NATIONWIDE CHILDREN'S HOSPITAL TOLEDO

MEDICAL STAFF
PROVIDER EFFECTIVENESS POLICY

October 31, 2024

EXHIBIT A

Professional Practice Evaluation Policy

ARTICLE 1: PROFESSIONAL PRACTICE EVALUATION

1.1. Purpose

The Medical Staff, by delegation from the Hospital Board ("Board") and through the Department Chair, Section Chiefs, and Medical Executive Committee ("MEC"), collects and reviews information regarding Providers'[1] credentials and performance to evaluate current clinical competency and determine each such Provider's eligibility to be granted/regranted and maintain Clinical Privileges at the Hospital.

1.2. Professional Practice Evaluation

A. The Hospital/Medical Staff performance improvement program initiatives are designed to: (1) promote safe, quality patient care and continuously improve the quality of care; and (2) provide for Professional Practice Evaluation (PPE), including focused and ongoing PPE (FPPE/OPPE). Such activities are peer review protected.

B. PPE applies to all Providers granted Clinical Privileges at the Hospital. Performance evaluation of Providers shall be conducted in a uniform and consistent manner by peers (or selected consultants to the Medical Staff):

1. For all new Privileges granted (*i.e.,* initial FPPE).

2. On an ongoing basis (*i.e.,* OPPE).

3. On a focused basis whenever a quality concern arises. In such event, all concerns as well as results of tracking and trending of peer review activities shall be considered.

C. Results of PPE activities are aggregated, tracked, trended, and maintained in the applicable peer review file for each Provider granted Privileges at the Hospital.

D. PPE Data

1. Examples of PPE data, as applicable, may include but are not limited to:

(a) Activity data (*e.g.,* inpatient admissions, patient encounters, procedures, length of stay, *etc.*)

(b) Performance data (*e.g.,* clinical care, medical/clinical knowledge, practice-based learning and improvement, systems based practice, interpersonal/communication skills, and professionalism)

(c) Medical Staff Department/Section specialty specific indicators/metrics.

(d) Comparison of the Provider's inpatient and outpatient complications and outcomes related to his/her peers and/or

[1] For purposes of this Policy, the term "Provider" means both Practitioners (Physicians, Dentists, Podiatrists, and Psychologists) and Advanced Practice Providers (APPs).

regional, national, or federal performance standards/guidelines/benchmarks where available.

(e) Clinical information obtained through peer case reviews.

(f) Pattern of blood and pharmaceutical usage.

(g) Requests for tests and procedures.

(h) Morbidity and mortality data including the use of autopsy.

(i) Use of consultants.

(j) Readmissions

(k) Return to surgery

(l) Number and types of complaints

(m) Other relevant data as determined by the MEC.

2. Methods to collect PPE data may include but are not limited to:

(a) Chart review.

(b) Proctoring/direct observation.

(c) Patient and/or family feedback.

(d) Feedback from other Providers and Hospital staff.

(e) Audits

(f) Other relevant methods as determined by the MEC.

E. The PPE process will be coordinated by the Department Chair and applicable Section Chief (as authorized agents of the MEC) with assistance by Quality Improvement Services ("QIS") and/or the Medical Staff Office.

1.3. Ongoing Professional Practice Evaluation ("OPPE")

A. Upon conclusion of the initial FPPE process, as set forth in Section 1.4, OPPE of the medical/clinical care provided by privileged Providers is conducted to ensure the consistent and continuous delivery of safe, quality patient care.

B. The Department Chair, in consultation with the applicable Section Chief, is responsible for recommending specific OPPE criteria to be regularly collected and monitored. Such OPPE criteria may include, but is not limited to, the PPE data set forth in Section 1.2 (D)(1). The Medical Staff Department Chair and Section Chiefs may, from time to time, recommend changes to the OPPE criteria. OPPE criteria, and changes thereto, must be approved by the MEC.

C. OPPE data may be acquired through multiple sources including, but not limited to, the sources set forth in Section 1.2 (D)(2).

D. OPPE activity is under the direction and guidance of the Department Chair and applicable Section Chief (as authorized agents of the MEC). OPPE data (including Department/Section specific metrics) pertaining to each Provider granted Privileges at the Hospital is gathered continuously by the Hospital QIS Department and reported to the Department Chair and applicable Section Chief at least annually for review. A copy of the Provider's OPPE report will also be made available to the Provider for review and discussion with the Department Chair and/or Section Chief. It is the responsibility of the Department Chair and/or Section Chief to document review and discussion of each Provider's OPPE-specific data, at least annually. Information regarding Provider specific OPPE is provided to the MEC and maintained in the applicable peer review file for each Provider.

1.4. Focused Professional Practice Evaluation ("FPPE")

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

1. New Privileges: all initial (new) Privileges granted (whether a new Provider granted Privileges at the Hospital for the first time or an established Provider at the Hospital who is granted a new Privilege) in accordance with subsection (B);

OR

2. Quality of Care Concerns: when a potential question or concern arises regarding a privileged Provider's current clinical competence and/or ability to safely perform a Privilege granted in accordance with subsection (C).

B. Initial (New) Privileges

1. Initial FPPE begins when a Provider is granted new Privileges.

2. The initial FPPE process will be documented on the approved evaluation form.

3. Upon a Provider's completion of initial FPPE, the MEC shall take one of the following actions:

(a) End the initial FPPE:

(i) No quality issues are identified following completion of initial FPPE.

(ii) The Provider is performing in accordance with established clinical competency expectations.

(iii) The initial FPPE process has been successfully completed.

(b) Extend/continue the initial FPPE.

(c) Initiate FPPE for a quality concern pursuant to subsection (C) or other form of remediation (not resulting from the corrective action process).

(d) Initiate the corrective action process in accordance with the procedure set forth in the Medical Staff Bylaws or Advanced Practice Provider Policy.

(5) Failure to Complete Initial FPPE

(a) If a Provider does not have sufficient volume at the Hospital at which the initial FPPE is being conducted to complete initial FPPE by the time of regrant of Privileges, then the MEC may either:

(i) Determine that the Provider is not eligible for regrant of Privileges.

OR

(ii) Recommend that the Board regrant Privileges at the Hospital (subject to continuation of the initial FPPE period) based, in part, upon supplemental data from another Medicare-certified/participating hospital(s) (*i.e.,* at which the Provider primarily practices) to confirm current clinical competence.

C. FPPE for a Quality Concern

1. FPPE for a quality concern may be initiated by the MEC, at any time, either as part of the PPE process set forth in this PPE Policy or as a result of the corrective action process (pursuant to the Medical Staff Bylaws or Advanced Practice Provider Policy) when any of the following occurs:

(a) Egregious single event.

(b) Concern(s) identified during initial FPPE.

(c) Concern(s) identified through OPPE.

(d) Concerns/complaints expressed by patients, Hospital staff, or Providers.

(e) Other quality patterns or trends of concern.

2. FPPE for a quality concern is to be designed in a manner that best provides oversight of the care being provided by the Provider relative to the issue under review.

3. FPPE for a quality concern that is initiated and managed by the MEC as part of the PPE process pursuant to this Policy is not Adverse; and, therefore, does not give rise to any procedural due process rights pursuant to the Medical Staff Bylaws/Fair Hearing Policy or Advanced Practice Provider Policy, as applicable, nor is it reportable to federal or state authorities with the exception that:

   (a) An FPPE based upon quality concerns that includes a voluntary limitation on a Physician's or Dentist's Privileges (*e.g.,* proctoring, *etc.)* for more than 30 days is reportable to the NPDB. Other providers may be reported at the discretion of the Hospital.

   (b) Resignation by a Physician or Dentist of his/her Privileges while under an FPPE for a quality concern (that includes a voluntary limitation on Privileges) is reportable to the NPDB. Other Providers may be reported at the discretion of the Hospital.

3. An FPPE for quality concerns may consist of any/all of the following:

   (a) Retrospective medical record review

   (b) Proctoring/direct observation

   (c) External peer review

   (d) Additional education and/or training

   (e) As otherwise determined appropriate by the MEC.

4. In the event the MEC implements an FPPE for quality concerns as part of the PPE process pursuant to this Policy, the Provider will be notified in writing.

5. Although not required, it is the expectation that the MEC will meet with the Provider to review the reason for the FPPE and its scope.

6. A Provider may voluntarily agree to enter into a remediation agreement and/or to limit the exercise of his/her Clinical Privileges during the course of an FPPE for quality concerns implemented and managed by the MEC as part of the PPE process pursuant to this Policy. In the event that a Provider refuses to cooperate with the MEC pursuant to this Policy, the MEC may initiate the corrective action process pursuant to the Medical Staff Bylaws or Advanced Practice Provider Policy.

1.5. <u>External Peer Review</u>

A. External peer review may be requested when appropriate Hospital peer expertise is not available.

1.6. <u>Results of PPE</u>

A. Tracked/trended Provider PPE data is considered by the MEC when making a recommendation to the Board to continue, limit, or revoke existing Privileges.

B. The results of PPE may be used to:

1. Determine if generally accepted standards of care have been met.

2. Implement change or to improve the performance of a Provider.

3. Improve care and care processes.

C. Should a Provider's FPPE or OPPE data indicate a conduct or clinical competence/quality concern, the applicable provisions of this Policy, the Medical Staff Bylaws, or other appropriate Medical Staff Policy [*i.e.,* the Advanced Practice Provider Policy, Impairment Policy (attached hereto as Exhibit B), or Professional Conduct Policy (attached hereto as Exhibit C)] will be followed.

1.7. Assessment of PPE Process

Periodically, as needed, a meeting shall be held consisting of the Medical Staff President, the Department Chair and Section 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 PPE process as set forth in this Policy.

1.8. Peer Review Committee Members

All members/agents of a peer review committee 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: PROVIDER HEALTH & CONDUCT

2.1. Impaired Providers

A. An impaired Provider 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 use or abuse of drugs, alcohol, or other substances that adversely impair the Provider's ability to practice.

B. The procedure for addressing Provider impairment is set forth in the Impairment Policy attached hereto as Exhibit B and incorporated by reference herein.

2.2. Provider Conduct

The procedure for addressing Provider conduct matters is set forth in the Conduct Policy attached hereto as Exhibit C and incorporated by reference herein.

EXHIBIT A-1

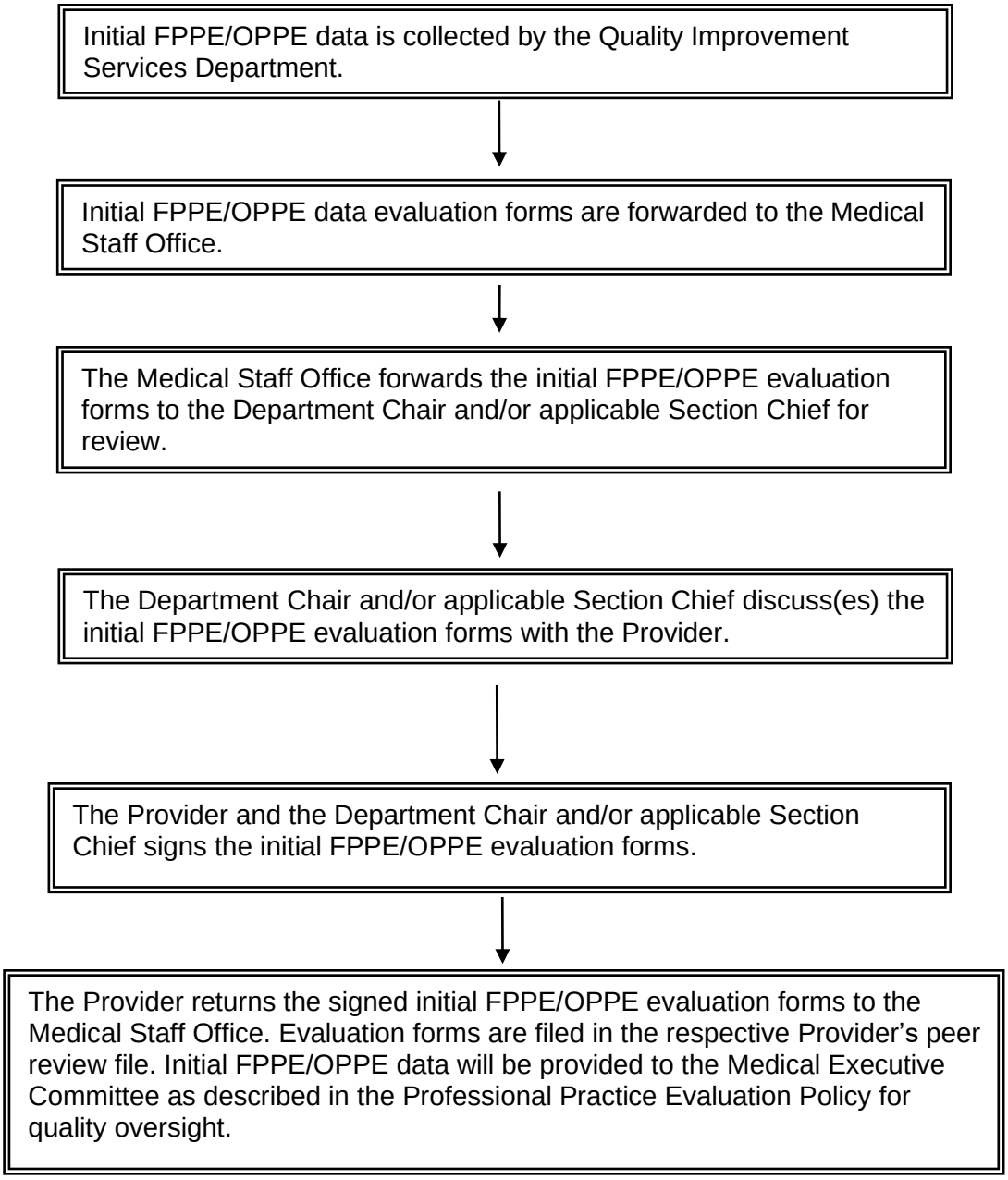
Initial FPPE/OPPE data is collected by the Quality Improvement Services Department.
Initial FPPE/OPPE data evaluation forms are forwarded to the Medical Staff Office.
The Medical Staff Office forwards the initial FPPE/OPPE evaluation forms to the Department Chair and/or applicable Section Chief for review.
The Department Chair and/or applicable Section Chief discuss(es) the initial FPPE/OPPE evaluation forms with the Provider.
The Provider and the Department Chair and/or applicable Section Chief signs the initial FPPE/OPPE evaluation forms.
The Provider returns the signed initial FPPE/OPPE evaluation forms to the Medical Staff Office. Evaluation forms are filed in the respective Provider's peer review file. Initial FPPE/OPPE data will be provided to the Medical Executive Committee as described in the Professional Practice Evaluation Policy for quality oversight.

EXHIBIT A-2

PEER REVIEW 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. Providers[2] 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 Medical Staff President and MEC which, in turn, authorizes other 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 Providers with Privileges at the Hospital. In order 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 peer review discussions confidential.

- 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. Peer review activities should be conducted 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 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 the Provider Effectiveness Policy, the fact that Providers are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Providers from participating in the peer review process with respect to his/her colleagues.

[2] For purposes of this document, the term “Provider” means both Practitioners (Physicians, Dentists, Podiatrists, and Psychologists) and Advanced Practice Providers (APPs).

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 rules/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 Provider performance cannot be used as evidence in a state civil lawsuit.

To preserve the confidentiality of quality management data, it is imperative that Providers involved in peer review observe the following instructions in the performance of peer review:

- Peer review forms 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 peer review form is completed, making additional copies of the form is prohibited.

- Discussing peer review matters with Providers outside of the PRC meeting/peer review process is prohibited unless specifically requested/authorized by the PRC.

- Discussing peer review matters with anyone in a public setting 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 information, deliberations, and materials. 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 Advanced Practice Provider Policy, as applicable.

NAME (Print)	SIGNATURE	DATE SIGNED

EXHIBIT B

Impairment Policy

1.1 Introduction

A. This Impairment Policy (Policy) provides collegial steps and educational efforts that can be taken to address impaired Providers.[3] The goal of these efforts is to arrive at voluntary, responsive actions by the Provider to 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 Advanced Practice Provider 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 Advanced Practice Provider Policy from doing so. Further, this Policy does not preclude an authorized individual from summarily suspending a Provider pursuant to the Medical Staff Bylaws or Advanced Practice Provider 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 Advanced Practice Provider 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 impairment matter is handled by the Medical Staff as a Medical Staff matter.

1.2 Reports of Provider Impairment

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

A. Reports of impairment regarding a Provider may be made by any individual. Individuals who witness suspected impairment should:

1. Document the incident (*e.g.,* through the Hospital's incident reporting system).

2. 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.

3. Although knowledge of the reporting individual's identity is preferred for purposes of follow up, such report may be made anonymously. The fact

[3] For purposes of this Policy, the term "Provider" means both Practitioners (Physicians, Dentists, Podiatrists, and Psychologists) and Advanced Practice Providers (APPs).

that a report is anonymous will not preclude the matter from being reviewed; 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.

B. Reporting should be done in a prompt fashion.

C. Providers with an impairment are encouraged to voluntarily self-report to a Medical Staff leader so that assistance can be provided to the Provider. 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 Provider impairment 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 Provider's Rights

A. The Provider Review & Effectiveness Committee (Committee) addresses issues of alleged Provider impairment. The composition of (and related information regarding) the Committee is set forth in the Medical Staff Organization Policy.

B. Upon receipt of a report of suspected Provider 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 Provider, 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 Provider 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 or other authorized Committee agents to report back to the Committee. For purposes of this Policy, a reference to the Committee shall include the Committee members and other authorized Committee agents.

3. In the event that a member of the Committee is the subject of the report or otherwise has a conflict of interest with respect to the Provider who is the subject of the report, another Provider shall be appointed to participate in review of the matter and the Committee member with the conflict of interest shall not participate in the Committee proceedings as a Committee member.

4. Individuals who are interviewed will be reminded that this is a confidential peer review process and that the discussion is not permitted to be disclosed to others outside of the peer review process.

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 may be considered.

6. The Committee may notify the Provider 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 Provider:

1. Submit to a physical examination and/or mental evaluation, at the Provider'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 Provider 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 Provider's present ability to continue to practice in a hospital setting.

(e) Whether any limitations should be placed on the Provider 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. Providers have the following rights with respect to the Committee.

1. Engagement with the Committee is voluntary. A Provider has the right to refuse to participate in this process.

2. A Provider has the right to respond, in writing, to allegations raised in a report or to otherwise respond to any documentation that the Provider receives from the Committee. All such written responses will be maintained in the Provider's quality file.

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

A. Upon completion of review of a report of Provider impairment, the Committee will prepare a written report (which may be set forth in meeting minutes) setting forth its findings as to whether the Provider 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 Provider is impaired, the Committee has the authority to enter into a voluntary agreement with the Provider to:

1. Undertake rehabilitation through an approved treatment provider[4] in an effort to resolve the impairment at issue. If appropriate under the circumstances, relevant facts regarding the impairment or possible impairment may be reported to the State Medical Board of Ohio, the Ohio Board of Nursing, or other appropriate state licensing entity.

   (a) The Committee will encourage rehabilitation when appropriate and will assist the affected Provider in locating a rehabilitation program or properly qualified individual to treat the affected Provider.

   (b) The Provider 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 Advanced Practice Provider Policy, as applicable, in the following instances:

   (a) If the Provider agrees to participate in an approved inpatient rehabilitation program.

   (b) If the Provider's approved treatment provider recommends that the Provider not treat patients for a period of time while undergoing treatment.

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

C. In the alternative, the Committee may:

1. Recommend that corrective action be initiated against the Provider pursuant to the applicable provisions of the Medical Staff Bylaws or Advanced Practice Provider Policy, as applicable.

2. Recommend that the Provider be permitted to continue treating patients but that such treatment be monitored for continual assessment of the Provider's ability to competently provide safe patient care.

[4] An approved treatment provider (for purposes of substance abuse) shall be one recognized and approved by the State Medical Board of Ohio, the Ohio Board of Nursing, or other appropriate licensing entity, as applicable. For other types of impairment (*e.g.,* physical or mental/emotional, *etc.*) the treatment provider will be agreed upon by the Provider and the Committee.

3. Take any other action consistent with the purposes of this Policy and the Medical Staff Bylaws or Advanced Practice Provider 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 Provider.

E. If the Committee concludes that there is no reason to believe that the Provider 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 peer review file and the Provider'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 Provider is impaired; and, if the Committee recommends a course of treatment/action but the affected Provider refuses to accept the Committee's recommendation or to otherwise comply with the requirements of this Policy (*e.g.,* Provider noncompliance with a voluntary agreement with Committee), the Committee will refer the matter to the MEC for consideration as to whether corrective action should be initiated.

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 Advanced Practice Provider Policy, as applicable.

1.5 Return to Practice and Monitoring

A. The Provider must request, in writing, termination of a leave of absence and reinstatement or a new grant of his/her appointment and/or Privileges, as appropriate, pursuant to the procedure set forth in the Medical Staff Bylaws/Credentials Policy or Advanced Practice Provider Policy, as applicable.

B. Upon sufficient proof that an impaired Provider has successfully completed a rehabilitation or treatment program, the Committee may recommend that the Provider's Medical Staff appointment and/or Privileges be reinstated or granted, as applicable.

C. Prior to recommending reinstatement or a new grant of Medical Staff appointment and/or Privileges, the Committee must obtain a written assessment from the individual overseeing the Provider's rehabilitation or treatment program. The Provider 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 Provider's condition.

2. Whether the Provider 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 Provider has complied with the terms of the rehabilitation program or other course of treatment.

4. If applicable, whether the Provider attends Alcoholics Anonymous or other similar meetings regularly.

5. Whether monitoring of the Provider 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 Provider has been rehabilitated or has otherwise recovered from the mental or physical impairment.

7. Whether, in the opinion of the treatment provider, the Provider is in need of additional treatment; and, if so, the scope of such treatment.

8. Whether, in the opinion of the treatment provider, the Provider 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 Provider 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 or a new grant of such Provider's Medical Staff appointment and/or Privileges. The Committee or MEC, as applicable, will be solely responsible for selecting a Provider 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 Provider comply with all requirements imposed in any aftercare contract(s) between the Provider and aftercare provider, if applicable, and any other obligations imposed by Ohio laws, rules/regulations and/or the MEC/Board, as applicable. Additionally, the Provider must agree to:

1. Execute any and all authorizations and releases necessary to ensure that information is provided to the Committee.

2. Provide the Committee with copies of any and all aftercare contracts between the Provider and the treatment provider.

3. Provide the Committee with any information the Provider is required to provide the State licensing board in the event the Provider has entered into a contract with the State licensing board with respect to his/her impairment.

F. The Provider may, as applicable, also be asked to:

1. Execute a contract between the Provider and the Hospital setting forth the monitoring process to be adhered to by the Provider and the Committee.

2. Provide the Committee with the name of one or more Medical Staff Members with comparable Privileges to that of the Provider who is/are willing to assume responsibility for the care of the Provider's patients in the event the Provider is unable or unavailable to care for them.

3. Submit a written record of attendance at recovery meetings to the Committee.

4. Submit, at the request of the Committee, to random blood and/or urine testing with the results of such testing to be submitted to the Committee. The cost of such testing shall be borne by the Hospital. The Committee shall determine the method by which the specimen is to be collected and the manner in which the testing is to be done. If the specimens for such testing are not submitted in accordance with the Committee's time requirements, the Provider's Privileges shall be automatically suspended until compliance has been established to the satisfaction of the Committee.

1.7 External Reporting Requirements

The Chief Operating Officer and CMO (and 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 Provider or information related to an impaired Provider. Any reports of criminal activity required under state and/or federal law will be reported immediately to the Chief Operating Officer and CMO (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 procedure followed hereunder including letters, notes, reports, meeting minutes, other writings/communication and/or materials prepared by or on behalf of the Committee will be treated as confidential peer review documents to the full extent permitted by law and will be

retained in the Provider'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 Committee, and all individuals providing information to the Committee, will be deemed to be engaged in 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 Committee will be made available to the MEC to the extent such files contain information relevant to an application for, as applicable, Medical Staff reappointment and/or regrant of Privileges.

1.10 Education

The Committee is responsible for assuring that education is provided to Providers 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

Conduct Policy

1.1 Introduction

A. The Code of Conduct, a copy of which is attached hereto as Exhibit C-1 and incorporated by reference herein, and this Conduct Policy (collectively, the "Policy") define Provider [5] conduct expectations and provide a procedure to assist the Medical Staff in dealing with Providers who engage in unprofessional conduct at the Hospital.

B. All Providers 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 Advanced Practice Provider Policy, as applicable, in addition to applicable Hospital/Medical Staff policies and procedures. All Providers are further required to work cooperatively with other Providers and Hospital employees and to participate in the discharge of Medical Staff or APP responsibilities. To that end, the Hospital requires all Providers to conduct themselves in a professional and cooperative manner.

C. This Policy is intended to address those situations in which 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 Providers who fail to conduct themselves in a professional manner. The goal of these efforts is to arrive at voluntary, responsive actions by the Provider 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 Advanced Practice Provider Policy, as applicable, including initiation of formal corrective action against a Provider 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 Advanced Practice Provider Policy, as applicable, from doing so; nor, does this Policy preclude an authorized individual from summarily suspending a Provider pursuant to the Medical Staff Bylaws or Advanced Practice Provider 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 Advanced Practice Provider Policy, as applicable, unless a different definition is provided in this Policy.

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.

[5] For purposes of this Policy, the term "Provider" means both Practitioners (Physicians, Dentists, Podiatrists, and Psychologists) and Advanced Practice Providers (APPs).

B. Unprofessional conduct includes, but is not limited to, the following:

1. Impertinent or inappropriate comments to patients, other Providers, 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 Advanced Practice Provider functions or to do so in a disruptive manner.

5. Repeated or deliberate violation of the Medical Staff Bylaws, Advanced Practice Provider Policy 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 Providers including, but not limited to, refusing to listen to legitimate questions, concerns, or requests.

7. Imposing unreasonable requirements on other Providers or Hospital staff.

8. Threatening or intimidating physical contact or attacks leveled at other Providers, Hospital staff, or patients (*e.g.,* throwing objects, *etc.*).

9. Intimidation or retribution against any patient, a patient's family member, other Provider, or Hospital employee who reports or witnesses a Provider's unprofessional conduct; or, protecting any person who refuses to cooperate in review of a Provider.

1.3 Report and Documentation of Unprofessional Conduct

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

1. Document the incident (*e.g.,* through the Hospital's incident reporting system).

2. 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 Provider'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 Provider Review & Effectiveness Committee (PREC) addresses allegations of unprofessional conduct by Providers. 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 pursuant to this Policy. If, at any time, the PREC reasonably believes that the behavior of the Provider 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 Provider Impairment Policy.

C. The PREC will act expeditiously in reviewing reports of unprofessional conduct by Providers. Each report should be sufficiently reviewed to determine whether the report has validity. This review should consist of:

1. Reviewing documents and talking with individuals (including the complainant and the Provider as appropriate). Individuals who are interviewed will be reminded that this is a confidential peer review process and that the discussion is not permitted to be disclosed to others outside of the peer review process.

2. Determining whether the report reflects a first-time issue or whether there have been any prior incidents, or collegial or formal interventions with the Provider, in order to determine whether a pattern or trend is developing or has developed.

D. Reviews may be conducted by the PREC as a whole or a review may be assigned to one or more PREC members or other authorized PREC agents to report back to the PREC. For purposes of this Policy, a reference to the PREC will include the PREC's members and other authorized PREC agents.

E. In the event that a member of the PREC is the subject of the report or otherwise has a conflict of interest with respect to the Provider who is the subject of the report, another Provider shall be appointed to participate in review of the matter and the PREC member with the conflict of interest shall not participate in the PREC proceedings as a PREC member.

F. The PREC may notify the Provider upon receipt of a report of unprofessional conduct; however, such notification is not required prior to proceeding with review of the matter.

G. 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 may also be considered.

1.5 Provider's Rights

A. Engagement with the PREC is voluntary. A Provider has the right to refuse to participate in the process.

B. A Provider 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 Provider receives from the PREC. All written responses will be maintained in the Provider'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 Provider's quality file.

B. If the PREC determines that the report of unprofessional conduct can be resolved by an informal conversation with the Provider, the PREC will designate the individuals who should have such meeting with the Provider. 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 Provider with a copy of such letter placed in the Provider's quality file.

C. If the PREC determines that the report of unprofessional conduct raises a significant concern or that the Provider 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 Provider meet with the PREC.

2. Encourage the Provider to engage in remediation (*e.g.,* anger management, counseling, boundaries education, *etc.*).

3. Issue a letter of warning to the Provider.

4. Develop a voluntary remediation plan with the Provider.

5. Refer the matter to the MEC 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 Provider (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 Provider that if the unprofessional conduct continues, the matter will be referred to the MEC for initiation of the corrective action process.

F. If the PREC recommends a course of action but the Provider refuses 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 MEC for consideration as to whether corrective action should be initiated.

G. If the PREC at any time deems corrective action to be warranted, the PREC 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 Advanced Practice Provider Policy, as applicable.

1.7 Reporting Requirements

The Chief Operating Officer and CMO (and 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 Provider or information related to a Provider. Any reports of criminal activity required under state and/or federal law will be reported immediately to the Chief Operating Officer and CMO (and 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 Providers 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

Provider 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 Provider regain and retain the ability to practice safely and competently.

1.10 Confidentiality and Immunity

A. All documentation pursuant to this Policy and the procedure followed hereunder including letters, notes, reports, meeting minutes, other writings/communication and/or materials prepared by or on behalf of the PREC will be treated as confidential peer review documents to the full extent permitted by law and will be retained in the Provider'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 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 PREC, and all individuals providing information to the PREC, will be deemed to be engaged in 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 MEC to the extent such files contain information relevant to an application for, as applicable, Medical Staff reappointment and/or regrant of Privileges.

EXHIBIT C-1

PROVIDER CODE OF PROFESSIONAL CONDUCT

Patient and staff safety depend on “mutual accountability,” “fostering a questioning attitude,” and professional, interpersonal communication. However, patient and staff 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 staff.
- ✓ I will provide open, honest, and helpful communication.
- ✓ 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.

ADOPTION AND APPROVAL

ADOPTED BY THE MEDICAL EXECUTIVE COMMITTEE: October 30, 2024

APPROVED BY THE BOARD OF MANAGERS: October 31, 2024