ORGANIZATION MANUAL

Medical Staff
Sycamore Medical Center
Miamisburg, Ohio

Effective: 11/10/2010
Revised: 4/18/11

TABLE OF CONTENTS

Page

Article 1. FUNCTIONS OF THE MEDICAL STAFF 1

Section 1.1. General 1
Section 1.2. Position descriptions 1

Article 2. PROFESSIONAL MEDICAL STAFF COMMITTEES 8

Section 2.1 Designation 8
Section 2.2 Medical Executive Committee 8
Section 2.3 Credentials Committee 9
Section 2.4 Wellness CommitteE 10
Section 2.5 Performance Improvement Council 12
Section 2.6 Utilization Review Committee 14
Section 2.7 Clinical Quality Review Committee 15
Section 2.8 Pharmacy & Therapeutics Committee 17
Section 2.9 Perioperative Services Governance Committee 18
Section 2.10 Osteopathic Methods And Concepts Committee. 19
Section 2.11 Medical Records Committee 20

Article 3. MEDICAL STAFF MEETINGS AND PROCEDURES 22

Section 3.1 Medical Staff Meetings 22
Section 3.2 Special Meetings 22
Section 3.3 Regular Meetings Of Clinical Services And Committees 22
Section 3.4 Notice Of Committee Meetings 23
Section 3.5 Quorum 23
Section 3.6 Attendance Requirements 23
Section 3.7 Manner Of Action 24
Section 3.8 Minutes 24
Section 3.9 Participation By Chief Of Staff 24
Section 3.10 Voting And Meeting Options 24

Article 4. RULES AND REGULATIONS 26

Section 4.1 Outpatient (Ambulatory), Observation and Admission Status 26
Section 4.2 Patient Safety 28
Section 4.3 Utilization 28
Section 4.4 Peer Review 29
Section 4.5 Orders 33
Section 4.6 Records 33
Section 4.7 Consultation 42
Section 4.8 Discharge 43
Section 4.9 Basic Rules For The Use Of Hospital Facilities 43
Section4.10 Emergency Department On-Call Physicians 44
Section 4.11 Sources Of Patient Care Provided Outside The Hospital 45

Section 4.12 House Staff 45
Section 4.13 Professional Liability Action 46
Section 4.14 Conduct 46
Section 4.15 Disruptive Medical Staff Member..46
Section 4.16 Copying Of Medical Staff Files 47
Section 4.17 Rape Examinations 47
Section 4.18 Restraints Or Seclusion 48
Section 4.19 Pronouncement Of Death 48
Section 4.20 Use Of Investigational/Experimental Drugs Or Devices 48
Section 4.21 Cancer Staging 49

Article 5. ADOPTION, AMENDMENT OR REPEAL 51

ARTICLE 1.
FUNCTIONS OF THE MEDICAL STAFF

SECTION 1.1. GENERAL

The Medical Staff is non-departmentalized. Clinical Services shall be organized according to the Medical Staff Bylaws.

This Organization Manual adopts and incorporates by reference the definitions contained in the Medical Staff Bylaws unless otherwise provided herein.

SECTION 1.2. POSITION DESCRIPTIONS

1.2.1. Medical Staff Officers

(a) Chief of Staff

Reports to: Board of Directors and Medical Executive Committee, as needed to the Hospital President.

Position Purpose: The purpose of this position is to provide overall leadership and guidance to the Medical Staff. Additionally, it is essential that the Chief of Staff promote effective communication among the Medical Staff, Medical Executive Committee, Hospital administration, and the Board. The Appointee occupying this position will serve as the elected representative of the Medical Staff and will be responsible for Bylaws implementation, Medical Staff involvement in securing and maintaining accreditation, providing information to the Board concerning matters that pertain to the care and treatment of patients and generally facilitating positive relationships among administration, the Medical Staff and other support services of the Hospital.

Accountabilities and Functions: Coordinates the activities and concerns of Hospital administration, nursing service and other patient care services with those of the Medical Staff.

- Communicates and represents the opinions, policies, concerns, needs and grievances of the Medical Staff to the Board, the President of the Hospital and other officials of the Medical Staff.
- Calls, presides at, and is responsible for the agenda of all general and special meetings of the Medical Staff.
- Serves as chair of the Medical Executive Committee, a member of the Professional Practice Committee of the Board, an *Ex-*

Officio attendee to the Board of Directors meetings, and an *Ex-Officio* invitee of all other Medical Staff committees.

- Consults with the Vice President Medical Affairs on matters of special concern to Medical Staff Appointees and maintains medical liaison with the Vice President Medical Affairs to assist in settling grievances and problems of the Medical Staff.

Responsibilities: Responsible for the enforcement of the Medical Staff Bylaws, Organization Manual, and Credentials Policy Manual, for implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been recommended against a Practitioner.

Responsible for all administratively related activities of the Medical Staff, unless otherwise provided for by the Hospital.

Responsible, in conjunction with the Medical Executive Committee, for assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Medical Staff or the Hospital.

Responsible, in conjunction with the Medical Executive Committee, for the development and implementation of policies and procedures that guide and support the provision of services.

Responsible, in conjunction with the Clinical Service Chiefs, for the recommendations for a sufficient number of qualified and competent persons to provide care or service.

Responsible, in conjunction with the Clinical Service Chiefs, for the determination of the qualifications and competence of Clinical Service personnel who are not licensed independent practitioners and who provide patient care services.

Responsible for participating in the evaluation of existing programs, services, and facilities of the Hospital and Medical Staff and recommending continuation, expansion, abridgment or termination of each.

Responsible, in conjunction with the Medical Executive Committee, for participating in evaluating financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment, and for assessing the relative priorities of services and needs and allocation of present and future resources.

Responsible for appointing Medical Staff Appointees to the following committees: Credentials (excluding the chair), Utilization Review Committee, Clinical Quality Review Committee, Performance Improvement Council (except co-chair and its Hospital appointees), Pharmacy & Therapeutics, Operating Room, Medical Records and Wellness Committees.

Position Requirements: The Appointee occupying this position must meet the Qualifications of Officers as outlined in the Medical Staff Bylaws. Prior experience within our hospital system as a Clinical Service Chief, Credentials Committee member, Board member, Medical Executive Committee member or other similar Medical Staff leadership position is required. The Appointee occupying this position should have received education and training concerning medical administrative activities and Medical Staff leadership.

(b) Chief of Staff-Elect

Reports to: Chief of Staff and Medical Executive Committee

Position Purpose: The purpose of this position is to provide continuity in leadership during times when the Chief of Staff is absent or otherwise unable to perform his/her assigned functions and to provide the appointee with experience prior to assuming the Chief of Staff position. The Chief-Elect will be expected to remain knowledgeable about all Medical Staff issues of current Medical Staff interest. At the conclusion of the term of the Chief of Staff, the Chief-Elect will succeed as Chief of Staff.

Accountabilities and Functions: Assists the Chief of Staff with any functions specified by the Chief of Staff and the Medical Executive Committee. Is an Ex-Officio invitee to the Board of Directors meetings. Is a member of the Medical Executive Committee and the Risk Management/Claims Committee. Is an *Ex-Officio* invitee to the Professional Practice Committee. Is co-chair of the Performance Improvement Council. As such, this Appointee will be expected to represent the findings and recommendations of the Performance Improvement Council to the Medical Executive Committee.

Responsibilities: Responsible, in conjunction with the Medical Executive Committee, for continuing surveillance of the professional performance of all Practitioners and AHPs who have delineated Clinical Privileges.

Responsible, in conjunction with the Medical Executive Committee for the continuous assessment and improvement of the quality of care, treatment, and services provided, and for the maintenance of quality assessment and performance improvement programs as appropriate.

Co-chairs the Bylaws Committee, when enacted, in conjunction with the immediate past Chief of Staff to foster open communication of Bylaws changes between the Hospital Board, administration and Medical Staff proper.

Position Requirements: The Appointee occupying this position must meet the Qualifications of Officers as outlined in the Medical Staff Bylaws. Prior successful service as a Clinical Service Chief, Credentials Committee member, Board member, Medical Executive Committee member or other similar Medical Staff leadership position is required. Individuals occupying this position should have received education and training concerning medical administrative activities and Medical Staff leadership

(c) Vice Chief at Large

Reports to: Chief of Staff and the Medical Executive Committee

Position Purpose: To provide additional leadership to the Medical Staff, perform the functions of Secretary and Treasurer and promote effective communication between Physicians, Hospital administration, and other members of Medical Staff leadership.

Accountabilities and Functions: Assists the Chief of Staff as directed by the Chief of Staff and the Medical Executive Committee. Is Co-chairman for the Medical Records Committee and will report findings quarterly to the Performance Improvement Council.

Meets regularly with the officers of the Medical Staff to discuss current concerns and develop plans and goals for the hospital system.

Is a member of the Medical Executive Committee and attends quarterly Medical Staff Meetings.

Will assist the Chief of Staff with corrective action issues, including medical records and behavioral concerns, when requested.

Position Requirements: Must meet the Qualifications of Officers as outlined in the Medical Staff Bylaws. Prior successful service

as a Clinical Service Chief, Medical Staff committee member, Board member or similar leadership experience is required.

(d) Vice Chief of Medical Staff Credentials Program

Reports to: Chief of Staff and Medical Executive Committee. Recommendations from the Credentials Committee are carried forward by the Vice Chief to the MEC. Recommendations from the MEC are carried forward by the Chief of Staff to the Professional Practice Committee and then to the Board of Directors for final approval.

Position Purpose: To provide oversight for the Credentials Program of the Hospital and direction to the Hospital Board of Directors in the credentialing, appointment and privileging of Medical Staff Appointees and AHPs. To maintain compliance with the credentialing policies of the Hospital, the Hospital's accrediting agency standards, and applicable law.

The goal of the Credentials Program is to minimize potential liability, clearly define granted Privileges, ascertain the provider's qualifications for Medical Staff appointment and/or to perform requested Privileges, periodically review information from legal and ethical sources and performance data that impact the provider's appointment and/or Privileges, and minimize the effect of social, economic, political and other non-medical factors on credentialing.

Accountabilities and Functions: Together with the VPMA will develop, edit and maintain, on behalf of the Board, a fully documented Credentials Policy Manual, criteria for appointment/reappointment and granting/regranting of Clinical Privileges and associated policies and procedures that are utilized in the credentials process.

Appointment/reappointment and Clinical Privileges for the purpose of assuring that existing Medical Staff policies, accreditation standards, and state requirements are followed.

Will oversee processing of requests for all appointments to the Medical Staff and/or Privileges, and will specifically review those applications that fall outside of guidelines for a "clean" application.

The Vice Chief in conjunction with the medical staff services department is responsible for the maintainance of accurate and complete documentation concerning the entire credentialing process. This includes the maintenance, security, storage and

retrievability of credentials' files, minutes and other documents pertaining to the overall credentials program within the Hospital and the processing of individual applications for appointment and Clinical Privileges.

Position Requirements: Appointees occupying this position must meet the Qualifications of Officers as outlined in the Medical Staff Bylaws. Prior service as a Clinical Service Chief, Board member, Medical Executive Committee member, or other similar Medical Staff leadership position is required. Past participation on the Credentials Committee is highly recommended. Specific training is necessary for performance and will be recommended by the immediate past Credentials Committee chair.

1.2.2 Medical Staff Clinical Service Chiefs

Reports to: Chief of Staff

Position Purpose: The purpose of this position is to provide leadership to those organized Clinical Services to discuss policies, service needs, programs, and other issues affecting the provision of patient care by providers in the Clinical Service.

Reporting Relationship: Clinical Service Chiefs report directly to the Chief of Staff, Medical Executive Committee and, through written communication, to the Credentials Committee.

Accountabilities and Functions: Are members of the Medical Executive Committee and provide formal and informal positions on issues affecting the provision of patient care by providers in the Clinical Service. The Clinical Service Chief is selected by the Clinical Service to serve a two-year term.

Responsibilities: as outlined in the Medical Staff Bylaws.

Position Requirements: Must meet the qualifications as outlined in Article in the Medical Staff Bylaws.

1.2.3 Assistant Medical Staff Clinical Service Chiefs

Reports to: Medical Staff Clinical Service Chief

Position Purpose: The purpose of this position is to assist the respective Clinical Service Chief to provide leadership to those Clinical Services who choose to organize to discuss policies, service needs, programs, and other issues affecting the provision of patient care by providers in the Clinical Service.

Reporting Relationship: The assistant Clinical Service Chief reports directly to the respective Clinical Service Chief and, if so directed, to the Chief of Staff, Medical Executive Committee, and/or other appropriate committees.

Accountabilities and Functions: Regularly attends the Clinical Quality Review Committee and other committees as appointed in order to provide formal and informal positions on issues affecting the provision of patient care by providers in the Clinical Service. The assistant Clinical Service Chief is selected by the active members of the respective Clinical Service to serve a two-year term.

May represent the Clinical Service Chief at the Medical Executive Committee in his/her absence with vote.

Responsibilities: as outlined in the Medical Staff Bylaws.

Position Requirements: Must meet the qualifications as outlined in the Medical Staff Bylaws.

ARTICLE 2.
PROFESSIONAL MEDICAL STAFF COMMITTEES

2.1 DESIGNATION

There will be a Medical Executive Committee (MEC) and the following standing committees/councils report to the Medical Executive Committee: Credentials Committee, Performance Improvement Council, and the Wellness Committee. The following committees will submit minutes to the Chief of Staff who will submit these reports to MEC as appropriate: the Performance Improvement Council, Pharmacy & Therapeutics, Utilization Review Committee, Clinical Quality Review, Operating Room Medical Records, Osteopathic Methods and Concepts and the Infection Prevention and Control Committee. The Chief of Staff shall provide Medical Staff oversight for these committees and/or functions and will report to the MEC on an as needed basis regarding issues identified, which directly affect the Medical Staff. The Chief of Staff shall appoint the chair (except for Credentials Committee, which is an elected position) and members of Medical Staff committees/councils and recommend Medical Staff members for membership in Hospital and joint Medical Staff/Hospital committees/councils. Nothing in this Manual shall preclude joint meetings of Affiliate Hospitals Medical Staff committees to the extent that such meetings will assist in assuring quality patient care and effective peer review.

2.2 MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the Medical Executive Committee are as set forth in the Bylaws. The Medical Executive Committee shall nominate three (3) eligible Physician candidates for class C community Board of Director membership. The Medical Executive Committee shall select the organized Medical Staff section representative to the AMA and OSMA on an annual basis. In addition, the Medical Executive Committee supervises overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its clinical units as well as conducts periodic review of Medical Staff Bylaws, Organization Manual, Credentials Policy Manual and Medical Staff policies, and makes recommendations for changes to the Medical Staff and to the Board of Directors as outlined in the Medical Staff Bylaws.

It is the responsibility of the Medical Executive Committee to initiate, investigate, review, and report on corrective action, and on any other matters involving clinical, ethical, or professional conduct of any individual Practitioner. This responsibility may be delegated to the Clinical Quality Review Committee or a focused professional practice quality improvement panel selected by the Chief of Staff with the intent to improve the Practitioner's performance. The panel shall conduct the review as peers following the time frames set for that focused review by the MEC.

2.3 CREDENTIALS COMMITTEE

2.3.1 Composition

The Credentials Committee shall be composed of the Vice Chief, Medical Staff Credentials Program, the immediate past Vice Chief, Medical Staff Credentials Program the immediate past Chief of Staff, the Vice President of Medical Affairs, a Board member (*Ex Officio*) and representatives from each of the following Clinical Services: Anesthesiology, Cardiology Emergency Medicine, Family Medicine, Internal Medicine, Medical Imaging, Obstetrics/Gynecology, Orthopedics, Pathology, Pediatrics, and Surgery. The Vice Chief, Medical Staff Credentials Program shall be an elected position. Nomination and election of the Vice Chief shall occur biannually by the process outlined in the Bylaws. This Appointee may serve consecutive two-year terms. Member appointments shall be for terms of three (3) years. The Chief of Staff shall appoint new Clinical Service representatives after receipt of nominations from the Clinical Service chiefs.

2.3.2 Duties

The Credentials Committee shall investigate the qualifications of all applicants for appointment and/or Privileges, and shall review the Clinical Services assignments and the Medical Staff category and/or Privileges requested.

At an interval no greater than every twenty-four (24) months, it shall review all information available on each Practitioner and privileged AHP, including recommendation from the Clinical Service Chiefs. This information shall be used for the purpose of determining its recommendations for reappointment to the Medical Staff, reassignment to the Clinical Service and for the regranting of Clinical Privileges. The committee shall transmit its recommendations in writing, which may be reflected by its minutes, to the Medical Executive Committee. Where non-reappointment/regrant of Privileges, or a change in appointment category, Clinical Service or Privileges is recommended, the reason(s) for such recommendation shall be stated and documented.

The Credentials Committee shall review qualifications of all privileged Allied Health Professionals, subject to recommendation of the Allied Health Professionals Council and Clinical Service Chief prior to their being permitted access to patients and their medical records, and the committee shall establish processes as necessary to accomplish this review.

The Credentials Committee shall establish criteria for new procedures, provided such procedures are approved to be performed at the Hospital and evaluate the qualifications of any Practitioner applying for these Privileges.

The Vice Chief of the Medical Staff Credentials Program, and/or designee, shall be available to meet with the Board or its applicable committee on all recommendations that the Credentials Committee may make. The Credentials Committee may also create an *ad hoc* committee to deal with specific concerns.

2.3.3 Meetings, Reports and Recommendations

The Credentials Committee shall meet as often as necessary to accomplish its duties but at least six (6) times a year. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Medical Executive Committee with a copy to the President and the Board.

SECTION 2.4 WELLNESS COMMITTEE

2.4.1 Purpose

The Wellness Committee is a Medical Staff oversight committee whose primary purpose is not to discipline but rather to identify, assist and foster rehabilitation of impaired Medical Staff Appointees and AHPs with Clinical Privileges and/or scope of practices. The Wellness Committee's processes are separate from the Medical Staff corrective action function. An impaired individual is one who is unable, or potentially unable, to exercise his/her Privileges with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skills, or excessive use or abuse of drugs including alcohol.

The committee serves to educate the Medical Staff and other Hospital staff about health, addressing prevention of physical, psychiatric or emotional illness, and impairment recognition issues specific to Physicians and others with Privileges at the Hospital including facilitation of confidential diagnosis, treatment and rehabilitation from potentially impairing conditions;

The committee will encourage self-referral and referral by other Practitioners, AHPs, and Hospital staff.

The committee will examine the evidence for impairment of Medical Staff Appointees and others with Privileges at the Hospital including evaluation of the credibility of a complaint, allegation or concern;

The committee will facilitate referral of the affected person, if indicated, to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;

Committee members will seek to maintain confidentiality of the person seeking referral or referred for assistance, except as limited by law, ethical obligation, or when safety of a patient or staff is threatened;

The committee will provide support to Medical Staff Appointees and other privileged Practitioners/AHPs with impairment while monitoring recovery, including safety of patients until the rehabilitation or corrective action process is completed, and maintaining confidentiality;

The committee will report to the Medical Staff leadership instances in which a recovering person is providing unsafe treatment to patients.

The functions of the committee include: (i) reviewing concerns in an orderly and expeditious fashion that have been received by the Chief of Staff or otherwise referred to this committee in accordance with the Practitioner Wellness Policy and (ii) monitoring current cases of impairment of individuals with Privileges at the Hospital and (iii) fulfilling its responsibilities under the Practitioner Wellness Policy which is fully incorporated herein. Concerns about impairment of individuals with Privileges at the Hospital will be taken to the next scheduled meeting, or addressed sooner at the discretion of the chair or otherwise stated in the Practitioner Wellness Policy. When problems are presented, documentation will be obtained in a timely fashion. Suggestions or allegations of impairment of individuals with Privileges at the Hospital will be investigated in a thorough manner;

When the committee finds that a formal, professional evaluation is necessary to determine whether a problem truly exists, it will carry out an intervention in confidence, encouraging the suspected impaired individual with Privileges at the Hospital to voluntarily submit to the evaluation. If necessary, the committee may seek the help of the Montgomery County Medical Society Physician's Effectiveness Committee and/or the Ohio State Medical Association Physician's Effectiveness Program to do an intervention. Any intervention will be attended by the Chief of Staff, or his/her designee, who will deliver executive decision for definitive action, (i.e., requirement of a formal evaluation). The impaired individual will be encouraged to take a voluntary leave of absence or face suspension of Hospital Privileges. Immediacy of response for evaluation will depend on the magnitude of the perceived problem. If there is still inability to obtain compliance, the impaired privileged individual will be reported to the Ohio State Medical Board, or other applicable licensing entity, and to the Medical Executive Committee.

When an individual with Privileges comes to the Hospital acutely impaired, the Chief of Staff, Clinical Service Chief, or his/her designee, will be notified promptly and, if appropriate, will take the necessary actions to prevent risk to patient safety or care. The Wellness Committee will be notified of this action and shall investigate and determine whether additional action is required.

The committee is delegated the responsibility of establishing protocols for the evaluation and treatment of Medical Staff Appointees, and others with Hospital Privileges, whose physical or mental capacity is questioned. Any physical or mental condition, which would reasonably be expected to impair the Practitioner/privileged AHP, could subject the Practitioner/privileged AHP to investigation. Such investigations are to be conducted in a confidential and impartial manner.

2.4.2 Composition

The membership of the committee shall consist of ten (10) members. There are eight (8) members of the Medical Staff, appointed by the Chief of Staff, preferably not Clinical Service Chiefs or members of the Medical Executive Committee. There are two (2) additional members - the Vice President Medical Affairs and the Chief of Staff.

2.4.3 Meetings, Reports and Recommendations

The Wellness Committee shall meet as often as necessary to accomplish its duties but at least annually. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Medical Executive Committee.

SECTION 2.5 PERFORMANCE IMPROVEMENT COUNCIL

2.5.1 Purpose

The Performance Improvement Council ("PIC") is a joint committee of the Hospital and Medical Staff that establishes the quality assessment and performance improvement ("QAPI") priorities and receives and provides formal information sharing between the Clinical Quality Department and the leadership of the Hospital and Medical Staff. The PIC has the responsibility to charter, oversee and regularly evaluate QAPI programs and activities of the Hospital and its medical staff. The council receives and acts on summary reports from clinical and administrative committees as well as functions which track and trend information on clinical and other monitoring activities. It makes recommendations for quality assessment and performance improvement and effectively communicates those recommendations to the professional staff and Hospital groups with related responsibilities as specified in the Performance Improvement Plan.

PIC oversees organizational efforts to measure, assess and improve clinical activities outcomes, the quality and appropriateness of selected service, and identify problem in care and performance at the various levels of organizational leadership, functional area and Clinical Service and it is responsible for coordinating efforts to evaluate and monitor resource consumption and utilization management. Clinical review activities include appropriates of selected services/activities and management of the same in the following processes: (i) medication therapy; (ii) infection prevention and control; (iii) surgical management; (iv) blood products; (v) data management; (vi) discharge planning and utilization review; (vii) utilization management; (viii) complaints regarding medical staff related issues; (ix) restraint/seclusion usage; (x) mortality review; and (xi) “Never” events promulgated by CMS. Clinical review activities may be delegated to other committees and subcommittees that report through PIC.

PIC coordinates, prioritizes and monitors the Medical Staff, Hospital and medical education data gathering and analysis components of the quality review program, of QAPI activities using Plan, Do, Check Act ("PDCA") methodology, and coordinates the Medical Staff activities in these areas with those of the other professional and support services in the Hospital. Individualized Practitioner/resident data identified through PI processes will be delegated for handling to the Chief of Staff and/or CQRC as needed for further evaluation according to Medical Staff peer review process.

PIC annually evaluates the Hospital's overall PI program for its comprehensiveness, integration, effectiveness and cost efficiency, and revises the PI Plan as needed. The PI Plan includes evaluation mechanisms for every contracted patient care service and ensures that the list of all contracted services is maintained inclusive of the scope and nature of the services provided.

PIC reviews clinical risk management events, including root cause analyses of sentinel events, morbidity concerns and aggregate data on significant high risk events to identify possible patterns and communicate that information to the professional staff and Hospital groups with related responsibilities.

PIC periodically oversees the development and implementation of Hospital safety programs and an emergency preparedness plan that addresses disasters, both Hospital and community.

PIC annually reviews the Hospital Hazard Vulnerability Analysis (HVA) objectives and scope of the Emergency Operations Plan, Environment of Care, Staffing Effectiveness, Plan for Patient Care, Patient Safety Plan and the PI Plan.

PIC establishes formats for the aggregation, display and reporting of data and findings, as well as a system of follow-up to determine that recommended actions are implemented. It formats and schedules submissions of data and findings, committee minutes and special reports such that the entire clinical performance of the organization is monitored, the data is reported in a structured and comprehensive manner, and appropriate recommendations can be made based on that data to provide care within the Hospital of the highest quality.

PIC oversees quality assessment, performance improvement and peer review functions.

2.5.2 Composition

The composition of the PIC will total twenty (20) members equally representing Medical Staff and Hospital administration including the following:

Chief-Elect, Medical Staff - Co-chair; Vice President Medical Affairs, Kettering Medical Center - Co-chair; Hospital President; Hospital Vice Presidents; and Chief of Staff.

2.5.3 Meetings, Reports and Recommendations

The Performance Improvement Committee shall meet as often as necessary to accomplish its duties but at least quarterly. Medical Staff QAPI reviews are reported at least semi-annually that focus on clinical assessments, diagnostic procedures, and therapeutic interventions. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations and findings to the Medical Executive Committee and the hospital board as deemed appropriate. QAPI data and findings are used to develop continuing education activities, provide annual evaluations of improvement in clinical care and used in the credentialing process.

SECTION 2.6 UTILIZATION REVIEW COMMITTEE

2.6.1 Purpose

To insure high quality medical care and effective utilization of resources though review of ongoing issues, including case-specific utilization, physician and physician group profiling, and department and service line trending.

a. The Utilization Review Committee is a joint medical/administration committee which develops and amends annually a Utilization Review plan for approval by the Medical Executive Committee, Hospital Executive Council, and ultimately the Board of Trustees. The plan applies to all patients regardless of payment source, outlines the confidentiality and conflict of interest policy, and includes provision for:

(1) Reviewing admissions and medical necessity of admissions, continued hospitalization and extended stays;
(2) Discharge planning, including referral for appropriate post hospitalization care and physician follow-up;
(3) Reviewing medical necessity of professional services, such as, but not limited to, high cost procedures, drugs and biologicals.
(4) Data collection and reporting requirements;
(5) Identifying physician/case variations from evidence-based care.

b. Assist the organization with decision making and tracking of high volume, high risk, high cost and/or problem prone diseases or DRG's and recommending measures to improve outcomes. Reviewing cost and quality trends on a continuous basis, will improve clinical effectiveness and resource allocation.

c. Review, approve and recommend to the Medical Executive Committee all new physician order sets and protocols and significant revisions to existing orders/protocols, as the need arises.

2.6.2 Composition

The Utilization Review Committee will be co-chaired by the Medical Director for Clinical Quality and by a medical staff physician appointed by the Chief of Staff. The Committee shall consist of not less than four (4) or more than fifteen (15) members of the active Professional Staff, appointed annually by the Chief of Staff with reappointment of adequate members of incumbents to ensure continuity of philosophy and experience.

Experienced members shall be designated as Co-Chairs. Other members of the Committee will include at least two members of the Medical Staff and other physicians and hospital staff crucial to utilization review functions.

Due to conflict of interest, no committee member shall participate in the review of any case in which he/she was professionally involved in the care of the patient. No person serving on the Committee of this hospital may hold any financial interest in any hospital.

2.6.3 Meetings, Reports and Recommendations

The Utilization Review Committee shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Medical Executive Committee and the Performance Improvement Committee and as deemed appropriate.

SECTION 2.7 CLINICAL QUALITY REVIEW COMMITTEE

2.7.1 Purpose

The Clinical Quality Review Committee ("CQRC") is a peer review committee that is a subcommittee of PIC responsible to receive and/or identify and determine initial peer review issues and coordinate, track and trend clinical quality patterns and/or concerns as well as death reviews at the Hospital. Other clinical services, subsections and departments may be delegated to conduct peer review but their activities will be reported to CQRC.

The CQRC will:

a. Conduct review of surgical/invasive and manipulative procedures including tissue and non-tissue producing cases, with and without anesthesia and/or moderate sedation and cases which fail to meet predetermined criteria. These criteria may include: documentation, tissue examination, indications for surgery and post operative care. Define the scope and types of cases to be reviewed and provide tissue and audit review with including cases with minimum or no pathology to determine

the justification for all surgical procedures performed, scrutinize the relationship between preoperative diagnosis and the final postoperative diagnoses.

b. Review and evaluate internal and external data as it is necessary to understand the care that is being examined by the committee.

c. Monitor and assess utilization of blood and blood components for all service types of patients, including evaluation of appropriateness of all blood component transfusions; review all confirmed transfusion reactions in a timely manner; review ordering practices for, and distributing, handling, dispensing, and administering of, blood and blood products; and, monitor blood and blood component effects on patients. Serve to establish policies governing all transfusions of blood and blood derivations, systems for reporting transfusion reactions and will evaluate such policies and practices at regular intervals. Transfusion reactions will be considered adverse medical events and will be reported through the established quality assurance and performance improvement process. The committee shall investigate all transfusion reactions occurring in the hospital and shall recommend improvement in transfusion procedures. The committee will develop and policies and procedures regarding transfusions of potentially HIV/HCV infectious blood and blood products and defines the relationship and responsibilities of outside blood banks with appropriate notification procedures.

d. Monitor mortality review and complaints with quality concerns regarding medical staff related issues. Mortality review will consider the awareness of the critical nature of the cases, will analyze opportunities for early recognition of clinical deterioration, correct diagnosis and educational reporting of interesting cases for potential instructional use of the attending and house staff.

e. In the interest of objective peer review, members of the committee will not review their own cases or those of their practice associates. Reports will uphold confidentiality by using hospital case numbers and physician numbers.

2.7.2 <u>Composition</u>

The members of the CQRC will be appointed by the Chief of Staff and include, among others, appropriate assistant Clinical Service Chiefs.

2.7.3 <u>Meetings, Reports and Recommendations</u>

The Clinical Quality Review Committee shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations

to either the appropriate surgical clinical service, Performance Improvement Committee and the Medical Executive Committee as deemed appropriate.

SECTION 2.8 PHARMACY & THERAPEUTICS COMMITTEE

2.8.1 Purpose

The Pharmacy and Therapeutics (P&T) Committee:

a. Serves as a regulatory and advisory committee to the Medical Staff and Hospital administration in all matters pertaining to the evaluation, selection and utilization of medications, including equipment used to prepare and administer medications;

b. Recommends or assists in the formulation of educational programs designed to meet the needs of Practitioners, nurses, pharmacists or other health care providers on matters related to the selection, administration and monitoring of medication use;

c. Develops and maintains a formulary of drugs accepted for use in the Hospital and provides for its appropriate revisions. The selection and review of these drugs will be based on objective evaluation of their relative merit, safety and cost;

d. Establishes programs and procedures that help ensure cost effective drug therapy using indicators of patient outcome in their assessment;

e. Reviews adverse drug reactions and errors and develop programs and policies to minimize their occurrence and formulate procedures for reporting such reactions and errors; and assists the Staff in investigating such issues and implementing corrective actions;

f. Collects data, monitors and recommends process improvement to the Hospital and the Medical Staff, regarding procurement, storage and distribution; prescribing or ordering; preparing and dispensing; administering; and monitoring the effects on patients of medications used in the Hospital and enteral nutrition products in the Hospital;

g. Reviews medication errors and determine actions which should be taken to minimize their occurrence;

h. Develops a medication safety program for the Hospital that promotes safe medication administration and reduces preventable medication errors;

i. Recommends to the Medical Staff and Hospital policies regarding nutrition care issues.

j. Establishes priorities for ongoing assessment of medication used in the Hospital.

k. Monitors the anticoagulation management program for efficiency and effectiveness;

l. Recommends drugs that are stocked on nursing units;

m. Evaluates clinical data concerning new drugs requested for use in the Hospital, and advises the Staff and pharmacists on the choice of use of drugs;

n. Review Pharmacy and Therapeutics related policies at least every three (3) years and updates more frequently as necessary;

2.8.2 Composition

The P&T Committee is a joint Medical Staff/Hospital committee. Its membership consists of representatives from the Medical Staff, nursing, pharmacy, nutrition services and other health care providers. The chair shall be appointed by the Chief of Staff and the members appointed jointly by the Chief of Staff and the Hospital executive committee. The number of members will not exceed twenty (20).

The committee may appoint subcommittees as needed and the chair or director of pharmacy may invite non-members to attend as needed.

2.8.3 Meetings, Reports and Recommendations

The Pharmacy and Therapeutics Committee shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Performance Improvement Committee and the Medical Executive Committee as deemed appropriate.

SECTION 2.9 PERIOPERATIVE SERVICES GOVERNANCE COMMITTEE

2.9.1 Purpose

The Perioperative Services Governance is a joint medical staff and hospital committee and shall be responsible for the following: the Operating Rooms (OR), the Post Anesthesia Care Units (PACU), the Ambulatory Surgery Center (ASC) (pre and post operative care), and the Pre-Admission Testing (PAT) services including the Pre-Operative Clinic, Endoscopy Services (GI) Outpatient Surgery Center and Central Sterile Processing. The Perioperative Services Governance Committee will:

a. Review, revise and develop policies and procedures for Perioperative Services;

b. Recommend policy revisions to the Medical Executive Committee for approval;

c. Monitor compliance with Perioperative Services policies;

d. Monitor and evaluate effectiveness of Perioperative Services, including patient safety issues and performance improvement activities.

e. Upon request, provide comments to the Credentials Committee regarding Practitioners' use of Perioperative Services;

f. Review and prioritize requests for capital equipment, instruments and medical supplies;

g. Review and comply with regulatory and accrediting agency requirements.

h. The co-chairs of the Perioperative Services Committee may in urgent situations:

i. Discuss team interactions;

b. Interpret and enforce Perioperative Services policies, if necessary, between meetings of the Perioperative Services Committee

2.9.2 Composition

The composition of the OR Committee will not exceeed thirty (30) members and will have adequate representation from both Medical Staff and Hospital administration including the following:

Clinical Service Chief, Surgery - Co-chair; Administrative Director, Perioperative Services - Co-chair

2.9.3 Meetings, Reports and Recommendations

The Operating Room Committee shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Performance Improvement Committee Hospital Executive Council and to the Medical Executive Committee as deemed appropriate.

SECTION 2.10 OSTEOPATHIC METHODS AND CONCEPTS COMMITTEE.

2.10.1 Purpose

The purposes/functions of the committee are as follows:

a. To make recommendations to improve utilization of osteopathic principles and practice; to record osteopathic findings, describe osteopathic manipulative

treatment, and to apply such modalities as part of the comprehensive care received by patients.

b. To establish and record retrospective and current audits of patient charts relating the application of osteopathic principles and practice to patient diagnosis and treatment.

c. To inform osteopathic Physicians of the evaluations of patient charts done by the committee to improve utilization of osteopathic principles and practices.

2.10.2 Composition

The Osteopathic Methods and Concepts Committee shall consist of at least two (2) osteopathic Physicians on the active Medical Staff.

2.10.3 Meetings, Reports and Recommendations

The Osteopathic Methods and Concept Committee shall meet as often as necessary to accomplish its duties but at least annually. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Performance Improvement Committee and to the Medical Executive Committee as deemed appropriate.

SECTION 2.11 MEDICAL RECORDS COMMITTEE

2.11.1 Purpose

The purposes and function of the Medical Records committee are as follows:

a. Using the Kettering Health Network definition for a complete medical record as standard for comparison, will review reporting of record reviews that substantiates compliance with the standard.

b. Will assure implementation of actions plans to repair such deficiencies as are identified.

c. Will address concerns regarding records completions as brought forth to the committee from the administration or the medical staff.

d. Will recommend policies regarding maintenance and proper recording of sufficient data to evaluate patient care, as well as matter of confidentiality, access, and legal release of information.

2.11.2 Composition

The Vice Chief at Large will serve as the Co-chair of the Medical Records Committee along with the Network Medical Records Administrator. It shall include as members the Vice President Medical Affairs, the Director of Medical

Records for the hospital, the Medical Director of Clinical Quality, medical staff electronic medical records representative, at least one additional medical staff member, as appointed by the Chief of Staff and one additional member from the medical records department.

2.11.3 Meetings, Reports and Recommendations

The Medical Records Committee shall meet as often as necessary to accomplish its duties but at least quarterly. The committee shall maintain a permanent record of its proceedings and actions, and report its recommendations to the Performance Improvement Committee and to the Medical Executive Committee as deemed appropriate.

ARTICLE 3.
MEDICAL STAFF MEETINGS AND PROCEDURES

SECTION 3.1 MEDICAL STAFF MEETINGS

The Medical Staff shall meet quarterly throughout the Medical Staff Year. One of these meetings will be designated by the MEC as an annual meeting. Written notice of these meetings shall be sent at least seven (7) days in advance to all Appointees and shall also be conspicuously posted.

The primary objective of the meetings shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda. Written minutes of all meetings shall be prepared and recorded.

SECTION 3.2 SPECIAL MEETINGS

The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting within twenty (20) days after receipt of a written request signed by not less than ten percent (10%) or fifty (50) Appointees, whichever is less, of the active Medical Staff, or upon resolution by the Medical Executive Committee. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

Written or printed notice stating the time, place, and purpose of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each Appointee of the Medical Staff at least ten (10) days before the date of such meeting. The attendance of an Appointee of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

A special meeting of any committee or Clinical Service may be called by the chair, Clinical Service Chief, medical director, or a Medical Staff officer.

SECTION 3.3 REGULAR MEETINGS OF CLINICAL SERVICES AND COMMITTEES

Regular meetings shall be those Clinical Service meetings as well as Medical Staff and Medical Staff/Hospital committees that are identified in the Bylaws and related Manuals. Committees may, by resolution, provide the time for holding regular meeting without notice other than such resolution.

Each Clinical Service is required to have an adequate number of meetings to process business at a minimum of two meetings a year.

Each committee of the Medical Staff shall hold its first meeting of the calendar year at a time and place designated by the Chief of Staff subject to

review by the Medical Executive Committee. The Chief of Staff or each committee chair shall establish a time for regular meetings, shall select a recorder to record minutes of meetings, and shall adopt such rules of procedure necessary to accomplish the purposes for which the committee was established.

SECTION 3.4 NOTICE OF COMMITTEE MEETINGS

Written notice of any regular or special committee meeting not held pursuant to resolution will be provided to all persons entitled to be present not less than ten (10) days before the date of such meeting. Personal attendance at a meeting constitutes a waiver of notice of such meeting, except when a person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting was not duly called or convened.

SECTION 3.5 QUORUM

Medical Staff Meetings. Those Active staff members present.

Medical Executive Committee. Fifty percent (50%) of the voting members of the committee. Those members not meeting this requirement will receive a letter of reprimand from the Chief of Staff, which will outline the requirements of said position, up to and including removal from the position.

Credentials Committee. Minimum of five (5) medical staff members.

Performance Improvement Committee. A minimum of three (3) medical staff members.

Committee/Clinical Service Meetings. Those active members present.

SECTION 3.6 ATTENDANCE REQUIREMENTS

a) Meeting Attendance. All Medical Staff Appointees are encouraged to attend meetings of the Medical Staff. Meeting attendance is required for active Medical Staff Appointees. At a minimum, each active Medical Staff Appointee is required to attend at least fifty percent (50%) of Clinical Service meetings and fifty percent (50%) of the quarterly Medical Staff meetings. Active Medical Staff Appointees who do not meet attendance requirements may be subject to assignment to provisional status and other corrective or administrative disciplinary measures as determined by the Medical Executive Committee. Meeting attendance will be considered by the Credentials Committee in evaluating a Practitioner at the time of reappointment.

b) Attendance by members of the Medical Executive, Credentials, and Performance Improvements Committees. Members of the Medical

Executive Committee, Credentials Committee, and Performance Improvement Council, are expected to attend at least fifty percent (50%) of the meetings held. The Medical Executive Committee may require Medical Staff meeting attendance on any Medical Staff, joint Medical Staff/Hospital committee or Clinical Service meetings. Those members not meeting this requirement will receive a letter of from the Committee Chair, which will outline the requirements of said position, up to and including removal from the position.

SECTION 3.7 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members, in Good Standing, present and voting at a meeting at which a quorum is present is the action of the group. In unusual circumstances, action may be taken without a meeting by the Medical Staff, Clinical Service or committee by presentation of the question to each member, in Good Standing, eligible to vote, in person or by mail, and their vote returned to the chair of the group, Clinical Service Chief, or to the Chief of Staff in the case of a Medical Staff vote. Such vote shall be binding so long as the question is voted on by at least the number of voting members of the group that could constitute a quorum.

SECTION 3.8 MINUTES

Minutes of all meetings, except as noted in the Bylaws, shall be prepared and include a record of attendance and the vote taken on each matter. Minutes are to be signed by the presiding chair or officer, forwarded to the Medical Executive Committee or the parent committee in the case of a subcommittee, and presented to the attendees at a subsequent meeting for acceptance. Minutes shall be made available, upon request to and at the discretion of the Chief of Staff to any active or associate Medical Staff Appointee who functions in an official capacity within the Hospital so as to have a legitimate interest in them. When access is approved, it shall be afforded in a manner consistent with the confidentiality policies of the Hospital concerning Medical Staff minutes and activities. A permanent file of the minutes of each meeting shall be maintained.

SECTION 3.9 PARTICIPATION BY CHIEF OF STAFF

The Chief of Staff and/or any representative assigned by the Chief of Staff may attend any committee or Clinical Service meetings of the Medical Staff.

SECTION 3.10 VOTING AND MEETING OPTIONS

3.10.1 Voting. Unless otherwise specified in the Bylaws/Manuals, voting may occur in any of the following ways as determined by the chair of the respective committee; the Clinical Service Chief; or, for voting by the Medical Staff, as determined by the Chief of Staff:

a) By hand or voice ballot at a meeting at which a quorum is present.

b) By written ballot at a meeting at which a quorum is present.

c) Without a meeting by written ballot or electronic ballot provided such ballots are received prior to the deadline date set forth in the notice advising of the purpose for which the vote is to be taken.

d) Absentee written ballot provided the ballots are received prior to the deadline set forth in the notice advising of the purpose for which a vote is to be taken.

3.10.2 Meeting Options. Unless otherwise specified in the Bylaws/Manuals, Practitioners may participate in and act at any meeting by conference call or other communication equipment through which all persons participating in the meeting can communicate with each other. Participation by such means shall constitute attendance and presence in person at the meeting.

ARTICLE 4.
RULES AND REGULATIONS

SECTION 4.1 OUTPATIENT (AMBULATORY), OBSERVATION AND ADMISSION STATUS

Provisional Diagnosis and Status: No patient shall be admitted to the Hospital until a provisional diagnosis has been documented in the medical record and an admission order from the admitting Practitioner, or his/her alternate, secured. Justification for the assignment of status shall reflect Medical Staff approved criteria.

Patients: The Hospital shall accept patients suffering from all types of diseases except those whose medical needs are beyond the scope of care provided at a Hospital facility. Patients presenting to a Hospital facility– for treatment outside the Hospital's scope of service will be stabilized and transferred to another appropriate facility.

Protection of Other Persons: Practitioners admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients and personnel from those who are a source of danger from any cause whatever or to assure the protection of the patient from self-harm.

This Hospital has the obligation of minimizing the risk of hazards and safeguarding all patients, visitors and personnel. Therefore, when any patient whose mental or physical condition causes him/her to be disturbing and/or unsafe to himself/herself, other patients, and personnel of this Hospital, the patient may be transferred to a private room.. This transfer will be discussed with and approved by the attending Practitioner. In case of disagreement, the appropriate Clinical Service Chief will be contacted, and if a mutual decision with the attending Practitioner cannot be reached, a Medical Staff officer or designee, shall be consulted to make a final disposition made by such an officer or designee.

Transfer of Service: Patient transfer from the admitting Practitioner's care to another Practitioner is arranged by agreement of the current attending Practitioner and receiving Practitioner whether the transfer is requested by the patient or patient's appropriate legal representative or by the attending Practitioner.

To complete a patient transfer of service the attending Practitioner must order a transfer of service with appropriate documentation of reasons for transfer in the Practitioner's progress notes as well as the receiving ―Practitioner documenting acceptance of the patient transfer in the -Practitioner's progress notes and orders.

Assignment of Cases:

(1) Unattached patients shall be attended by Medical Staff Appointees with appropriate Privileges and shall be assigned by the Clinical Service concerned in the treatment of the disease which necessitated admission.

(2) It is expected that private patients shall be attended by their own Practitioner. All Practitioners with Clinical Privileges are required to provide continuity of care to all patients in their practice for whom they are responsible, and to provide care that is effective, safe, patient and family centered, efficient, timely and within the parameters of granted Privileges. In the event that a Practitioner plans to be away from the Hospital for a scheduled absence (*e.g.* vacation or absences for personal reasons, but not including a leave of absence as defined in the Credentials Policy Manual), such Practitioner shall make adequate arrangements prior to departure for coverage for his/her private patients that are inpatients or who may present to the Emergency Department while the Practitioner is away on such planned absence. The Practitioner, unless in a group practice in which all Practitioners have common Privileges or in a designated call coverage group made known in advance to the Medical Staff Services Department, shall notify the Medical Staff Services Department and the Emergency Department of such period of scheduled absence, and shall identify the covering Practitioner who shall have similar Medical Staff Privileges, have agreed in writing to provide this coverage, and be located within the Hospital's geographic service area and close enough to provide timely care for the private Practitioner's inpatients and/or Emergency Department patients. If the Practitioner is also scheduled to be on-call during the scheduled absence, he/she must also arrange for backup on-call coverage with another Practitioner who meets the above criteria, and shall notify the departments identified above and other Hospital areas/departments as may be required in the Manuals, and/or Medical Staff/Hospital policies. In the case of the patient requiring admission who has no attending Practitioner on the Medical Staff and does not elect or is unable to choose one, he/she shall be referred to the appropriate Clinical Service on-call Practitioner.

(3) Practitioners to whom unattached patients are referred have a responsibility to provide care to the patient at least once for the problem for which the patient was referred, regardless of ability to pay and to provide continued care or secure referral to another proper available care provider.

(4) Practitioners, who assume responsibility for unattached patients, are expected to respond to a request from the Emergency Department to

provide consultative or in Hospital care in a timely fashion, to meet patient care needs.

(5) All patients who are placed in a Hospital bed as an inpatient or observation status are required to be seen by the admitting or consulting Practitioner (who is permitted by the State and Hospital to admit patients to a hospital) in a timely fashion with documentation of that visit in the medical record. Medicare patients must be under the care of a M/DO. Patients transferred or admitted to an ICU shall be seen by the attending or consulting Physician within a time frame consistent with the clinical condition of the patient, usually no longer than twelve (12) hours. Patients placed in a non-ICU bed as an outpatient (ambulatory), observation status or admission, shall be seen by the admitting or consulting Practitioner within a time frame consistent with the clinical condition of the patient, but within twenty-four (24) hours. All patients, with the exception of patients awaiting nursing home placement who shall been seen at least weekly require daily patient visits by the attending Practitioner with privileges or his/her covering Practitioner and these visits must be documented in the progress notes as a part of usual care. Medical student progress notes will not be a part of the medical record until they are signed by a supervising resident or Physician. To provide appropriate continuity of care for patients who are hospitalized by Practitioners other than the patient's primary care Physician, the attending is responsible to communicate, when appropriate, with the primary care Physician regarding the patient's Hospital course and the plan of care post hospitalization.

SECTION 4.2 PATIENT SAFETY

The Hospital and its Medical Staff have a responsibility to promote patient safety and medical error reduction. This is accomplished through the identification and prevention of medical errors through the prospective analysis and re-design of vulnerable patient systems, the promotion of a culture of non-punitive reporting, and the responsibility to tell a patient if he or she has been harmed by the care provided. Each Practitioner is expected to participate in the patient safety program at the hospital by actively supporting and following the Hospital policies and procedures related to providing safe medical care, including the Hospital's Patient Safety Performance Improvement initiatives and Patient Safety Culture Survey approved by the Medical Executive Committee, and informing patients and their families about unanticipated outcomes of care.

SECTION 4.3 UTILIZATION

The history and physical and progress notes must document the patient's clinical course in sufficient detail to provide a reasonable understanding of the

patient's evolving condition, diagnoses, treatment, and plan of care. In addition, the notes must provide sufficient information regarding the severity of illness and/or intensity of service that requires continued use of Hospital resources.

Medical Staff Practitioners are required to provide appropriate diagnoses or clinical indications to justify diagnostic tests and therapeutic interventions performed by Hospital Departments.

Admissions prior to the day of surgery will be permitted if the medical condition warrants Hospital admission criteria. If prior approval for non-emergency surgery or admission is required by the payor, the Medical Staff Practitioner is responsible (whenever possible) for obtaining such approval prior to surgery or admission.

If approval for performance of any non-emergency procedures is required by the third party payor, such approval must be obtained prior to performance of that procedure.

It is the Practitioner's responsibility to abide by the stipulations made by the payor for patient services as long as these requirements are consistent with the Bylaws and Organization Manual of the Medical Staff and consistent with appropriate standards of care.

Periodic review of the appropriateness of patient care may be made by the staff of clinical quality department. Deviations from Medical Staff approved criteria will be referred to the utilization Physician reviewer.

SECTION 4.4 PEER REVIEW

The peer review function for Practitioners and AHPs with delineated Clinical Privileges will be performed with intention to safeguard Practitioner confidentiality to the greatest extent and to promote objective and unbiased considerations. The purpose of all peer review is to promote excellent clinical outcomes and the safety of patients and staff. Peer review is to be done with the intention to identify and improve processes which may impair the ideal delivery of clinical care. Its intent is performance improvement and not indictment of individuals. Issues of disruptive behavior are not addressed via peer review (refer to Disruptive Medical Staff Member Section of this Manual). Peer review is a necessary element of professionalism and all Appointees of the Medical Staff are expected to actively participate in the process, when requested.

Situations may arise when Practitioners outside the Medical Staff may be asked to participate in the peer review process. In this event, the Practitioner subject to peer review will be apprised of this need and will be invited to

nominate unbiased external Practitioners for consideration. When a determination is made by CQRC of Type 2 or Type 3 issue, the Practitioner will be given written notification by Special Notice within thirty (30) days.

If a subcommittee is appointed to investigate a peer review matter by the Medical Executive Committee or the Chief of Staff, the subcommittee members will follow the following guidelines:

1. Any predetermined review by which criteria are established to evaluate a diagnosis, treatment outcome, procedure or other parameter must not be exclusively directed at one Practitioner, and should shall include all Practitioners involved in the same. This procedure does not preclude an investigation of an individual Practitioner based upon a specific complaint.

2. Once the initial chart review indicates further inquiry is necessary, the Practitioner involved should be notified in writing by Special Notice that a review will take place.

3. The Medical Executive Committee will maintain a file for each investigation containing the written complaint if any and all relevant correspondence, clinical records, and committee minutes. The Practitioner who is the subject of investigation, will be provided a summary of the complaint and the nature of the supporting evidence. The file documents are confidential and are subject to the privileges from disclosure to the persons outside the review proceedings (Ohio Rev. Code Section 2305.251).

4. Minutes shall be maintained by the investigating committee and shall identify any deviation from the appropriate standard of care or violation of Hospital and/or Medical Staff Bylaws, policies, rules and/or regulations. When such is the case, the Practitioner will be notified by Special Notice, and asked to respond. When a Practitioner's response satisfies the committee or if for other reasons the committee feels that no action is appropriate, the investigation will be terminated with a positive comment and an appropriate letter ~~is~~ shall be sent by Special Notice to the Practitioner.

5. When the investigation reveals a significant deviation or violation as aforementioed; or, if for other reasons the investigating committee feels that further action is necessary, the affected Practitioner shall be invited to meet with the committee to discuss the case(s). The chair of the committee shall make efforts to see that each member of the committee reviews the complete file so they are well informed before the meeting. This shall include comparing any internal reviewer's report with any patient charts in question. If the matter is resolved at

this level, the review will be terminated with a positive comment and a letter to that effect shall be sent by Special Notice to the Practitioner.

6. If the majority of the committee is still not satisfied after meeting with the Practitioner**,** it can refer the matter and the complete file back to the Medical Executive Committee with or without recommendation. The Medical Executive Committee will act at that point, based on the recommendation, or otherwise send the file to an outside reviewer. External peer review shall be initiated by request, which is approved by the Medical Executive Committee, from any one of the following:

   Medical Staff Clinical Service
   Clinical Quality Review Committee (CQRC)
   Medical Executive Committee
   Clinical Service Chief
   Chair of CQRC
   Chief of Staff
   President of the Hospital or designee
   Board of Directors

Indications for an external review include, but are not limited to, the following:

1) Ambiguity when dealing with vague or conflicting recommendations from committee review(s) where conclusions from the review could impact a Practitioner's appointment or Privileges**;**

2) Lack of internal expertise, when no one on the Medical Staff has adequate expertise in the clinical procedure or area under review;

3) When the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credentials file, or for assistance in developing a benchmark for quality monitoring;

4) To promote impartiality in peer review. The Medical Executive Committee or Board of Directors may require external peer review in any circumstance deemed appropriate by either of the bodies. If referred to an outside reviewer, upon receipt of the reviewer's report, if the Medical Executive Committee is satisfied, the review will be terminated with a positive comment and an appropriate letter ~~is~~ shall be sent by Special Notice to the Practitioner (unless the Board has required such review in which event the Board will act on the reviewer's report. If not satisfied, the Medical Executive Committee will decide on an appropriate action as set forth in the Bylaws and make its recommendation to the Board for final action.

Peer review issues will ultimately be classified as follows:

Type I: Issues related to documentation (administrative or clerical)

Ia: Issues that are not expected to directly impact patient care (*i.e.* failure to timely authenticate orders)

Ib: Issues that have the potential to or that actually impact patient care and/or failure to comply with administrative or regulatory standards (*i.e.* H & P not complete, not present on chart prior to procedure, thus leading to delayed procedure and/or cancellation)

Type II: Minor deviations related to reasonably prudent standard of care (lesser severity (*i.e.* resulting in temporary harm or prolonged hospitalization and/or treatment)

IIa: Patient care issues that could have affected outcome, less than desired care that did NOT result in an actual adverse outcome. (*i.e.:* "near miss" events)

IIb: Same as IIa above, but in which patient complication or adverse outcome actually occurred.

Type III: Major deviations related to reasonably prudent standard of care (lesser severity (*i.e.* death or major permanent loss of function)

IIIa: Major events that could have resulted in drastic adverse outcome, (*i.e:* wrong site surgery)

IIIb: Same as IIIa above, but which actually resulted in an adverse outcome.

Identification of potential Type I issues may be from case managers, health information services personnel, medical director clinical quality, Vice President Medical Affairs, or by a member of the Medical Executive Committee.

Identification of potential Type 2 or Type 3 issues may arise from any of the following: complaints by patients, written complaints by Hospital or Medical Staff, routine chart and outcome reviews by members of the Quality Department, routine chart review by appropriate Hospital staff and/or committees, routine review of clinical outcomes and documentation statistics, or by focused professional practice evaluation as requested by a Clinical Service Chief, the Medical Executive Committee, or the Professional Practice Committee of the Board of Directors.

A practitioner who has received a Type 2 or Type 3 determination will be notified in writing by Special Notice and given the opportunity to appeal the decision. This appeal may be in writing or in person. Appeals shall be directed to the chair

of the Clinical Quality Review Committee, the Clinical Service Chief or the Chief of Staff.

The aggregate data from Type 1, Type 2, and Type 3 issues will be reviewed as indicated and during the biennial reappointment/regrant of Privileges and recredentialing process of the Medical Staff.

SECTION 4.5 ORDERS

a) Admission Orders: All inpatients must have orders upon admission provided by an Appointee of the Medical Staff with Clinical Privileges or a non-Appointee with appropriate Clinical Privileges within the scope of his/her licensure.

b) Written Orders: All orders for diagnostic procedures, treatment or medication shall be in writing or directly entered into the electronic medical record or physician order entry system. All orders, including telephone and verbal orders, must be dated, timed and authenticated within forty-eight (48) hours by the ordering Practitioner or another Practitioner responsible for the care of the patient. Telephone and verbal orders shall be accepted, recorded and carried out when dictated to credentialed personnel within the scope of their licensure, certification or registration. Telephone and verbal orders are to be written down by authorized staff and then read back to the ordering Practitioner (except in an emergency or during a procedure when repeating back the order is adequate). Documentation of verbal orders includes the time the verbal order was received, and the date and names of individuals who gave, received, recorded and implemented the orders. Orders received over the telephone shall be accepted from credentialed Hospital Medical Staff Practitioners or residents if the ordering Practitioner's/resident's identity is not in doubt and the orders are read back to the Practitioner [/resident] and confirmed. Faxed orders may be accepted if the fax is signed by the ordering Practitioner and the sending fax site is identified. Orders may be accepted via email or two-way pager services if sent through a Hospital approved site or another secure site and the ordering Practitioner is clearly identified. Orders received from Practitioners via any of the above means will be transcribed into the record and dated, timed and authenticated by signature or electronic verification.

SECTION 4.6 RECORDS

4.6.1 Content, Review and Evaluation

a) Content: The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to

medications and services. A complete medical record of a patient in admission, observation or ambulatory status shall, as applicable, identification data; chief complaint(s); history of present illness; relevant past history; social history; family history; review of systems; relevant physical examination; admitting/provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; multidisciplinary notes and flow sheets; medication administration records; special reports such as consultations, clinical laboratory reports, radiology/imaging reports, and a discharge summary including outcome of hospitalization, discharge/final diagnoses, disposition of the case, and provisions for follow-up care. CMS also requires evidence in the medical record of appropriate findings by clinical and other staff involved in the care of the patient; documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia; properly executed informed consent forms; all Practitioners' orders; nursing notes; reports of treatment; medication records; vital signs, and other information necessary to monitor the patient's condition.

b) Legibility: Appointees of the Medical Staff and others with Clinical Privileges have a responsibility to make legible entries into the medical record. The Medical Staff has a legibility policy to assure all individuals having access to patient medical records can read information contained within the medical record. Non-compliance may result in progressive corrective action including notification, education (including possible remedial handwriting programs), and suspension(s) for incomplete medical records.

c) Non-Medical Comments: Criticism, impertinent and inappropriate comments, drawings or language, or personal attacks against Practitioners/AHPs, Hospital personnel, or the Hospital and its policies shall not appear in the medical record. Any alleged violation of this rule shall be referred to the Chief of Staff and/or the Vice President of Medical Affairs for interpretation, judgment, and action. If warranted, they may refer the incident to the Medical Executive Committee for review and recommendation.

d) History and Physical: A current complete history and physical examination (H & P) consists of the following required elements: chief complaint, history of present illness, relevant past history, social history, family history, review of systems, relevant physical examination, impression, and plan of care. For those patients for which a surgery/procedure is to be

performed, the H & P must include indications for the surgery/procedure as documented by the operating surgeon/Practitioner performing the procedure. A complete H & P, and any updates thereto, shall be placed on the patient's chart within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

The H & P records are the responsibility of the attending Physician. H & Ps shall be properly documented, and authenticated, dated, and timed. Medical student H & P'swill not be part of the medical record unless they are written and signed by a supervising resident or the attending Physician. Medical student dictation will not be transcribed by the Hospital.

The H & P must be completed and documented by one of the following:

- Doctor of medicine or osteopathy
- Doctor of podiatric medicine (in accordance with Ohio State law and as indicated in the Credentials Policy Manual)
- Doctor of dental surgery or of dental medicine (in accordance with Ohio State law and as indicated in the Credentials Policy Manual)
- Physician Assistants [if privileged to do so by the Hospital and in accordance with Ohio State law (e.g., within scope of practice, etc.)]
- Certified Nurse Practitioners/Advanced Practice Nurses [if privileged to do so by the Hospital and in accordance with Ohio State law (e.g., within scope of practice, etc.)]

NOTE: H & P's completed and documented by PA's and APN's must be authenticated by the attending Physician.

Should the H & P be provided by a non-credentialed Practitioner, a Practitioner without appointment/Privileges at the Hospital, (i.e. patient's primary care Practitioner), then an update meeting the required contents of the H&P as defined in this section must be completed and documented by a Practitioner who is appropriately credentialed and privileged in accordance with the Medical Staff Bylaws and other related Manuals.

The update, if any, shall indicate the following: the H & P was reviewed, the patient was examined, and that "no change" has

occurred in the patient's condition since the H & P was completed. Any changes in the patient's condition must be documented in the update note and placed in the patient's medical record within twenty-four (24) hours of admission or registration, but prior to surgery or a procedure requiring anesthesia.

If the Practitioner finds that the H & P done before admission is incomplete, inaccurate, or otherwise unacceptable, the Practitioner reviewing the H & P, examining the patient, and completing the update may disregard the existing H & P and conduct and document in the medical record a new H & P within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia.

e) Ambulatory/Outpatient H & P
Ambulatory patients who are undergoing procedures not requiring moderate sedation or anesthesia, except local anesthesia, do not require a complete H & P on the chart. Only a pertinent note concerning the nature of the disease process leading to the procedure and the intended procedure is necessary in these cases. Other pertinent positive findings, such as drug allergies and serious pre-existing disease entities should also be noted.

f) Anesthesia/Procedural Sedation: Outpatients undergoing surgery or procedures under any anesthesia or procedural sedation, except local anesthesia without any pre-operative medication, require an H & P.

g) Pre-Operative/Pre-procedure Record: Emergencies excepted, patients shall not be taken to the operating/procedure room unless the medical record contains a signed and witnessed informed consent form, a plan of care for the surgery/ procedure and anesthesia/—procedural sedation, and an acceptable current H & P. In emergency conditions, an acceptable H & P may be limited to major significant conditions requiring the immediate surgery/procedure. Surgery/procedure time may be forfeited on the authority of the Perioperative Governance Committee as outlined in the Operating/Procedure Room Policy, as such policy may be amended from time to time, when the start of the operation/procedure is delayed for more than fifteen (15) minutes.

h) Pre-Operative Attestation Informed Consent: To assist the patient in providing informed consent, the Practitioner

performing the surgery or procedures shall provide a plan of care for the patient including informing the patient and/or appropriate surrogate(s) regarding the need for, benefits, alternative options, risks, and potential complications associated with the surgery/procedure.

To assist the patient in providing informed consent, the Practitioner responsible for managing the patient's care, treatment, and services (or his/her designee) shall ensure that the patient and/or appropriate surrogate(s) is informed of the potential benefits, risks, and side effects of the patient's proposed care, treatment and services, the likelihood of the patient achieving his or her goals, and any potential problems that might occur during recuperation. This informed consent process includes a discussion about reasonable alternatives to the patient's proposed care, treatment and services. The discussion encompasses risks, benefits and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment and services. Risks and benefits associated with blood transfusion when blood or blood components may be needed with an operative procedure are also discussed. Documentation of risks, benefits and alternatives must be present in the patient record. The Informed Consent Policy, as such policy may be amended from time to time, outlines the details of the informed consent process.

To assist the patient in providing informed consent, the Practitioner or CRNA providing anesthesia or procedural sedation shall provide an anesthesia or procedural sedation plan of care including documenting patient American Society of Anesthesiology (ASA) classification and informing the patient and/or appropriate surrogate(s) of the need for, benefits, alternative options, risks, and potential complications associated with anesthesia or procedural sedation prior to administration of pre-operative medication.

i) Anesthesia Documentation: a pre-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia services.

An intra-operative anesthesia record shall be maintained.

A post-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia no later than forty-eight (48) hours after surgery or a procedure

requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery is completed in accordance with State law and regulation and Hospital policies and procedures that have been approved by the Medical Staff and that reflect current standards of anesthesia care

j) Surgical Record: All operations or procedures performed in the Hospital shall be described in full through immediate dictation or by a hand-written report. The operative report must be in sufficient detail to provide necessary clinical and billing information, must be entered immediately into the patient's medical record upon completion of the operative or high-risk procedure and before the patient is transferred to the next level of care (unless an immediate progress note is entered—see below) and must include the following elements:

- the name and hospital identification number of the patient
- the date/time of surgery
- the names(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s) (even when performing those tasks under supervision)
- the name of the procedure
- findings of the procedure (including complications, if any)
- a description of the procedure/techniques (including the type of anesthesia administered)
- any estimated blood loss
- any specimens/tissues removed or altered
- pre-operative diagnosis
- the postoperative diagnosis
- description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include:
- prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

The report/note must be dated, timed, and signed by the surgeon/Practitioner who performed the surgery/high risk procedure

When the original or a hard copy of the full operative report is not placed in the medical record immediately after surgery or procedure, a progress note of the operation or procedure is entered immediately. This immediate postoperative/procedure note, completed before the patient is transferred to the next level of care, includes the same elements outlined above.

All tissues and foreign material surgically removed, will be processed in accordance with Hospital policy.

4.6.2 Discharge Summary

To facilitate continuity of care, a discharge summary containing at a minimum the reasons for and outcome of hospitalization, significant findings, procedures performed and care, treatment, and services rendered, the final diagnoses, the patient's condition and disposition at discharge, instructions to the patient and/or appropriate surrogate(s), and provisions for follow- up care will be included in a completed medical record. For normal newborns, uncomplicated deliveries, or patients whose admitted Hospital stay is less than forty-eight (48) hours with uncomplicated care, a discharge progress note, which includes the outcome of hospitalization, the patient's condition at discharge/disposition of the case, discharge instructions, and provisions for follow up care, may be substituted for a discharge summary. A discharge progress note may also be used to satisfy the discharge summary requirements for the initial hospitalization when a patient is transferred to another network facility.

Any multi-service patient (one whose medical care is provided by more than one specialist or attending Practitioner) shall have a single discharge summary, which includes all areas of care. The attending Physician will be responsible for the discharge summary.

4.6.3 Completion of Records - Requirements:

a) A history and physical (H&P), discharge summary, consultation and operative/procedure note shall be authenticated with a handwritten or electronic signature as well as timed and dated. Rubber stamp signatures are not acceptable for authentication. Electronic, verbal or telephone orders must be authenticated within forty-eight (48) hours.

b) Charts must be accurately and legibly completed within fourteen (14) days from allocation date. Charts are complete only after dictated reports and required entries are signed, dated and timed within required timeframes; merely dictating before the deadline is not sufficient. Charts may be identified as incomplete prior to discharge if required elements are not performed as mandated by the stricter rules set forth in the Medical Staff Manuals, Hospital policy or accrediting and/or regulatory standards/requirements. Examples of such incomplete records would be lack of an immediate post-operative note and failure to authenticate electronic, verbal or telephone orders within forty-eight (48) hours.

c) Notification of suspension of Hospital privileges for incomplete or delinquent medical records will be given to the Practitioner either

verbally, by Special Notice, or by receipted facsimile. For records that are not able to be completed within the fourteen (14) day period due to extenuating circumstances (e.g. illness, vacation) a prior waiver with time extension may be requested from the officers listed below.

d) Automatic suspension of Privileges for incomplete or delinquent medical records results in the affected Practitioner not being able to admit or write orders for new patients; but does not in any way remove the Practitioner's responsibilities for call coverage, for patients already under his/her care in the Hospital, or for the provision of services which have been scheduled prior to the suspension and which cannot be appropriately rescheduled.

e) Suspension of Practitioners who supervise AHPs may result in the AHP's Privileges being suspended as well if the AHP has no other collaborating or supervising Practitioners.

f) Any Practitioner whose Hospital Privileges have been suspended because of incomplete or delinquent records, or portions thereof, may in the event of unusual or extenuating circumstances obtain authority to care for or admit a specific patient from the Chief of Staff or designee, Chief-Elect, Vice Chief, Medical Staff Credentials Program, Vice Chief at-Large, or the Vice President of Medical Affairs. The approving officer and Practitioner shall both notify the admissions office of the nature of the special circumstances prior to the admission of the patient. For removal of the suspension prior to curing medical records deficiencies, Practitioners may submit a plan of compliance and petition for restoration to one of the above officers. Upon approval of the plan, the officer will contact the Health Information Management Department to restore such Practitioner's admitting and ordering Privileges.

g) A Practitioner who has received three suspension letters during any consecutive 12-month period, and who subsequently has incomplete or delinquent medical records; or a Practitioner who has been under suspension for two (2) consecutive weeks without an excused waiver will be assessed a fine of $500.00 in addition to the imposition of the automatic suspension. Reinstatement of Clinical Privileges cannot occur until the Practitioner completes all delinquent and incomplete records and pays the fine to the Medical Staff Services Department. If Privileges are reinstated, any single subsequent delinquency or failure to complete the medical records as required during the same consecutive 12-month period will result in a fine of $1000.00, an automatic suspension, and the Practitioner will be required to present an acceptable corrective action plan in person to the Medical Executive Committee. If Clinical Privileges are reinstated, any subsequent noncompliance with medical record requirements in the

same consecutive 12-month period will result in immediate termination of both Medical Staff appointment and Clinical Privileges. Notice of such termination will be sent by Special Notice, and reasonable attempts will be made to contact the Practitioner personally. Signature of receipt of the notice or documentation of the date of the personal contact will constitute completion of the notification process. The Practitioner who is so terminated will not be eligible for the hearing and appeal process and will need to reapply to the Medical Staff for appointment and Clinical Privileges. For patient safety reasons, and in order to not jeopardize the continuity of patient care, in the event of such imminent automatic termination, the Chief of Staff or his/her designee may intervene to permit the Practitioner to have a limited extension of appointment with Privileges restricted to caring for currently hospitalized patients and for patients previously scheduled for procedures or admission. Following the discharge of the last patient, the automatic termination will take effect.

h) Practitioners who resign while under suspension will be designated as "Resigned: NOT in Good Standing" status and will be so reported by the Medical Staff Services Department in any future queries to the Medical Staff regarding status.

i) A suspension for failure to complete medical records lasting thirty one (31) days or more may be reportable to the National Practitioner Data Bank and the State licensing board if such failure is determined through a professional review action with final finding to relate to professional competence or conduct and adversely affects or could adversely affect a patient's health or welfare.

4.6.3.1 Chart Review: Clinical Service Chiefs, or designees, who are assigned utilization or quality issues for review will have charts available. These charts shall be reviewed in a timely fashion and will be subject to addition to the Practitioner's incomplete medical record profile.

4.6.3.2 Denial Appeals Process: The attending Practitioner or consultant will appeal third party payor denial of payment for services rendered at Hospital when, in the Practitioner's opinion, such services were medically necessary. It is preferable that these appeals occur while the patient is in-house or immediately following discharge. These appeals may be performed through direct verbal/written communication with the payer's medical director or through appropriate documentation in the medical record. Requests for appeals of denials post discharge will be placed in the medical record and will be a component of a Practitioner's incomplete medical records profile.

4.6.3.3 Ownership: All records, including medical images, are the property of the Hospital. Copies of the medical record may be removed from the Hospital's jurisdiction and safekeeping only in accordance with patient authorization, a court order/subpoena signed by a judge, or statute. In case of readmission of a patient, all available records shall be provided, if requested, for the use of the attending Practitioner, whether the patient is being attended by the same Practitioner or another.

4.6.3.4 Access to Records: Access to medical records shall be afforded to Medical Staff Appointees in Good Standing for bona fide study and research (with appropriate Institutional Review Board ("IRB") authority) consistent with preserving confidentiality of personal information concerning individual patients. Subject to the discretion of the Hospital President, former Appointees of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods in which they attended such patients in the Hospital. Review of medical records is limited to Medical Staff and Hospital professionals who are responsible for providing care to the patient. Practitioners performing peer review and utilization functions may review any chart assigned for review. Practitioners on the Medical Staff who have the permission of the attending Practitioner and the patient or patient*'s* legal representative may review the medical record of a currently hospitalized patient. Practitioners not on the Medical Staff, with the permission of the attending Practitioner or his/her designee, and with permission of the patient or patient's legal representative, may review the medical record of a currently hospitalized patient.

SECTION 4.7 CONSULTATION

The responsibility for patient care rests with the attending Practitioner but consultation is recommended when there is a reasonable doubt as to the diagnosis and/or treatment. Consultation is required when the patient needs care which is beyond the attending Practitioner’s scope of Privileges.

Medical Staff Appointees are expected to respond to requests for consultations in a timely fashion that meets patient care demands and the need for appropriate utilization of services. The Medical Staff Appointee requesting consultation will be responsible to provide appropriate clinical information and time-to-response expectations on the order sheet. Guidelines for time-to-response expectations are as follows:

a) Emergent consultations: 30-60 minutes (*e.g.,* immediate threat to life, limb or body organ)

b) Urgent consultations: 4 hours (*e.g.,* impending threat to life, limb or body organ)

c) Routine consultations: 24 hours

Practitioner to Practitioner contact is the preferred way of initiating all consultations, but is required for emergent and urgent consultations.

Consultation with other active and courtesy Appointees shall be sought as appropriate in order to provide the best possible care for the Hospital's patients

If circumstances are such as to render consultation undesirable or unnecessary, consultation shall not be performed and the reasons thereof shall be communicated with the Practitioner requesting the consult.

Hospital patients with substance abuse issues are encouraged to be referred or consultation to an Appointee with substance abuse expertise or referred to an external community based substance abuse service.

The consultant must be an Appointee of the Medical Staff, well qualified to give an opinion in the field in which his/her opinion is sought. Medical Staff Privileges in the field concerned are the usual accepted evidence of qualifications.

A satisfactory consultation includes examination of the patient, review of the chart, and a written report of the findings and recommendations signed, dated, and timed by the consultant which is made a part of the record. Pre-surgical consultation reports, at least in brief form, shall be recorded prior to the operation.

In circumstances of grave urgency or when consultation is required by rules of the Hospital, the Hospital President and/or designee shall at all times have the right to call in a consultant after conference with the Chief of Staff or an available member of the Medical Executive Committee.

SECTION 4.8 DISCHARGE

Patients shall be discharged only by order of the attending Physician or his/her covering Physician.

SECTION 4.9 BASIC RULES FOR THE USE OF HOSPITAL FACILITIES

The exercise of Privileges are contingent upon the Practitioner's abiding by the Medical Staff Bylaws, and other related Manuals, all applicable policies, and compliance with accreditation and regulatory requirements. Failure to do so may subject the Practitioner to corrective action in

accordance with the process set forth in the Medical Staff Bylaws and other related Manuals**.**

SECTION 4.10 EMERGENCY DEPARTMENT ON-CALL PHYSICIANS

Appointees of the Medical Staff have an obligation to work with the Hospital—administration to provide coverage of emergency medical conditions arising within or presenting to the Hospital as required by law. The Emergency On-Call list is developed by Medical Staff Services in conjunction with Hospital administration. Providers may be On-call at multiple network hospitals as long as there are plans to provide alternate coverage should more than one facility require emergent services at one time.

The Emergency On-Call list is intended to provide urgent and emergent consultation to patients either seeking care in the ED or within the Hospital and its affiliated units.. Time constraints for urgent and emergent responses are further defined in §5.8.2. The call lists will be available on the Hospital Intranet.

If there are discrepancies, administrative or reimbursement concerns, it is the responsibility of the currently listed on call Practitioner to see to the emergent needs of the patient first and deal with the non-clinical issues secondarily. If an on call Practitioner is unavailable for duty on the day that they are specified for call, it is their responsibility to find and report to the Medical Staff Office and/or the Emergency Department, a suitable on-call replacement Practitioner**.**

On-Call Practitioners must respond to emergency requests for evaluation in a timely fashion and provide stabilization and/or emergent definitive treatment as requested by the consulting Physician without regard to insurance status or payment capability. Emergency patients referred to the provider in the outpatient setting will also receive initial stabilizing care without regard to immediate payment capability.

If stabilization and/or definitive treatment of the patient's medical condition are not available within the current capabilities of the Hospital, the patient may be transferred to an appropriate facility upon certification by the physician–that the medical benefits of the transfer outweigh the risks and that the transfer is in the best interest of the patient. An on call Practitioner may not request that a patient be transferred to a second hospital for the Practitioner's convenience. In the circumstance where needed services do exist at our facility, a patient or appropriate surrogate may still request a transfer to another Hospital. Transfer may occur only when that facility has verified availability of services and an accepting physician has been established. This process must be clearly documented in the medical record and on the appropriate COBRA Transfer form.

SECTION 4.11 SOURCES OF PATIENT CARE PROVIDED OUTSIDE THE HOSPITAL

The Medical Executive Committee will approve contractual sources of patient care provided by entities outside the Hospital. A written agreement defining the nature and scope of patient care will include providing care in a timely fashion and consistent performance of patient care processes according to appropriate accreditation standards. Expectations for the performance of contracted services will be met by verification that all Practitioners who will be providing patient care, treatment and services have appropriate privileges by providing a copy of the list of privileges to the Hospital when requested. Written agreements will specify that the contracted organization will ensure that all contracted services provided by the Practitioners will be within the scope of their privileges. The written agreement will also include the expectation that consistent performance of patient care processes must be provided according to appropriate accreditation and regulatory standards.

SECTION 4.12 HOUSE STAFF

House Staff Physicians (MD or DO) who are members of a Hospital or affiliated postdoctoral education program approved by the ACGME or AOA, will be supervised for all clinical activities by a Physician with Privileges at–the Hospital, according to Hospital policies, including the Hospital's House Staff Policy Manual. Hospital affiliated House Staff educational program policies regarding supervision must be consistent with the Hospital's House Staff Policy Manual. House Staff with an unrestricted State Medical Board of Ohio license or equivalent may provide direct inpatient and/or outpatient medical care within the scope of their licensure with appropriate supervision. The supervising Physician is responsible for fostering an environment in which House Staff members under their supervision acquire the requisite skill and training to practice within a specialty. Concurrently, the supervising Physician has the responsibility for assuring that there is no difference or adverse variation in the quality of care provided when a House Staff member treats a patient. The supervising Physician’s name will be documented on all patients’ medical records whose care is provided as a part of a post-graduate training program. Delegated clinical responsibilities are defined in the House Staff Policy Manual for all levels of post-graduate training and are based on a system of graded authority which includes direct observation and knowledge of the House Staff member's education, experience, skills and abilities. Documentation in the medical record by a House Staff member and supervising Physician is confirmation that supervision has taken place. When House Staff members episodically see patients which are not assigned to a teaching panel, the patient’s attending Physician, after being notified by the House Staff member, assumes the responsibility for the residents’ supervision. The supervising Physician

will countersign the following documents: the history and physical, the discharge summary, the operative/–high risk procedure report, and the consultation report. The supervising Physician will also be responsible for completing the medical record in a timely manner in situations where the House Staff member may not complete his/her responsibilities in regard to the medical record.

The Graduate Medical Education Committee (GMEC) must communicate to the MEC and the Hospital Board of Directors about the safety and quality of patient care provided by, and the related educational and supervisory needs of, its participants in professional graduate education programs.

SECTION 4.13 PROFESSIONAL LIABILITY ACTION

Each individual with Clinical Privileges at the Hospital will notify Medical Staff Services Department within thirty (30) days of a final settlement or judgment of a professional liability action.

SECTION 4.14 CONDUCT

Unprofessional and unethical conduct and the violation of this Organizational Manual or Hospital policy may be grounds for corrective action.

All Practitioners are required to abide by the Code of Conduct Policy and the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal Health Insurance Portability and Accountability Act of 1996 regulations.

It is the desired culture of the Medical Staff that all Practitioners conduct themselves in a professional manner at all times, one that promotes to promote patient safety and the delivery of competent, quality care; to foster a congenial working environment; and to not disrupt the operations of the hospital.

Violations in conduct will be evaluated and acted upon as delineated in the Bylaws.

SECTION 4.15 DISRUPTIVE MEDICAL STAFF MEMBER

The stated goal of the Medical Staff is to ensure professional behavior at all times that promotes patient safety and the delivery of competent quality care, fosters a congenial working environment, and does not disrupt the operations of the hospital. Any and all reports of disruptive behavior are taken seriously.

Disruptive behavior within the Hospital will be addressed in accordance with policies which are similar in goals for both Hospital employees and Practitioners. It is the intention of the Hospital administration and this Medical Staff that these policies are enforced in a firm, fair and equitable manner. Any form of retaliation against the person(s) bringing complaint will not be tolerated.

Disruptive behavior by Medical Staff Practitioners will be dealt with by the Vice President for Medical Affairs, Clinical Service Chief, and/or Chief of Staff. The report of the behavior will be documented, the incident investigated and appropriate actions will be taken. Collegial intervention is outlined in the Code of Conduct Policy and the corrective action procedure is set forth in the Bylaws. Behavior that creates a risk for immediate harm may result in summary suspension of Medical Staff appointment and Clinical Privileges pending further investigation. As appropriate, the VPMA may choose to involve the Hospital executive team when disruptive behavior poses risk to the Hospital. Consultation with the Wellness Committee and outside resources may also be utilized.

SECTION 4.16 COPYING OF MEDICAL STAFF FILES

All Medical Staff records (including those of Allied Health Professionals) are confidential, including but not limited to the credentialing files and anything used in the credentialing process, committees, services, and Medical Staff meeting minutes, reports and discussions and deliberations concerning this information. Such information shall be disclosed only to those persons and only for the purposes listed in the policy concerning Confidentiality of Medical Staff/AHP Records. Confidentiality must be maintained for subsequent use of the information, and is the responsibility of the person requesting the information and anyone receiving the information.

SECTION 4.17 RAPE EXAMINATIONS

Rape examination is a formal legal collection of evidence when the allegation of sexual assault has occurred. Emergency Department Physicians and nurses are specifically trained in this procedure. Patients presenting to the Emergency Department from the outpatient environment or the inpatient setting with a request for rape examination will be evaluated, evidence collected and medical treatment offered as dictated in the ED Policy Manual, as such manual may be amended from time to time. If a Sexual Assault Nurse Examiner ("SANE") professional is available, the evidence collection and exam may be deferred to that person. Medical treatment of injury or infection is addressed by the ED Physician or may be assumed by the patient’s private Physician in attendance at the time of the evaluation.

SECTION 4.18 RESTRAINTS OR SECLUSION

It is the desired culture of the Medical Staff to minimize the use of physical and chemical restraints with proactive situation management. Should a need for short term restraint arise, the processes delineating their use are clearly outlined in Hospital policy.

SECTION 4.19 PRONOUNCEMENT OF DEATH

Only a licensed Physician may pronounce a patient dead. The Physician need not personally examine the body. A resident, nurse, paramedic or other competent observer may report findings on the telephone for the Physician to make the death pronouncement. The Physician pronouncing the patient is responsible for completing the death/autopsy form on all Hospital deaths. The death certificate is a state form and must be signed by a fully licensed Physician or coroner. Ideally this should be a Physician with an established Physician -patient relationship who is familiar with the patient's history. In general, this is the presiding attending Physician for an admitted patient, the Physician of record or the Physician predominantly involved in the current care of the patient for outpatients.

The following deaths require reporting to the coroner: accidental deaths, homicidal deaths, suicidal deaths, occupational deaths; deaths while confined; therapeutic deaths; death during anesthesia induction or the immediate post-anesthesia period; death during or following diagnostic or therapeutic procedures; death due to administration of drug, vaccine or other substance; "medical malpractice"; abortion-related death; special circumstances ("delayed death"); any death about which there is doubt, question or suspicion; any unattended death at home or in a public or outdoor place. Any doubt regarding reportable cases should be referred to the coroner's office for clarification.

SECTION 4.20 USE OF INVESTIGATIONAL/EXPERIMENTAL DRUGS OR DEVICES

A Practitioner must obtain Kettering Health Network ("KHN") Institutional Review Board ("IRB") approval prior to using any investigational/experimental drugs or devices for research studies or emergency use. Industry-sponsored research studies may be submitted to a KHN-approved central IRB for review. All IRB submissions begin initially with the KHN Innovation Center who will assist with preparation and submission to the IRB. Investigational/experimental drugs or devices are defined as any non-FDA approved drug/device or a drug/device used in a research study. IRB approval is for protection of patients' rights and does not imply credentials beyond those approved by the Medical Staff and Board. Requests for Privileges to perform investigational procedures

shall be processed through the Hospital's usual credentialing and privileging process. The granting of Medical Staff Privileges for new procedures that are necessary to use investigational/experimental devices will follow the Medical Staff process for privileging described in the Credentials Policy Manual.

Research Studies: To obtain IRB approval of a research study of an investigational/experimental drug or device, contact KHN Innovation Center for assistance in preparing and submitting a protocol, informed consent form, and other required documents to the IRB Office for approval.

Emergency Use: Emergency use is defined as the use of an investigational/experimental drug or device on a human subject in a life-threatening situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval for its use. A written request, usually in letter form, that includes the risks, benefits, and consent, signed by the requesting Practitioner**,** stating the life-threatening situation or one-time need and, the absence of standard acceptable treatment, is submitted to the IRB Office with the assistance of the KHN Innovation Center. The IRB Chair or designee will review the request and approve or disapprove its use. In accordance with FDA Regulation 21 CFR 50.23 and CFR 56.104, the protocol and consent form are reviewed and approved by the IRB Committee within five (5) working days of initial approval. The standard guidelines for obtaining informed consent apply.

Patients currently on research protocols from the Hospital or other institutions who are admitted, must follow Pharmacy Department Policy, as such policy may be amended from time to time, covering investigational drug procedures.

When the IRB receives a request from a Practitioner for an emergency use of an investigational/experimental drug or device, the IRB must examine each case to assure itself and the Hospital that the emergency use was justified and compliant with FDA regulations 21 CFR 50.23 and CFR 56.104

SECTION 4.21 CANCER STAGING

All newly diagnosed cancers will be staged by the managing Physician (defined as the treating Physician, usually the surgeon, medical oncologist, or radiation oncologist) using the American Joint Commission on Cancer-TMN staging format or a format approved by the KHN Network Cancer Committee. The staging will be entered on a form adopted by the Cancer Committee and the completion of the staging will be required to complete

the medical record on the patient. Cases that cannot be staged will be so indicated on the staging form with a reason why it cannot be staged.

ARTICLE 5.
ADOPTION, AMENDMENT OR REPEAL

This Medical Staff Organization Manual may be adopted, amended, or repealed, in whole or in part, in accordance with the applicable provision set forth in the Medical Staff Bylaws

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee on
March 31, 2011

____

Martha Johnston, MD
Chief of Staff

Approved by the Board of Directors on
April 18, 2011 after receipt of a recommendation by the
Medical Executive Committee

____

Roy Chew
Secretary