitioner at the Hospital who is granted a new Privilege); or

FPPE may also be implemented for:

2. Quality of Care Concern: when a potential question or concern arises regarding a privileged Practitioner's current clinical competence, and/or professional behavior, and/or the ability to safely perform any Privilege.

B. New Privileges

1. Clinical competency monitoring with FPPE will be conducted for a specified minimum period of time and/or performance volume, consistent with the Privilege set, as determined by the applicable Section/Department Chief and approved by the Credentials Committee. The FPPE parameters should be formatted as in the example below.

The duration of the FPPE for Dr. _____ shall be for a minimum of (example - three (3) months) or until at least (example - five (5)) episodes of (kind of care activity) are available for evaluation and verification by (the applicable Section/Department Chief or designee).

2. The Credentials Committee will oversee this process consistent with the Medical Staff Bylaws or APP Policy, as applicable. The Section/Department Chief or designee(s), in conjunction with QIS , will oversee the performance data gathering and provide a summary report to the Credentials Committee. Should the Credentials Committee determine that the FPPE results are inconclusive so as to not allow for a Privilege-specific competency determination, the FPPE monitoring can be extended for up to one (1) additional year, but not to exceed a total of two (2) years, per FPPE review episode.

C. Quality of Care Concern

1. Quality of care concerns that can initiate a FPPE may include a single untoward clinical incident, a sentinel event, an adverse event, evidence of undesired clinical practice trends, or significant unprofessional behaviors.
2. Medical Staff leadership will communicate with the Practitioner and appropriate Hospital leadership, including the Chief Medical Officer, during or upon conclusion of FPPE activity that was initiated to assess a quality of care concern and as determined by the Medical Staff Bylaws or APP Policy, as applicable.
3. PPE, such as FPPE, can be accomplished through review of Hospital-based outpatient and/or inpatient procedures or care management using internal or external peer review group(s). Selected outpatient and/or inpatient episodes of care will be reviewed by screening selected medical

records for criteria related to care management concerns. Examples of screening criteria may include:

- (a) Review of operative and other clinical procedure(s) performed and their outcomes (may use internal or external peer review).
- (b) Pattern of blood and pharmaceutical usage.
- (c) Requests for tests and procedures.
- (d) Morbidity and mortality data including the use of autopsy.
- (e) Practitioner's use of consultants.
- (f) Other relevant data as determined by the Medical Staff.

4. Methods to collect PPE data may include:

- (a) Periodic chart review.
- (b) Direct observation.
- (c) Patient and/or family feedback.
- (d) Monitoring of diagnostic and treatment techniques or practices.
- (e) Discussion with other individuals involved in the care of each patient including consulting Practitioners, assistants at surgery, nursing personnel, and administrative personnel.

5. FPPE action or work plans may include, but are not limited to, one or more of the following items. The charge to the group conducting the FPPE will suggest which methods to include.

- (a) Comparison of the Practitioner's inpatient and outpatient complications/outcomes related to his/her peers, regional, national or federal performance standards and/or guidelines, where available.
- (b) Retrospective, concurrent, or prospective medical record review.
- (c) Proctoring results.
- (d) External peer review.
- (e) Simulation results.
- (f) Discussion with other individuals involved in the care of the Practitioner's patients and/or patient cases relative to the substance of the FPPE.

- D. External peer review will be conducted when appropriate internal peer expertise is not available.
- E. FPPE convened due to quality of care concerns may follow the informal collegial intervention procedure prescribed in the Medical Staff Bylaws (led by the Vice President of the Medical Staff) or APP Policy, as applicable, or may be conducted by a “peer professional group” consisting of members determined by the relevant Section/Department Chief, Chief Medical Officer, Credentials Committee chair, and Medical Staff President. This focused “peer professional group” will be appointed jointly by the President of the Medical Staff and the Chief Medical Officer.

1.5. Results of PPE

- A. The information resulting from PPE activity (FPPE and/or OPPE) is used as part of the Medical Staff’ informal routine peer review process. Based upon this ongoing analysis, several actions may occur including but not limited to:
 - 1. Determination that the Practitioner is performing well (or within the desired expectations) and that no further action is warranted.
 - 2. Determination that an issue(s) exists that should be addressed by a period of FPPE.
 - 3. Determination that an issue(s) exists that should be addressed by informal remediation.
 - 4. Determination that a recommendation should be made to the MEC for initiation of the formal corrective action process.
 - 5. Determination that zero performance should trigger FPPE whenever the Practitioner actually performs the Privilege.
- B. In addition, the information will be reviewed on an aggregate basis to determine (a) whether certain Privileges should continue to be recognized by the Board of Directors because the Privileges are important to the Hospital’s mission of providing patient care; or (b) whether such Privileges should be eliminated.

1.6. Assessment of PPE Process

Periodically as needed, a meeting shall be held consisting of the Medical Staff President, the Section/Department Chiefs, and members of Hospital administration (including, but not limited to, the Chief Medical Officer and Chief Nursing Officer) to assess: 1) the effectiveness of the FPPE/OPPE process; and 2) to determine what changes, if any, should be made to the professional practice evaluation process as set forth in this Policy. Such meeting(s) may be a part of the agenda of any regularly scheduled meeting or may be called as a special meeting.

1.7. Peer Review Committee Members

All members of a Peer Review Committee (PRC), and individuals requested to act as an agent of a PRC, must sign a confidentiality statement, a copy of which is attached hereto as Exhibit A-2 and incorporated by reference herein, prior to engaging in peer review activities.

ARTICLE 2: PRACTITIONER/ADVANCED PRACTICE PROVIDER HEALTH & CONDUCT

2.1. Impaired Practitioners and Advanced Practice Providers

- A. An impaired Practitioner/Advanced Practice Provider (APP) is one who is unable to safely and competently practice according to acceptable and prevailing standards of care by reason of mental illness or physical illness or because of habitual or excessive use or abuse of drugs, alcohol, or other substances that adversely impair the Practitioner's or APP's ability to practice.
- B. The procedure for addressing Practitioner/APP impairment is set forth in the Medical Staff Practitioner/APP Impairment Policy attached hereto as Exhibit B and incorporated by reference herein.

2.2. Practitioner/Advanced Practice Provider Conduct

The procedure for addressing Practitioner/APP conduct matters is set forth in the Medical Staff Practitioner/APP Professional Conduct Policy attached hereto as Exhibit C and incorporated by reference herein.

ARTICLE 3: GUIDELINES FOR PRACTITIONER IN-HOUSE SERVICE

- 3.1. Since it is essential to patient safety that effective transitions in care occur, Practitioners who have performed 24 hours of continuous in-house service may remain on site at the Hospital to write notes, complete orders, transfer patient care with hand-off to oncoming Practitioners, and perform other activities that do not involve direct patient care. These Practitioners should refrain from performing elective surgical procedures or having any direct clinical responsibility for the subsequent 10 hours except as set forth in Section 3.2 below.
- 3.2. In certain circumstances, a Practitioner may remain beyond the 24 hours of continuous in-house service to continue to provide care to a single patient or a category of patients. Reasons for such extensions of duty are limited to reasons of required continuity for severely ill or unstable patients, an extremely long and complex surgical procedure, humanistic attention to the needs of a patient or family, or in an emergent situation when no other required specialists are available. Under these circumstances, the Practitioner should hand over the care of other patients where another Practitioner is available to provide for their continuing care.
- 3.3. If a Practitioner is believed to be providing direct patient care for more than 24 hours and none of the pressing patient care needs as listed in Section 3.2 above apply, then Hospital personnel and/or Medical Staff observing the Practitioner should notify the Chief Medical Officer, a Medical Staff officer, or the Administrator-on-Call to assess the situation. If it is confirmed that a Practitioner is working beyond 24 hours of continuous in-house service and none of the circumstances set forth in Section 3.2 above apply, then he or she should be excused from direct clinical duties for the subsequent 10 hours.

EXHIBIT A-1

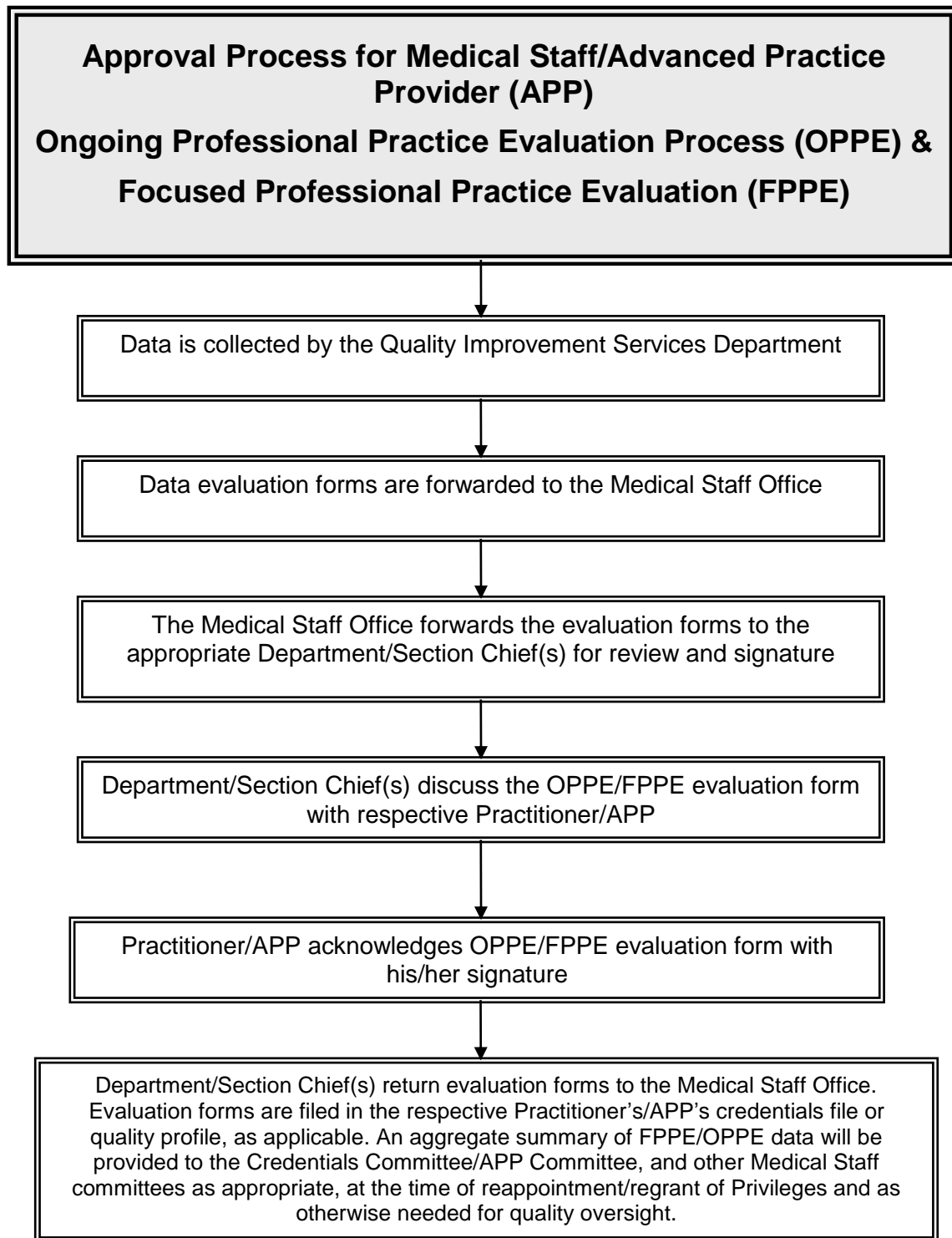


EXHIBIT A-2

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 the Hospital. Practitioners/Advanced Practice Providers 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 maintaining the quality of medical care. The Board delegates this responsibility to the Medical Staff through the Chief of Staff and MEC which, in turn, authorizes the PRCs to act. 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 Advanced Practice Providers 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/Advanced Practice Provider 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 this 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 Bylaws, Hospital and Medical Staff policies, and state and federal laws 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/Advanced Practice Providers performance cannot be used as evidence in a state civil lawsuit.

To preserve the confidentiality of quality management data, it is imperative that Practitioners and Advanced Practice Providers involved in peer review 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 Advanced Practice Providers 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.
- Discussions of PRC reviews with Hospital employees other than those involved in the peer review or performance improvement process are 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

EXHIBIT B

Practitioner/Advanced Practice Provider Impairment Policy

Nationwide Children's Hospital

A Medical Staff Document

1.1 Introduction

- A. This Practitioner/Advanced Practice Provider (APP) Impairment Policy (Policy) provides collegial steps and educational efforts that can be taken to address impaired Practitioners.¹ The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to informally resolve the concerns that have been raised.
- B. Nothing in this Policy should be construed as requiring its implementation as a condition precedent to any action that might otherwise be taken pursuant to the Medical Staff Bylaws or APP Policy, as applicable, including the initiation of corrective action proceedings.
- C. This Policy does not preclude any person authorized to impose a summary suspension pursuant to the Medical Staff Bylaws or APP Policy from doing so. Further, this Policy does not preclude an authorized individual from summarily suspending a Practitioner pursuant to the Medical Staff Bylaws or APP Policy, as applicable, based upon information that the authorized individual learns as a result of this Policy, nor is any individual who imposes such a suspension precluded from continuing as a participant in the procedure set forth herein.
- D. The definitions set forth in the Medical Staff Bylaws or APP Policy will apply to this Policy unless otherwise provided herein.
- E. This Policy does not govern the process that is followed in the event a matter is referred to Human Resources for management. Rather, this Policy is limited to the process to be followed in the event an impaired Practitioner is handled by the Medical Staff as a Medical Staff matter.

1.2 Reports of Practitioner Impairment

The following procedure will be followed with respect to reports of Practitioner impairment.

- A. Reports of impairment regarding a Practitioner may be made by any individual. Individuals who witness suspected impairment should:
 - 1. Report the incident to their supervisor or to the Medical Staff President or Vice President. If an individual initially provides a verbal report to his/her supervisor or to the Medical Staff President or Vice President, it is the responsibility of the individual making the report (or the supervisor or Medical Staff President or Vice President) to document the incident and provide such documentation to the Medical Staff office.
 - 2. Although knowledge of the reporting individual's identity is preferred for purposes of follow up, such report may be made anonymously. The fact that a report is anonymous will not preclude the matter from being reviewed; however, the fact of anonymity means that it may not be

¹ For purposes of this Policy, the term "Practitioner" means Physicians, Dentists, Podiatrists, and Psychologists granted Medical Staff appointment and/or Privileges at the Hospital in addition to Advanced Practice Providers granted Privileges at the Hospital.

possible to validate the concerns and that no response back to the concerned individual will be able to be made.

- B. Reporting should be done in a prompt fashion.
- C. Practitioners with an impairment are encouraged to voluntarily self-report a Medical Staff leader so that assistance can be provided to the Practitioner. It is the responsibility of the individual who receives the report to document the incident and provide such documentation to the Medical Staff office.
- D. The individual, if known, who files a report regarding alleged impairment on the part of a Practitioner will be advised that follow-up action has been taken but will not be provided specific details of the resolution. No individual who in good faith reports suspected impairment, or who otherwise participates in the procedure set forth herein, will be retaliated against for such report or participation.

1.3 Committee Review and Practitioner's Rights

- A. The Practitioner/APP Wellness Committee (Committee) addresses issues of alleged Practitioner impairment. The Committee will be composed of the Chief Medical Officer, the Medical Staff President, and the Medical Staff Vice President. The Committee reports to the MEC.
- B. Upon receipt of a report of suspected Practitioner impairment, the Committee will proceed to review the matter.
 - 1. Each report should be sufficiently reviewed to determine whether the report has validity. This assessment should consist of (a) reviewing documents and talking with individuals (including the complainant and the Practitioner, as appropriate); and (b) determining whether the report reflects a first-time issue or whether there have been any prior incidents, or formal or informal interventions, with the Practitioner in order to determine whether a pattern or trend has developed.
 - 2. Reviews may be conducted by the Committee as a whole or a review may be assigned to one or more committee members to report back to the Committee. The CNO shall be invited to participate on the Committee in the event of suspected APP impairment.
 - 3. To the extent a report involves a Practitioner who is a member of the Committee or otherwise has a conflict of interest with respect to the Practitioner who is the subject of the report, such Practitioner may not participate as a committee member and another Practitioner may be appointed to participate in review of the matter.
 - 4. Individuals who are interviewed should be reminded that this is a confidential peer review process and the discussion should not be disclosed to others.
 - 5. The Committee will rely upon the most recent complaint of impairment in conducting its review of the event; provided, however, that consideration

of reports of past incidents, if any, received during the Practitioner's current appointment and/or Privilege period may be considered for trending purposes.

6. The Committee may notify the Practitioner upon receipt of a report; however, such notification is not required prior to proceeding with review of the matter.

C. As part of its review, the Committee may request that the Practitioner:

1. Submit to a physical examination and/or mental evaluation, at the Practitioner's expense, by a Physician or other qualified individual chosen by the Committee who will submit a report to the Committee containing, at a minimum, the following information:
 - (a) Whether the Practitioner is suffering from an impairment.
 - (b) The nature and scope of the impairment.
 - (c) Whether such impairment is treatable and, if so, recommendations as to the proper course of treatment.
 - (d) The Practitioner's present ability to continue to practice in a hospital setting.
 - (e) Whether any limitations should be placed on the Practitioner with respect to his or her practice.
2. In the event a second opinion is requested by the Committee, such subsequent evaluation will be at the Hospital's expense.

D. The Committee may continue to utilize the collegial and educational steps noted in this Policy as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

E. Practitioners have the following rights with respect to the Committee.

1. Engagement with the Committee is an informal process. A Practitioner has the right to refuse to participate in this process.
2. A Practitioner has the right to respond, in writing, to allegations raised in a report or to otherwise respond to any documentation that the Practitioner receives from the Committee. All such written responses will be maintained in the Practitioner's quality file.

1.4 Committee Action Upon Completion of Review of Report of Practitioner Impairment

- A. Upon completion of review of a report of Practitioner impairment, the Committee will prepare a written report setting forth its findings as to whether the Practitioner is impaired and, if so, will provide its recommendations as to what action(s) should be taken.

B. If the Committee concludes that there is reason to believe that the Practitioner is impaired, the Committee has the authority to enter into a voluntary agreement with the Practitioner to:

1. Undertake rehabilitation through an approved treatment provider; and, if appropriate, that such be reported to the State Medical Board or other appropriate licensing entity.
 - (a) The Committee will encourage rehabilitation when appropriate and will assist the affected Practitioner in locating a rehabilitation program or properly qualified individual to treat the affected Practitioner.
 - (b) The Practitioner will be financially responsible for the costs of his or her rehabilitation/treatment.
2. Seek counseling.
3. Request a leave of absence pursuant to the Medical Staff Bylaws or APP Policy, as applicable, in the following instances:
 - (a) If the Practitioner agrees to participate in an approved inpatient rehabilitation program.
 - (b) If the Practitioner's approved treatment provider recommends that the Practitioner not treat patients for a period of time while undergoing treatment.

The fact that a treating provider has opined that the affected Practitioner may continue to treat patients while undergoing treatment will not preclude the Committee from recommending that corrective action be taken limiting such Practitioner's Privileges in the event the Practitioner does not otherwise voluntarily agree to such limitation.

C. In the alternative, the Committee may:

1. Recommend that corrective action be initiated against the Practitioner pursuant to the applicable provisions of the Medical Staff Bylaws or APP Policy, as applicable.
2. Recommend that the Practitioner be permitted to continue treating patients but that such treatment be monitored for continual assessment of the Practitioner's ability to provide safe patient care.
3. Take any other action consistent with the purposes of this Policy and the Medical Staff Bylaws or APP Policy, as applicable.

D. Unless corrective action is recommended, the Committee will not be required to obtain the approval of the MEC with respect to any arrangements agreed to by the Committee and the Practitioner.

- E. If the Committee concludes that there is no reason to believe that the Practitioner is impaired, the initial documentation submitted to the Committee, the Committee's report and recommendation (if any), and all other documentation compiled by the Committee as part of its review will be maintained, on behalf of the committee, by the Medical Staff Office as confidential peer review documents. The finding of the Committee will be documented in the Committee's minutes.
- F. If the Committee concludes that there may be merit to the report but that the facts are insufficient to warrant immediate action, the Committee will maintain the file and the Practitioner's activities and practice will be monitored until it can be established that there is, or is not, a reasonable belief that impairment exists.
- G. If the Committee determines that there is a reasonable basis for believing that the affected Practitioner is impaired; and, if the Committee has recommended a course of treatment/action but the affected Practitioner has refused to accept the Committee's recommendation or to otherwise comply with the requirements of this Policy (e.g., Practitioner noncompliance with a voluntary agreement with Committee), the Committee will notify the Credentials Committee and refer the matter to the MEC (for consideration as to whether corrective action should be initiated), the CEO or CNO, as applicable, and, if required, to the State Medical Board of Ohio, the Ohio Board of Nursing, or other appropriate licensing agency.
- H. If the Committee at any time deems corrective action to be warranted, the Committee will make such recommendation to the MEC consistent with this Policy and in accordance with the procedure set forth in the Medical Staff Bylaws or APP Policy, as applicable.

1.5 Reinstatement and Monitoring

- A. The Practitioner must request, in writing, termination of a leave of absence and reinstatement of his/her appointment and Privileges pursuant to the procedure set forth in the Medical Staff Bylaws/Credentials Policy or APP Policy, as applicable.
- B. Upon sufficient proof that an impaired Practitioner has successfully completed a rehabilitation or treatment program, the Committee may recommend that the Practitioner's Medical Staff appointment and/or Privileges be reinstated.
- C. Prior to recommending reinstatement, the Committee must obtain a written assessment from the provider overseeing the Practitioner's rehabilitation or treatment program. The Practitioner will agree to execute all necessary releases and authorizations and to pay all fees, if any, in order that reports from the rehabilitation/treatment provider can be submitted to the Committee. Such reports will include, at a minimum, the following information:
 - 1. The nature of the Practitioner's condition.
 - 2. Whether the Practitioner is participating in a program or other course of rehabilitation/treatment; and, if so, the nature of the program or course of rehabilitation/treatment.

3. Whether the Practitioner has complied with the terms of the rehabilitation program or other course of treatment.
 4. If applicable, whether the Practitioner attends Alcoholics Anonymous or other similar meetings regularly.
 5. Whether monitoring of the Practitioner is necessary after completion of the rehabilitation/treatment program; and, if so, recommendations with respect to such monitoring.
 6. Whether, in the opinion of the treatment provider, the Practitioner has been rehabilitated or has otherwise recovered from the mental or physical impairment.
 7. Whether, in the opinion of the treatment provider, the Practitioner is in need of additional treatment; and, if so, the scope of such treatment.
 8. Whether, in the opinion of the treatment provider, the Practitioner is capable of providing continuous competent care to his or her patients and resuming his or her practice in a hospital setting.
- D. The fact that a treatment provider submits information favorable to the Practitioner will not preclude the Committee from obtaining a second opinion if the Committee believes such opinion necessary; nor, will it preclude the MEC from obtaining such an opinion prior to recommending reinstatement of such Practitioner's Privileges. The Committee or MEC, as applicable, will be solely responsible for selecting a Practitioner to provide a second opinion, and the costs associated with obtaining such second opinion will be borne by the Hospital.
- E. The Committee will require that the Practitioner comply with all requirements imposed in any aftercare contract(s) between the Practitioner and aftercare provider, if applicable, and any other obligations imposed by Ohio law or the MEC/Board, as applicable. Additionally, the Practitioner must agree to:
1. Execute any and all authorizations and releases necessary to insure that information is provided to the Committee.
 2. Provide the Committee with copies of any and all aftercare contracts between the Practitioner and the treatment provider.
 3. Provide the Committee with any information the Practitioner is required to provide the State licensing board in the event the Practitioner has entered into a contract with the State licensing board with respect to his/her impairment.

1.7 External Reporting Requirements

The Hospital CEO or CNO, as applicable, will be notified prior to any reporting that is required by state and/or federal law of actions taken with regard to an impaired Practitioner or information related to an impaired Practitioner. Any reports of criminal activity required under state and/or federal law will be reported immediately to the

Hospital CEO or CNO, as applicable, for reporting to the appropriate authorities. Hospital legal counsel will be consulted prior to any such reporting.

1.8 Documentation

The Committee will maintain minutes as provided for in the Medical Staff Organization Policy. The confidential Committee peer review files will be maintained by the Medical Staff Office.

1.9 Confidentiality & Immunity

- A. All documentation pursuant to this Policy and the procedures followed hereunder including letters, notes, reports, meeting minutes, and/or other writings will be treated as confidential peer review documents to the full extent permitted by law and will be retained in the Practitioner's quality file and/or applicable peer review committee files, as appropriate, maintained in the Medical Staff Office.
- B. The identity of individuals providing information to the Committee and all information provided by such individuals, whether in writing or verbally, will be maintained as confidential peer review information to the full extent permitted by law.
- C. It is the intent of the Hospital and the Medical Staff that the members of the Committee, and all individuals providing information to the Committee, will be deemed to be engaged in a peer review activity and entitled to immunity to the full extent permitted by law.
- D. All parties involved in the procedures set forth in this Policy will maintain confidentiality and will not discuss the matter with anyone other than as needed to fulfill their obligations under this Policy.

1.10 Education

The Committee is responsible for assuring that education is provided to Practitioners regarding health and impairment issues. Such education will include, but not be limited to, review of this Policy and the process for reporting and addressing suspected impairment.

EXHIBIT C

Practitioner/Advanced Practice Provider Professional Conduct Policy

Nationwide Children's Hospital

A Medical Staff Document

1.1 Introduction

- A. The Medical Staff adopts the Practitioner/Advanced Practice Provider (APP) Code of Conduct, a copy of which is attached hereto as Exhibit C-1 and incorporated by reference herein, and this Practitioner/APP Professional Conduct Policy (collectively, the “Policy”) to define conduct expectations and to provide a procedure to assist the Medical Staff in dealing with Practitioners¹ who engage in unprofessional conduct at the Hospital.
- B. All Practitioners appointed to the Medical Staff and/or granted Privileges agree, as a condition of their appointment/Privileges, to abide by the Medical Staff Bylaws or APP Policy, as applicable, in addition to applicable Hospital/Medical Staff policies and procedures. All Practitioners are further required to work cooperatively with other Practitioners and Hospital employees and to participate in the discharge of Medical Staff or APP responsibilities. To that end, the Hospital requires all Practitioners to conduct themselves in a professional and cooperative manner.
- C. This Policy is intended to address those situations in which the Medical Executive Committee and/or the Board believe(s) that informal or collegial intervention, in lieu of initiation of formal corrective action proceedings, may be sufficient. This Policy provides collegial steps and educational efforts that can be taken by Medical Staff leaders to address Practitioners who fail to conduct themselves in a professional manner. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to informally resolve the concerns that have been raised.
- D. Nothing in this Policy should be construed as requiring its implementation prior to any action that might otherwise be taken pursuant to the Medical Staff Bylaws or APP Policy, as applicable, including initiation of formal corrective action against a Practitioner on the basis of a single incident of inappropriate behavior or continuation of such conduct. This Policy does not preclude any person authorized to impose a summary suspension pursuant to the Medical Staff Bylaws or APP Policy, as applicable, from doing so; nor, does this Policy preclude an authorized individual from summarily suspending a Practitioner pursuant to the Medical Staff Bylaws or APP Policy based upon information that the authorized individual learns as a result of this Policy. The authorized individual imposing such summary suspension will not be precluded from continuing as a participant in the procedure set forth in this Policy.
- E. Terms used in this Policy will have the same meaning as set forth in the Medical Staff Bylaws or APP Policy, as applicable, unless a different definition is provided in this Policy.

¹ For purposes of this Policy, the term “Practitioner” will include Physicians, Dentists, Podiatrists, Psychologists, and Advanced Practice Providers (APP) (e.g., advanced practice registered nurses, physician assistants, *etc.*) granted Clinical Privileges at the Hospital.

1.2 Definition of Unprofessional Conduct

- A. For purposes of this Policy, the term “unprofessional conduct” means disruptive behavior that undermines a culture of safety.
- B. Unprofessional conduct includes, but is not limited to, the following:
 - 1. Impertinent or inappropriate comments to patients, other Practitioners, or Hospital staff; or, entries/illustrations in medical records or other official documents that impugn the quality of care delivered, attack individuals, or are unprofessional.
 - 2. Sexual, ethnic, or other types of unlawful discrimination or harassment whether written, verbal, or physical in nature.
 - 3. Criticism presented in such a way as to blame, intimidate, threaten, humiliate, belittle, or impute stupidity or incompetence of others.
 - 4. Refusal to participate and cooperate in Medical Staff or APP functions or to do so in a disruptive manner.
 - 5. Repeated or deliberate violation of the Medical Staff Bylaws, APP or other Medical Staff Policies, or Hospital policies.
 - 6. Unprofessional, pejorative, or abusive behavior toward patients, members of their families, Hospital visitors, Hospital staff, or other Practitioners including, but not limited to, refusing to listen to legitimate questions, concerns, or requests.
 - 7. Imposing unreasonable requirements on other Practitioners or Hospital staff.
 - 8. Physical or mental impairment (including, without limitation, substance abuse), that adversely affects the Practitioner’s ability to safely and competently exercise his/her Privileges.
 - 9. Threatening or intimidating physical contact or attacks leveled at other Practitioners, Hospital staff, or patients (e.g., throwing objects, etc.).
 - 10. Intimidation or retribution against any patient, a patient’s family member, other Practitioner, or Hospital employee who reports or witnesses a Practitioner’s unprofessional conduct; or, protecting any person who refuses to cooperate in review of a Practitioner.

1.3 Report and Documentation of Unprofessional Conduct

- A. Individuals who witness incidents of unprofessional conduct by Practitioners should:

Report the incident to their supervisor or to the Medical Staff President or Vice President. If an individual initially provides a verbal report to his/her supervisor or

to the Medical Staff President or Vice President, it is the responsibility of the individual making the report (or the supervisor or Medical Staff President or Vice President) to document the incident and provide such documentation to the Medical Staff office.

- B. This Policy does not govern the process that is followed in the event the matter is referred to Human Resources for management. Rather, this Policy is limited to the process to be followed in the event an unprofessional conduct matter is handled by the Medical Staff as a Medical Staff matter.
- C. Reporting should be done in a prompt manner.
- D. Although knowledge of the reporting individual's identity is preferred for purposes of follow up, reports of unprofessional conduct may be made anonymously. The fact that a report is anonymous will not preclude the matter from being reviewed in accordance with the procedure set forth in this Policy; however, the fact of anonymity means that it may not be possible to validate the concerns and that no response back to the concerned individual will be able to be made.
- E. No individual who, in good faith, reports a Practitioner's unprofessional conduct or who otherwise participates in the procedure set forth herein will be retaliated against for such report or participation. The party who makes an allegation of unprofessional conduct will be advised when follow-up action has been taken, but will not be provided with specific details of the resolution.

1.4 PREC Review of Report

- A. The Practitioner Review and Effectiveness Committee (PREC) addresses allegations of unprofessional conduct by Practitioners. The composition of (and related information regarding) the PREC is set forth in the Medical Staff Organization Policy.
- B. In the event the unprofessional conduct matter is referred to the PREC for management, the PREC will address the matter itself pursuant to this Policy. If, at any time, the PREC reasonably believes that the behavior of the Practitioner may be related to health or impairment concerns, the PREC may consider whether the matter should continue to be handled pursuant to this Policy or pursuant to the Practitioner/APP Impairment Policy.
- C. The PREC will act expeditiously in reviewing reports of unprofessional conduct by Practitioners. Each report should be sufficiently reviewed to determine whether the report has validity. This review should consist of:
- D. Reviewing documents and talking with individuals (including the complainant and the Practitioner as appropriate). Individuals who are interviewed should be reminded that this is a confidential peer review process and the discussion should not be disclosed to others.
- E. Determining whether the report reflects a first time issue or whether there have been any prior incidents, or formal or informal interventions with the Practitioner, in order to determine whether a pattern or trend is developing or has developed.

- F. Reviews may be conducted by the PREC as a whole or a review may be assigned to one or more PREC members (e.g., a Medical Staff officer, Department Chief or Section Chief etc.) or another designated Medical Staff peer review committee (e.g., the APP Committee) to report back to the PREC. For purposes of this Policy, a reference to the PREC will include the PREC's designated agent(s).
- G. In the event that a member of the PREC is the Practitioner who is the subject of the report or otherwise has a conflict of interest with respect to the Practitioner who is the subject of the report, another Practitioner may be appointed to participate in review of the matter and the PREC member who has a conflict of interest or who is the subject of the report will not participate in the PREC proceedings as a PREC member.
- H. The PREC may notify the Practitioner upon receipt of a report of unprofessional conduct; however, such notification is not required prior to proceeding with review of the matter.
- I. The PREC will rely upon the most recent complaint of unprofessional conduct in conducting its review of the event; provided, however, that consideration of reports of past incidents, if any, received during the Practitioner's current appointment and/or Privilege period may be considered for trending purposes.

1.5 Practitioner's Rights

- A. Engagement with the PREC is an informal process. A Practitioner has the right to refuse to participate in the process.
- B. A Practitioner has the right to respond, in writing, to allegations raised in a report of unprofessional conduct or to otherwise respond to any communication that the Practitioner receives from the PREC. All written responses will be maintained in the Practitioner's quality file.

1.6 Action Following Conclusion of PREC Review

- A. If the PREC determines that a report of unprofessional conduct lacks validity, the matter will be closed. The fact that the report was filed and closed based upon lack of validity will be documented by the PREC in its minutes and a note to such effect will be maintained in the Practitioner's quality file.
- B. If the PREC determines that the report of unprofessional conduct can be resolved by an informal conversation with the Practitioner, the PREC will designate the individuals who should have such meeting with the Practitioner. The preference will be for the meeting to be held by two (2) or more members of the PREC unless circumstances dictate otherwise. The fact of the meeting will be reported back to the PREC and documented in a follow up letter provided to the Practitioner with a copy of such letter placed in the Practitioner's quality file.
- C. If the PREC determines that the report of unprofessional conduct raises a significant concern or that the Practitioner is developing a trend or pattern of

unprofessional conduct, the PREC may engage in one or more of the following activities:

1. Request that the Practitioner meet with the PREC.
 2. Encourage the Practitioner to engage in remediation (e.g., anger management, counseling, boundaries education, *etc.*).
 3. Issue an informal letter of warning to the Practitioner.
 4. Develop a voluntary remediation plan with the Practitioner.
 5. Refer the matter to the Medical Executive Committee for initiation of corrective action.
 6. Such other action as is appropriate to the circumstances.
- D. The PREC may continue to utilize the collegial and educational steps set forth in this Policy as long as the PREC believes that there is a reasonable likelihood that such efforts will resolve the concerns.
- E. All meetings with a Practitioner (whether with a member(s) of the PREC, one or more persons designated by the PREC, or the committee itself) should include a clear statement to the Practitioner that if the unprofessional conduct continues, the matter will be referred to the Medical Executive Committee for initiation of the corrective action process.
- F. If the PREC has recommended a course of action but the Practitioner has refused to accept the PREC's recommendation or to otherwise comply with the requirements of this Policy, such refusal will be reported by the PREC to the Medical Executive Committee (for consideration as to whether corrective action should be initiated), the CEO, CMO, and/or CNO, as applicable, and, if required, to the State Medical Board of Ohio, the Ohio Board of Nursing, or other appropriate licensing agency.
- G. If the PREC at any time deems corrective action to be warranted, the PREC will make such recommendation to the Medical Executive Committee consistent with this Policy and in accordance with the procedure set forth in the Medical Staff Bylaws or APP Policy, as applicable.

1.7 Reporting Requirements

The Hospital's CEO, CMO, and/or CNO, as applicable, will be notified prior to any reporting that is required by state and/or federal law of actions taken with regard to a Practitioner or information related to a Practitioner. Any reports of criminal activity required under state and/or federal law will be reported immediately to the CEO, CMO, and/or CNO, as applicable, for reporting to the appropriate authorities. Hospital legal counsel will be consulted prior to any such reporting.

1.8 Education

Education for the Medical Staff and other healthcare professionals will be provided regarding this Policy as needed. Such education will include, without limitation: the content of this Policy and the fact that it will be enforced, behavior expectations and the importance of adhering to standards of professional conduct, how to identify and resolve conflict, examples of unprofessional conduct, and the process for reporting, self-reporting, and addressing unprofessional conduct.

1.9 Self-Reporting Encouraged

Practitioners are encouraged to voluntarily self-report conduct issues to a member of the PREC or a Medical Staff leader for assistance so that appropriate steps can be taken to protect patients and help the Practitioner regain and retain the ability to practice safely and competently.

1.10 Confidentiality and Immunity

- A. All documentation pursuant to this Policy including letters, notes, reports, minutes, or other writings or communications submitted to or generated by the PREC will be treated as confidential peer review documents to the full extent permitted by law and will be retained in the Practitioner's quality file and/or in such other peer review committee files, as appropriate, maintained in the Medical Staff Office.
- B. The identity of individuals providing information to the PREC and all information provided by such individuals, whether written or oral, will be maintained as confidential peer review information to the full extent permitted by law.
- C. It is the intent of the Hospital and the Medical Staff that the members of the PREC and all individuals providing information to the PREC will be deemed to be engaged in a peer review activity and entitled to immunity to the full extent permitted by law.
- D. All parties involved in the procedure set forth in this Policy will maintain confidentiality and will not discuss the matter with anyone other than as needed to fulfill their obligations under this Policy.
- E. The files of the PREC will be made available to the Credentials Committee, APP Committee, and Medical Executive Committee to the extent such files contain information relevant to an application for, as applicable, Medical Staff reappointment and/or regrant of Privileges.
- F. If the PREC at any time deems corrective action to be warranted, the PREC will make such recommendation to the Medical Executive Committee consistent with this Policy and in accordance with the procedure set forth in the Medical Staff Bylaws or APP Policy, as applicable.

EXHIBIT C-1

PRACTITIONER/ADVANCED PRACTICE PROVIDER CODE OF CONDUCT

Professional Code of Conduct

Patient and Employee Safety depend on “mutual accountability,” “fostering a questioning attitude,” and professional interpersonal communication. However, patient and employee safety can be weakened by power, bullying, or improper behavior between people. For that reason, the Hospital expects all staff to be committed to a culture of safety. This means everyone uses appropriate and professional behavior at all times. We expect all staff to be accountable to act in a professional manner in interactions with each other and all patients, families, and visitors. This follows the Hospital's values of Do the Right Thing, Create a Safe Day Every Day, Promote Health and Well-Being, Are Agile and Innovative, and Get Results.

I support the Hospital's Safety Culture. I commit that my behavior will always follows the behaviors shown below:

Do the Right Thing:

- ✓ I will always act with integrity and honesty.
- ✓ I will be inclusive and respectful of everyone. I will treat others with professionalism and dignity.
- ✓ I will be responsible for forming and maintaining healthy interpersonal relationships with every member of the hospital staff.
- ✓ I will provide open, honest, and helpful communication with employees/staff and patients, families, and members of the team.
- ✓ I will treat others with sensitivity to cultural, religious, and lifestyle differences. Differences will be respected and valued.
- ✓ I will not complain about another team member. I will offer direct, timely, and helpful feedback.
- ✓ I will respect patient and colleague confidentiality and privacy.

Create a Safe Day Every Day:

- ✓ I will act in a safe manner and practice safety at work.
- ✓ I will always communicate promptly, clearly, and completely.
- ✓ I will recognize my own limits and seek collaborative input from others when appropriate, especially when they may be impacted by the decision.
- ✓ I will support a questioning attitude. I will welcome questions from others and respond respectfully and professionally.

Accountability:

- ✓ I will follow all policies, procedures, and regulatory requirements.

- ✓ I will honor my commitments and address conflicts of interests honestly and directly.
- ✓ I will be responsible not only for my commitments and what is expected of me, but also for my co-workers ("be their wingman").