Medical Staff Organization & Functions Manual

Kettering Medical Center System

A Medical Staff Document

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ARTICLE 1
MEDICAL STAFF OFFICERS

1.1. GENERAL

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

(A) For purposes of this Manual, the term "Hospital" means Kettering Medical Center, Sycamore Medical Center, and Troy Hospital (collectively referred to as the Kettering Medical Center System or KMCS). Kettering Medical Center, Sycamore Medical Center, and Troy Hospital have elected to have a unified Medical Staff.

(B) For purposes of this Manual, the term "Medical Staff" means the KMCS Medical Staff.

1.1.2 Use of a Designee: Whenever an individual is authorized to perform a duty by virtue of his/her position (*e.g,* the Hospital President/CEO, Chief Medical Officer (CMO), Chief of Staff, Department Chair, *etc.*), then reference to the individual shall also include the individual's authorized designee.

1.2. MEDICAL STAFF OFFICER POSITION DESCRIPTIONS

1.2.1 Chief of Staff

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

(B) Position Purpose: The purpose of this position is to provide overall leadership and guidance to the Medical Staff.

(1) Additionally, the Chief of Staff must 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 implementation of the Medical Staff governing documents, 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.

(2) The Chief of Staff shall facilitate Medical Staff/MEC review and approval of Medical Staff governing documents as needed, but at least every three years or as otherwise required by applicable laws, rules, regulations, and/or accreditation standards.

(C) Accountabilities and Functions: The Chief of Staff:

(1) Coordinates the activities and concerns of Hospital administration, nursing service, and other patient care services with those of the Medical Staff.

(2) 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.

(3) Calls, presides at, and is responsible for the agenda of all general and special meetings of the Medical Staff.

(4) Serves as: chair of the Medical Executive Committee, chair of the Distinguished Service Award Committee, a voting member of the Wellness Committee, a voting member of the Rules and Bylaws Committee, a voting member of the Quality Assurance and Performance Improvement Committee, a voting member of the Medical Staff Administration Committee, a member of the Network Rules and Bylaws Alignment 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.

(5) Consults with the Chief Medical Officer on matters of special concern to Medical Staff Appointees and maintains medical liaison with the Chief Medical Officer to assist in settling grievances and problems of the Medical Staff.

(D) Responsibilities: The Chief of Staff shall be responsible:

(1) For the enforcement of the Medical Staff governing documents, 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 or APP.

(2) For all administratively related activities of the Medical Staff, unless otherwise provided for by the Hospital.

(3) 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.

(4) In conjunction with the Medical Executive Committee, for the development and implementation of policies and procedures that guide and support the provision of services.

(5) In conjunction with the Clinical Department Chair, for the recommendations for a sufficient number of qualified and competent persons to provide care or services.

(6) In conjunction with the Clinical Department Chair, for the determination of the qualifications and competence of Clinical Department/Section personnel who are not licensed independent practitioners and who provide patient care services.

(7) 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.

(8) 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.

(9) For appointing Medical Staff Appointees to chair or serve as members of Medical Staff, Hospital, and joint Medical Staff/Hospital committees, as needed, unless otherwise provided in the Medical Staff governing documents.

(10) For providing Medical Staff oversight for the Medical Staff standing committees and functions and reporting to the MEC on an as needed basis regarding issues identified which directly affect the Medical Staff.

(E) Position Requirements: The Appointee occupying this position must meet the "Qualifications of Officers" set forth in the Medical Staff Bylaws. Prior experience within KMCS as a Clinical Department Chair, 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.

1.2.2 Vice Chief of Staff

(A) Reports to: Chief of Staff and Medical Executive Committee

(B) 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 Vice Chief of Staff 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 Vice Chief of Staff will automatically succeed to the office of Chief of Staff.

(C) Accountabilities and Functions: The Vice Chief of Staff:

(1) Assists the Chief of Staff with any functions specified by the Chief of Staff and the Medical Executive Committee.

(2) Is a voting member of the Medical Executive Committee.

(3) Is co-chair of the Quality Assurance and Performance Improvement Committee. As such, this Appointee will be expected to represent the findings and recommendations of the Quality Assurance and Performance Improvement Committee to the Medical Executive Committee.

(D) Responsibilities: The Vice Chief of Staff shall:

(1) Be responsible, in conjunction with the Medical Executive Committee, for continuing surveillance of the professional performance of all Practitioners and APPs who have delineated Clinical Privileges.

(2) Be 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.

(3) Serve as a voting member of the Rules and Bylaws Committee to assist the Immediate Past Chief of Staff to foster open communication between the Hospital Board, administration, and the Medical Staff regarding changes to the Medical Staff governing documents.

(4) Serve as an *Ex-Officio* invitee to the Network Rules and Bylaws Alignment Committee.

(5) Serve as a voting member of the Medical Staff Administration Committee.

(6) Serve as a voting member of the Distinguished Service Award Committee.

(E) Position Requirements: The Appointee occupying this position must meet the "Qualifications of Officers" set forth in the Medical Staff Bylaws. Prior successful service as a Clinical Department Chair, 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

1.2.3 Vice Chief at Large

(A) Reports to: Chief of Staff and the Medical Executive Committee

(B) Position Purpose: To provide additional leadership to the Medical Staff, perform the functions of Secretary and Treasurer, serve as chair of the Clinical Quality Review Committee and promote effective communication between Practitioners, Hospital administration, and other members of Medical Staff leadership.

(C) Accountabilities and Functions: The Vice Chief at Large will:

(1) Assist the Chief of Staff and the Medical Executive Committee.

(2) Chair the Clinical Quality Review Committee and report aggregate data regularly to the Quality Assurance and Performance Improvement Committee.

(3) Meet regularly with the officers of the Medical Staff to discuss current concerns and develop plans and goals for the Hospital system.

(4) Serve as a voting member of the Medical Executive Committee and attend Medical Staff meetings.

(5) Assist the Chief of Staff (as authorized agents of the applicable Medical Staff peer review committee) with Practitioner/APP issues including quality, medical records, and behavioral concerns, when requested.

(6) Serve as a voting member of the Medical Staff Administration Committee.

(D) Position Requirements: Must meet the "Qualifications of Officers" set forth in the Medical Staff Bylaws. Prior successful service as a Clinical Department Chair, Medical Staff committee member, Board member, or similar leadership experience is required.

1.2.4 Vice Chief of the Medical Staff Credentials Program

(A) Reports to: Chief of Staff and Medical Executive Committee.

(1) Written recommendations from the Credentials Committee are carried forward by the Vice Chief of the Medical Staff Credentials Program to the MEC.

(2) Written recommendations from the MEC are carried forward by the Chief of Staff to the Board Professional Practice Committee or the Board of Directors for final approval.

(B) Position Purpose:

(1) To provide oversight for the Credentials Program at the Hospital and direction to the Hospital Board of Directors in the credentialing, appointment, and privileging of Medical Staff Appointees and credentialing and privileging of APPs.

(2) To maintain compliance with the credentialing, appointment, and privileging policies of the Medical Staff, the Hospital's accrediting agency standards, and applicable laws, rules, and regulations.

(3) To support the goal of the Credentials Program 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 and performance data from appropriate sources in conjunction with the provider's appointment and/or Privileges, and minimize the effect of social, economic, political, and other non-medical factors on credentialing.

(C) Accountabilities and Functions: The Vice Chief of the Medical Staff Credentials Program shall:

(1) Chair the Medical Staff Credentials Committee and serve as a voting member of the Medical Executive Committee.

(2) Together with the CMO (and consistent with the procedure for adoption and amendment of Medical Staff Manuals and policies set forth in the Medical Staff Bylaws) develop, edit, and maintain the Credentials Policy Manual, Delineation of Clinical Privileges, criteria for appointment/reappointment and granting/re-granting of Clinical Privileges, and associated policies and procedures that are utilized in the credentialing, appointment, and privileging process.

(3) Assure that existing Medical Staff policies, accreditation standards, and state requirements are followed with respect to Medical Staff appointment/reappointment and Clinical Privileges.

(4) Oversee processing of requests for appointment/reappointment to the Medical Staff and/or Privileges, and specifically review those

applications that fall outside of guidelines for a completed application.

(5) In conjunction with the Medical Staff Services department, oversee maintenance of accurate and complete documentation concerning the credentialing, appointment, and privileging process. This includes the maintenance, security, storage, and retrieval of credentials files, minutes, and other documents pertaining to the overall Credentials Program within the Hospital and the processing of individual applications for appointment/reappointment and Clinical Privileges.

(6) Serve as a voting member of the Medical Staff Administration Committee.

(D) Position Requirements:

(1) Appointees occupying this position must meet the "Qualifications of Officers" set forth in the Medical Staff Bylaws. Prior service as a Clinical Department Chair, 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.

(2) The Vice Chief of the Medical Staff Credentials Program shall be an elected position. Nomination and election of the Vice Chief shall occur biennially in accordance with the process outlined in the Bylaws for election of Medical Staff officers. An Appointee may serve consecutive two-year terms as Vice Chief of the Medical Staff Credentials Program.

1.2.5 Immediate Past Chief of Staff

(A) Reports to: Chief of Staff and Medical Executive Committee.

(B) Position Purpose: To provide Medical Staff leadership continuity.

(C) Accountabilities/Functions/Responsibilities: The Immediate Past Chief of Staff shall:

(1) Serve as a voting member of the Medical Executive Committee, the Credentials Committee, and the Distinguished Service Award Committee.

(2) Serve as chair of the Rules and Bylaws Committee.

(3) Serve as a member of the Network Rules and Bylaws Alignment Committee.

(4) Be accountable for such other functions and responsibilities as may be assigned by the Chief of Staff or Medical Executive Committee.

(D) Position Requirements: The Chief of Staff shall automatically succeed to the position of Immediate Past Chief of Staff upon completion of his/her term as Chief of Staff.

ARTICLE 2
MEDICAL STAFF CLINICAL DEPARMENTS, SECTIONS, AND CLINICAL DEPARTMENT CHAIRS

2.1. MEDICAL STAFF CLINICAL DEPARTMENTS & SECTIONS

2.1.1 Following are the Medical Staff Clinical Departments, and Sections within such Clinical Departments, subject to change from time to time in accordance with the procedure set forth in Article 7 of the Bylaws.

(A) Anesthesiology

(1) Pain Management

(B) Cardiology

(C) Emergency Medicine

(1) Hyperbaric Medicine

(2) Wound Care

(D) Family Medicine

(1) Hospital Medicine

(2) Outpatient Family Medicine

(E) Internal Medicine

(1) Allergy

(2) Dermatology

(3) Endocrinology

(4) Gastroenterology

(5) Hematology/Oncology

(6) Hospital Medicine

(7) Infectious Diseases

(8) Nephrology

(9) Neurology

(10) Outpatient Internal Medicine

(11) Palliative Medicine

(12) Physical Medicine and Rehabilitation

(13) Psychiatry

(14) Psychology

(15) Pulmonary Medicine

(16) Rheumatology

(17) Sleep Medicine

(F) Medical Imaging

(1) Diagnostic Radiology

(2) Nuclear Medicine

(3) Radiation Oncology

(G) Obstetrics/Gynecology

(H) Orthopedics

(1) Podiatric Medicine

(I) Pathology

(J) Pediatrics

(K) Surgery

(1) Cardiothoracic Surgery

(2) Dental and Oral Surgery

(3) General Surgery

(4) Otolaryngology

(5) Neurosurgery

(6) Ophthalmology

(7) Orthopedic Surgery

(8) Plastic and Reconstructive Surgery

(9) Oral and Maxillofacial

(10) Trauma Surgery

(11) Urology

(12) Vascular Surgery

2.1.2 Assignment to Medical Staff Clinical Department & Section

(A) Each Practitioner shall be assigned to one Clinical Department and Section, as applicable.

(B) The exercise of Privileges within each Clinical Department/Section shall be subject to the rules and regulations therein and to the authority of the Clinical Department Chair.

2.2. MEDICAL STAFF CLINICAL DEPARTMENT LEADERSHIP

2.2.1 Clinical Department Chairs

(A) Report to: Chief of Staff and Medical Executive Committee. Clinical Department Chairs are elected, in accordance with the applicable procedure set forth in the Medical Staff Bylaws, by the active Appointees in the respective Clinical Department/Section(s) (subject to MEC review and Board approval) to serve for two year terms beginning on even numbered years.

(B) Position Purpose: The purpose of this position is to provide leadership to the respective Medical Staff Clinical Department/Section(s) and to discuss policies, service needs, programs, and other issues affecting the provision of patient care by providers in such Clinical Department/Section(s).

(C) Accountabilities and Functions: The Clinical Department Chairs: are voting members of the Medical Executive Committee and provide input on issues affecting the provision of patient care by providers in the respective Clinical Department/Section(s).

(D) Requirements/Responsibilities: The responsibilities of Clinical Department Chairs are as outlined in the Medical Staff Bylaws.

2.2.2 Medical Staff Clinical Department Vice-Chairs

(A) Report to: Respective Medical Staff Clinical Department Chair and, if so directed, to the Chief of Staff, Medical Executive Committee, and/or other appropriate Medical Staff committees. Clinical Department Vice-Chairs shall be elected in the same manner in which Clinical Department Chairs are elected.

(B) Position Purpose: The purpose of this position is to assist the respective Clinical Department Chair in providing leadership to the applicable Clinical Department/Section(s) and to discuss policies, service needs, programs, and other issues affecting the provision of patient care by providers in such Clinical Department/Section(s).

(C) Accountabilities and Functions: The Clinical Department Vice-Chairs:

(1) Regularly attend the Clinical Quality Review Committee and other Medical Staff committees as appointed in order to provide input on issues affecting the provision of patient care by providers in the respective Clinical Department/Section(s).

(2) May represent the Clinical Department Chair at the Medical Executive Committee in his/her absence with vote.

(D) Requirements / Responsibilities: The responsibilities of the Clinical Department Vice-Chairs are as outlined in the Medical Staff Bylaws.

ARTICLE 3 MEDICAL STAFF COMMITTEES; JOINT MEDICAL STAFF/HOSPITALCOMMITTEES; BOARD PROFESSIONAL PRACTICE COMMITTEE

3.1. DESIGNATION

3.1.1 Standing Medical Staff committees:

(A) Credentials Committee

(B) Clinical Quality Review Committee

(C) Distinguished Service Award Committee

(D) Medical Executive Committee

(E) Medical Records Committee

(F) Rules and Bylaws Committee

(G) Wellness Committee

3.1.2 Standing Joint Hospital/Medical Staff committees:

(A) Medical Staff Administration Committee

(B) Perioperative Services Governance Committee

(C) Pharmacy and Therapeutics Committee

(D) Quality Assurance and Performance Improvement Committee

(E) Utilization Review Committee

3.1.3 Board Committee

(A) Professional Practice Committee

3.1.4 Nothing in this Manual shall preclude joint meetings of Kettering Health Network or Kettering Medical Center System joint Hospital/Medical Staff committees to the extent that such meetings will assist in assuring quality patient care.

3.2. MEDICAL EXECUTIVE COMMITTEE

3.2.1 The composition and duties of the Medical Executive Committee are as set forth in the Bylaws.

3.2.2 In addition to the duties set forth in the Medical Staff Bylaws, the MEC shall:

(A) Nominate three (3) eligible Physician candidates for class C community Board of Director membership, as applicable.

(B) Select the organized Medical Staff section representative to the AMA and OSMA on an annual basis.

(C) Supervise overall Medical Staff compliance with accreditation and other regulatory requirements applicable to the Medical Staff or any of its clinical units as well as conduct periodic review of the Medical Staff governing documents and facilitate adoption and amendment of such documents as outlined in the Medical Staff Bylaws.

(D) Initiate, investigate, review, and report on corrective actions involving the clinical competence or conduct of any individual Practitioner or APP.

3.3. CREDENTIALS COMMITTEE

3.3.1 Composition

(A) The Credentials Committee shall be composed of the:

(1) Vice Chief of the Medical Staff Credentials Program (chair)

(2) Immediate Past Vice Chief of the Medical Staff Credentials Program

(3) Immediate Past Chief of Staff

(4) CMO

(5) A Board member (*Ex Officio*)

(6) Eligible representatives from each of the following Clinical Departments: Anesthesiology, Cardiology, Emergency Medicine, Family Medicine, Obstetrics & Gynecology, Medicine, Medical Imaging, Orthopedics, Pathology, Pediatrics, and Surgery.

(B) Member appointments to the Credentials Committee shall be for terms of three (3) years. The Chief of Staff shall appoint new Clinical Department representatives after receipt of nominations from the Clinical Department Chair.

3.3.2 Duties

(A) The Credentials Committee shall:

(1) Investigate the qualifications of all applicants for appointment and/or Privileges and shall review the Clinical Department/Section

assignments and the Medical Staff category and/or Privileges requested.

(2) Review all information available on each Practitioner and APP, including the recommendation from the Clinical Department Chair. This information shall be used for the purpose of determining recommendations for, as applicable, appointment/reappointment to the Medical Staff, assignment to the appropriate Clinical Department/Section(s), and for the granting/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 denial of appointment/reappointment and/or Privileges, or a change in appointment category, Clinical Department/Section, or Privileges is recommended, the reason(s) for such recommendation shall be stated and documented.

(3) Establish criteria for new services/procedures, provided such services/procedures are approved to be performed at the Hospital, and evaluate the qualifications of any Practitioner or APP applying for these Privileges.

(B) The Vice Chief of the Medical Staff Credentials Program 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.

3.3.3 Meetings, Reports, and Recommendations

(A) The Credentials Committee shall meet as often as necessary to accomplish its duties but at least six (6) times a year.

(B) The committee shall maintain a permanent record of its proceedings and actions and report written recommendations to the Medical Executive Committee with a copy to the President and the Board.

3.4. WELLNESS COMMITTEE

3.4.1 Composition

(A) The membership of the Wellness Committee shall consist of the Chief Medical Officer, the Chief of Staff, and up to eight (8) eligible members of the Medical Staff, appointed by the Chief of Staff, who are preferably not Clinical Department Chairs or members of the Medical Executive Committee.

3.4.2 Duties

(A) The Wellness Committee shall be responsible for fulfilling the responsibilities set forth in the Practitioner/APP Professional Conduct Policy and the Practitioner/APP Impairment Policy, as such Medical Staff Policies may be amended from time to time.

3.4.3 Meetings, Reports, and Recommendations

(A) The Wellness Committee shall meet as often as necessary to accomplish its duties but at least annually.

(B) The committee shall maintain a permanent record of its proceedings/actions and shall report to the MEC. The Wellness Committee shall provide information, as needed, to the CQRC, the Credentials Committee, and the MEC.

3.5. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT COMMITTEE

3.5.1 Composition

(A) The composition of the Quality Assurance and Performance Improvement Committee (QAPI) will be up to (20) members equally representing Medical Staff and Hospital administration to include: the Vice Chief of Staff (co-chair); Chief Medical Officer, Kettering Medical Center System (co-chair); Hospital President; Hospital Vice Presidents; and Chief of Staff.

3.5.2 Duties

(A) The QAPI Committee is a joint committee of the Hospital and Medical Staff that:

(1) Establishes the Hospital quality assessment and performance improvement (QA/PI) priorities and receives and provides formal information sharing of aggregate data and systemic issues between the Clinical Quality Department and the leadership of the Hospital and Medical Staff.

(2) Has the responsibility to charter, oversee, and regularly evaluate QA/PI programs and activities of the Hospital and its Medical Staff.

(3) 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.

(4) 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 (PI) Plan.

(5) Oversees organizational efforts to measure, assess, and improve clinical activities outcomes and the quality and appropriateness of selected services. Clinical review activities include appropriateness of selected services/activities and management of the same in the following processes:

(a) medication therapy

(b) infection prevention and control

(c) surgical management

(d) blood products

(e) data management

(f) discharge planning and utilization review

(g) utilization management

(h) complaints regarding Medical Staff related issues (subject to subsection (6) below).

(i) restraint/seclusion usage

(j) mortality review

(k) "Never" events promulgated by CMS.

Clinical review activities may be delegated by the QAPI committee to other appropriate Hospital and Medical Staff committees and subcommittees, as applicable.

(6) Identifies problems in care and performance. Concerns with respect to individual Practitioner or APP clinical competence or conduct shall be referred to the MEC, CQRC, or other appropriate Medical Staff peer review committee, as applicable.

(7) Is responsible for coordinating efforts to evaluate and monitor resource consumption and utilization management.

(8) Coordinates, prioritizes, and monitors the Medical Staff, Hospital, and medical education data gathering and analysis components of the quality review program and QA/PI 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.

(a) Individualized Practitioner or APP data identified through QA/PI processes will be delegated for handling to the CQRC for further evaluation according to the Medical Staff peer review process.

(b) Individualized resident data identified through QA/PI processes will be delegated for handling to the applicable graduate education/residency program committee.

(9) 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.

(10) 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 communicates that information to the professional staff and Hospital groups with related responsibilities.

(11) Periodically oversees the development and implementation of Hospital safety programs and an emergency preparedness plan that addresses disasters, both Hospital and community.

(12) 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.

(13) Establishes formats for the aggregation, display, and reporting of data and findings, as well as a system of follow-up to confirm that recommended actions are implemented. The committee coordinates, 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.

(14) Oversees Hospital systemic quality assessment and performance improvement functions.

(15) Uses QA/PI aggregate data and findings to develop continuing education activities and to provide annual evaluations regarding improvements in clinical care.

3.5.3 Meetings, Reports, and Recommendations

(A) The Quality Assurance and Performance Improvement Committee shall meet as often as necessary to accomplish its duties but at least quarterly.

(B) Medical Staff aggregate QA/PI reviews are reported at least semi-annually that focus on clinical assessments, diagnostic procedures, and therapeutic interventions.

(C) The committee shall maintain a permanent record of its proceedings/actions, and report recommendations and findings to the Medical Executive Committee and the Hospital Board as deemed appropriate.

3.6. UTILIZATION REVIEW COMMITTEE

3.6.1 Composition

(A) The Utilization Review Committee will be co-chaired by the Medical Director for Clinical Quality and by an eligible Medical Staff Physician, who is an experienced member of the committee, appointed by the Chief of Staff.

(B) The committee shall consist of not less than four (4) or more than fifteen (15) eligible Medical Staff members appointed annually by the Chief of Staff, with reappointment of an adequate number of incumbents to ensure continuity of philosophy and experience.

(C) Due to conflicts of interest, no committee member shall participate in the utilization review of any case in which the committee member has personal involvement in the care of the patient. No person serving on the committee may hold any financial interest in any hospital.

3.6.2 Duties

(A) The Utilization Review Committee is a joint Hospital and Medical Staff committee whose purpose is to insure high quality medical care and effective utilization of resources though review of ongoing data including case-specific utilization and Department/Section and service line trending.

(B) The Utilization Review Committee:

(1) Develops and amends annually a Utilization Review Plan for approval by the Medical Executive Committee, Hospital Executive

Council, and the Board. The plan applies to all patients regardless of payment source, outlines the confidentiality and conflict of interest policy, and includes provisions for:

(a) Reviewing admissions and medical necessity of admissions, continued hospitalization, and extended stays.

(b) Discharge planning including referral for appropriate post hospitalization care and Practitioner/APP follow-up.

(c) Reviewing medical necessity of professional services such as, but not limited to, high cost procedures, drugs, and biologicals.

(d) Data collection and reporting requirements.

(e) Identifying Practitioner/APP case variations from evidence-based care.

(2) Assists the organization with decision making related to, and tracking of, high volume, high risk, high cost, and/or problem prone diseases or DRG's and recommends measures to improve outcomes. Reviews cost and quality trends on a continuous basis to improve clinical effectiveness and resource allocation.

(3) Reviews, approves, and recommends to the Medical Executive Committee all new order sets and protocols, and significant revisions to existing orders/protocols, as the need arises, consistent with applicable laws, rules, and regulations.

3.6.3 Meetings, Reports, and Recommendations

(A) The Utilization Review Committee shall meet as often as necessary to accomplish its duties, but at least quarterly.

(B) The committee shall maintain a permanent record of its proceedings and actions and report its recommendations to the Medical Executive Committee and the Quality Assurance and Performance Improvement Committee as deemed appropriate.

3.7. CLINICAL QUALITY REVIEW COMMITTEE

3.7.1 Composition

(A) The Chief of Staff shall appoint eligible interdisciplinary clinical specialty Practitioner members to serve as voting members on the Clinical Quality Review Committee (CQRC) including, among others, appropriate Medical Staff Clinical Department Vice-Chairs.

(B) *Ex Officio* members, without vote, shall consist of the following senior Hospital management: VP Patient Care, Chief Medical Officer, Clinical Quality Medical Director, Utilization Medical Director, and VP Quality Department.

(C) The Vice Chief at Large serves as chair of the CQRC. The co-chair of the CQRC is a member of the Medical Staff appointed by the Chief of Staff after recommendation by the voting members of the CQRC.

(D) Only voting members of the CQRC may vote on Practitioner/APP peer review issues.

3.7.2 Duties

(A) The CQRC is a multidisciplinary Medical Staff peer review committee that:

(1) Receives and/or identifies, reviews, evaluates, and makes recommendations or determinations regarding individual Practitioner and APP peer review issues.

(2) Coordinates, tracks, and trends clinical quality patterns and/or concerns as well as death reviews at the Hospital.

(3) Engages in other peer review processes that promote clinical performance improvement and achieve quality outcomes.

(4) May receive reports and recommendations of other Medical Staff committees as designated by the Bylaws and other Medical Staff governing documents. Clinical Departments/Sections and/or Medical Staff committees may be designated by CQRC or the MEC to conduct peer review activities and report their activities, findings, and/or recommendations to the CQRC. The activities, proceedings, communications, and records of the CQRC (or prepared for, performed, or gathered on behalf of the CQRC) are confidential and privileged under Ohio's Peer Review Statute (Ohio Revised Code §§2305.25 *et seq*); therefore, members of this committee shall agree to hold all such activities, communications, records, and proceedings of the committee in strictest confidence.

(B) The CQRC will:

(1) 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.

(2) Define the scope and types of cases to be reviewed, provide tissue and audit review including cases with minimum or no pathology to determine the justification for all surgical procedures performed, and scrutinize the relationship between the preoperative diagnosis and the final postoperative diagnoses.

(3) Review and evaluate internal and external data as necessary to understand the care that is being examined by the committee.

(4) Review Practitioner/APP focused data and reports related to professional practice and/or quality review activities involving the quality of care. Summary reports from Medical Staff peer review committees of designated peer review activities shall be reported to the CQRC, as needed, at the discretion of such committee chair, or by invitation or direction of the CQRC chair(s).

(5) Initiate and/or conduct any attendant inquiry or other peer review process as a result of the CQRC's recommendation or actions.

(6) Act in accordance with the Medical Staff Peer Review Program Policy.

(C) The CQRC may appoint subcommittees and/or *ad hoc* committees, as needed, and the chair of such appointed subcommittees/*ad hoc* committees may invite non-members to present information as needed.

(D) In the interest of objective peer review, members of the CQRC or other Medical Staff peer review committees will not review their own cases. When possible, members should not review cases of their practice associates, relatives, direct economic competitors, or others where there is a potential conflict of interest.

3.7.3 Meetings, Reports, and Recommendations

(A) The Clinical Quality Review Committee shall meet as often as necessary to accomplish its duties, but at least quarterly, at a time and place designated by the chair(s). The expectation is that each committee member will attend these meetings.

(B) Executive sessions may be called by the CQRC chair and the *Ex Officio* members may attend and participate unless the chair, at his/her discretion, recuses such *Ex Officio* member(s). Any such executive session shall include the Chief Medical Officer, Clinical Quality Medical Director and/or the Utilization Medical Director (or, if both are unavailable, then such appropriate senior Hospital clinical management alternate as appointed by the President).

(C) The CQRC shall maintain a permanent record of its proceedings and actions and report its actions/recommendations to the appropriate Clinical Department Chair, Quality Assurance and Performance Improvement Committee, and the Medical Executive Committee as deemed appropriate.

3.8. PHARMACY & THERAPEUTICS COMMITTEE

3.8.1 Composition

(A) The Pharmacy and Therapeutics (P&T) Committee is a Kettering Health Network (KHN) joint Medical Staff/Hospital committee with membership consisting of eligible representatives from the KHN hospitals including representatives from the medical staffs, nursing, pharmacy, nutrition services, and other applicable health care providers.

(B) The committee may appoint subcommittees, as needed, and the committee chair or a KHN hospital pharmacy director may invite non-members to attend as needed.

3.8.2 Duties

(A) The P&T Committee:

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

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

(3) Develops and maintains a formulary of drugs accepted for use in the Hospital and provides for appropriate revisions to such formulary. The selection and review of formulary drugs will be based on objective evaluation of their relative merit, safety, and cost.

(4) Establishes programs and procedures that help ensure cost effective drug therapy using indicators of patient outcome in the assessment.

(5) Reviews adverse drug reactions and medication errors; develops programs and policies to minimize the occurrence of adverse drug reactions/medication errors; formulates procedures for reporting such reactions and errors; and, assists in investigating such issues and implementing corrective actions.

(6) Collects data, monitors, and recommends process improvements 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 and enteral nutrition products used in the Hospital.

(7) Develops a medication safety program for the Hospital that promotes safe medication administration and reduces preventable medication errors.

(8) Recommends to the Medical Staff and Hospital policies regarding nutrition care issues.

(9) Establishes priorities for ongoing assessment of medication used in the Hospital.

(10) Monitors the anticoagulation management program for efficiency and effectiveness.

(11) Recommends drugs that are stocked on nursing units.

(12) Evaluates clinical data concerning new drugs requested for use in the Hospital, and advises prescribers and pharmacists on the choice and use of drugs.

(13) Reviews P&T related policies at least every three (3) years and updates more frequently as necessary.

3.8.3 Meetings, Reports, and Recommendations

(A) The P&T Committee shall meet as often as necessary to accomplish its duties, but at least quarterly.

(B) The committee shall maintain a permanent record of its proceedings and actions and report its recommendations to the Quality Assurance and Performance Improvement Committee and the Medical Executive Committee as deemed appropriate.

3.9. PERIOPERATIVE SERVICES GOVERNANCE COMMITTEE

3.9.1 Composition

(A) The composition of the Perioperative Services Governance Committee will not exceed thirty (30) members and will have adequate representation from both the Medical Staff and Hospital administration including the following: Clinical Department Chair, Surgery (co-chair); Administrative Director, Perioperative Services (co-chair).

3.9.2 Duties

(A) The committee 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.

(B) The committee will:

(1) Review, revise, and develop policies and procedures for Perioperative Services.

(2) Recommend Perioperative Services policy revisions to the Medical Executive Committee for approval.

(3) Monitor compliance with Perioperative Services policies.

(4) Monitor and evaluate effectiveness of Perioperative Services including patient safety issues and performance improvement activities.

(5) Upon request, provide comments to the Credentials Committee regarding Practitioners'/APPs' use of Perioperative Services.

(6) Review and prioritize requests for capital equipment, instruments, and medical supplies.

(7) Review and comply with regulatory and accrediting agency requirements.

(8) The co-chairs of the Perioperative Services Committee may in urgent situations:

(a) Discuss team interactions.

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

3.9.3 Meetings, Reports, and Recommendations

(A) The committee shall meet as often as necessary to accomplish its duties, but at least quarterly.

(B) The committee shall maintain a permanent record of its proceedings and actions and report its recommendations to the Quality Assurance and

Performance Improvement Committee, Hospital Executive Council, and to the Medical Executive Committee as deemed appropriate.

3.10. MEDICAL RECORDS COMMITTEE

3.10.1 Composition

(A) The Medical Records Committee shall include as members: the Chief Medical Officer, the Director of Medical Records for the Hospital, the Medical Director of Clinical Quality, a Medical Staff electronic medical records representative, at least one additional eligible Medical Staff Appointee, as appointed by the Chief of Staff, and one additional member from the medical records department.

(B) The co-chairs of the Medical Records Committee will be:

(1) An active member of the Medical Staff appointed by the Chief of Staff; and,

(2) The Network Medical Records Administrator.

3.10.2 Duties

(A) The purposes and functions of the Medical Records Committee are as follows:

(1) Using the Kettering Health Network definition for a complete medical record as the standard for comparison, will review reports of record reviews that substantiate compliance with such standard.

(2) Assure implementation of action plans to correct such deficiencies as are identified.

(3) Address concerns regarding medical record completion as brought forth to the committee from the administration or the Medical Staff.

(4) Recommend policies regarding maintenance and proper recording of sufficient data to evaluate patient care, as well as matters of confidentiality, access, and legal release of information.

3.10.3 Meetings, Reports, and Recommendations

(A) The Medical Records Committee shall meet as often as necessary to accomplish its duties, but at least quarterly.

(B) The committee shall maintain a permanent record of its proceedings and actions and report its recommendations to the Quality Assurance and

Performance Improvement Committee and to the Medical Executive Committee as deemed appropriate.

3.11. RULES AND BYLAWS COMMITTEE

3.11.1 Composition

(A) The Rules and Bylaws Committee will be comprised of the Immediate Past Chief of Staff (chair), Chief of Staff, Vice Chief of Staff, two (2) At Large Appointees of the active Medical Staff appointed by the Chief of Staff, and the Chief Medical Officer (*Ex Officio*).

(B) The Chief of Staff, Immediate Past Chief of Staff in the capacity of chair of the Medical Staff Rules and Bylaws Committee, and an at-large member of the committee will serve on the Network Rules and Bylaws Alignment Committee. *Ex Officio* invitees to that committee include the Vice Chief of Staff and Chief Medical Officer.

3.11.2 Duties

(A) The Rules and Bylaws Committee shall provide regular review of the Hospital Medical Staff governing documents and recommend/communicate changes to and from the Network Rules and Bylaws Alignment Committee and Medical Staff/MEC.

3.11.3 Meetings, Reports, and Recommendations

(A) The Rules and Bylaws Committee will meet no less than annually and as otherwise needed at the request of the Board of Directors or Medical Executive Committee.

(B) The committee shall maintain a permanent record of its proceedings and actions and report to the MEC.

3.12. MEDICAL STAFF ADMINISTRATION COMMITTEE

3.12.1 The Medical Staff Administration Committee (MSAC) is a joint committee of the leadership of the Hospital and Medical Staff. The composition, duties, and meeting requirements of the MSAC are set forth in the MSAC charter, as such charter may be amended from time to time.

3.13. DISTINGUISHED SERVICE AWARD COMMITTEE

3.13.1 Composition

(A) The Distinguished Service Award Committee will be composed of the Chief of Staff (chair), Vice Chief of Staff, Immediate Past Chief of Staff and up

to four (4) active Medical Staff Appointees with at least ten (10) years of Medical Staff membership.

(B) *Ex Officio* members may include the Chief Medical Officer and a representative from Administration.

3.13.2 Duties

(A) The Distinguished Service Award Committee will:

(1) Promote recognition of Physicians who have made significant contributions to the growth and excellence of the Medical Staff, medical profession, Hospital, and community.

(2) Establish and maintain criteria for the nomination and selection of annual inductee Physicians for the Distinguished Service Award.

(3) Select inductees based on merit, transcending Clinical Department/Section affiliation.

(B) Distinguished Service Award Criteria

(1) The inductee must:

(a) Have been a Physician on the Medical Staff for a least twenty-five (25) years.

(b) Have held active, courtesy, or associate Medical Staff membership within the last three (3) years, to include posthumous Physicians.

(c) Be of highest moral character, ethics, and integrity.

(d) Have made exceptional contributions to the growth and professional excellence of the Medical Staff, Hospital, and profession evidenced by consistent quality care.

3.13.3 Inductee Selection Procedure

(A) The Medical Staff Office will supply an annual list of eligible Medical Staff Appointees with 25 or more years of service to the committee.

(B) Nominations, sponsored by a current active Medical Staff Appointee, must be submitted by the third quarter to the committee for consideration.

(C) Nominations will include a narrative describing the nominee's merits for the award.

(D) Nominations submitted will be reviewed by the committee along with a CV provided by the Medical Staff Office.

(E) The inductee(s) will have at least two-thirds (2/3) approval by the voting members of the committee.

(F) Nominations not chosen for the award may be considered again in the following year.

(G) The MEC will be notified of the nominees.

(H) The Distinguished Service Award will be presented at the holiday Medical Staff meeting.

3.13.4 Meetings, Reports, and Recommendations

(A) The committee shall meet as scheduled with advance written or electronic notification.

(B) Quorum shall be no less than five (5) appointed voting committee members including the chair.

(C) The committee shall maintain a permanent record of its proceedings and actions and report to the MEC.

3.14. PROFESSIONAL PRACTICE COMMITTEE

3.14.1 The Professional Practice Committee (PPC) is a Board committee. The composition, duties, and meeting requirements of the PPC are set forth in the PPC charter as such charter may be amended from time to time.

3.14.2 The PPC may serve as an *ad hoc* Joint Conference Committee as outlined in the Medical Staff Bylaws/Manuals.

ARTICLE 4
RULES AND REGULATIONS

4.1. OUTPATIENT (AMBULATORY), OBSERVATION, AND ADMISSION STATUS

4.1.1 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.

4.1.2 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 the Hospital. Patients presenting to a Hospital facility for treatment outside the Hospital's scope of service will be stabilized and transferred to another appropriate facility.

4.1.3 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.

(A) The Hospital has the obligation of minimizing the risk of hazards and safeguarding all patients, visitors, and personnel. Therefore, any patient whose mental or physical condition causes a disturbing or unsafe environment of care, 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 Department Chair will be contacted. If a mutual decision with the attending Practitioner cannot be reached, a Medical Staff officer shall be consulted to make a final disposition.

4.1.4 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 the patient's legal/authorized 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.

4.1.5 Assignment of Cases:

(A) Patients shall be attended by Medical Staff Appointees with appropriate Privileges and shall be assigned by the Clinical Department/Section concerned in the treatment of the disease which necessitated hospitalization.

(B) 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.

(1) 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), such Practitioner shall make adequate arrangements prior to departure for coverage for his/her private patients that are hospitalized or who may present to the Emergency Department while the Practitioner is away on such planned absence.

(2) The Practitioner, unless in a group practice in which all Practitioners have common Privileges or in a designated call coverage group, 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 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 absent Practitioner's hospitalized and/or Emergency Department patients.

(3) If the Practitioner is also scheduled to be on Emergency Call during the scheduled absence, the Practitioner must also arrange for backup Emergency 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.

(C) In the case of a patient requiring hospitalization who has no attending Practitioner on the Medical Staff and does not elect or is unable to choose one, the patient shall be referred to the appropriate Emergency Call Practitioner.

(D) Practitioners on the Emergency Call panel to whom patients are referred have a responsibility to provide outpatient 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.

(E) All hospitalized patients are required to be seen by the admitting/attending and, as applicable, consulting Practitioner in a timely fashion with documentation of such visit(s) in the medical record. Medicare patients must be under the care of a MD/DO. Patients transferred or admitted to an ICU shall be seen by the attending and, as applicable, 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/attending and, as applicable, consulting Practitioner within a time frame consistent with the clinical condition of the patient, but within twenty-four (24) hours. All patients require daily visits by the attending Practitioner documented in the progress notes. Medical student progress notes will not be a part of the medical record. To provide appropriate continuity of care for patients who are hospitalized by Practitioners other than the patient's primary care Physician, the attending Practitioner is responsible to communicate, when appropriate, with the primary care Physician regarding the patient's Hospital course and the plan of care post hospitalization.

4.2. PATIENT SAFETY

4.2.1 The Hospital and 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.

4.2.2 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.

4.3. UTILIZATION

4.3.1 The information contained in each patient's medical record (*e.g.,* history and physical, progress notes, *etc.*) 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, progress notes must provide sufficient information regarding the severity of illness and/or intensity of service that requires continued use of Hospital resources.

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

4.3.3 Admissions prior to the day of surgery will be permitted if the patient's medical condition satisfies Hospital admission criteria.

4.3.4 Periodic review of the appropriateness of patient care may be made by the staff of the Hospital Quality Department. Deviations from Medical Staff approved criteria will be referred to the utilization Physician reviewer.

4.4. PEER REVIEW

4.4.1 The peer review function for Practitioners and APPs with delineated Clinical Privileges will be performed with intention to safeguard Practitioner/APP confidentiality to the greatest extent and to promote objective and unbiased consideration.

4.4.2 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 with the intent of performance improvement and not indictment of individuals. The Medical Staff Peer Review/Professional Practice Evaluation Policy sets forth the peer review process and procedures with respect to Practitioners and APPs granted Privileges at the Hospital.

4.5. ORDERS

4.5.1 Admission Orders: All hospitalized patients must have orders assigning to an attending Practitioner, in Good Standing, with admitting Privileges granted in accordance with the Bylaws and Credentials Manual. The order to hospitalize must be written/entered or co-signed by the admitting Practitioner. Non-Appointees shall not have authority to admit or co-admit patients to the Hospital. Authorized APPs may accept and document a verbal/telephone admission order issued by the admitting Practitioner in accordance with the requirements set forth in Section 4.5.2.

4.5.2 Written/Electronic, Telephone, and Verbal Orders: All orders shall be in writing or directly entered into the electronic medical record or electronic order entry system. All orders must be dated, timed, and authenticated promptly by the ordering Practitioner or another qualified Practitioner responsible for the care of the patient who is acting in accordance with his/her State scope-of-practice laws and the governing documents of the Medical Staff. In order to reduce the opportunity for transcription errors and the potential risk to patient safety, telephone and verbal orders shall be used infrequently and shall be accepted, recorded, and carried out when dictated by the ordering Practitioner to authorized Hospital personnel within the scope of their practice and licensure, certification, or registration. Telephone and verbal orders are to be recorded by authorized Hospital staff and then read back (except in an emergency or during a procedure when repeating back the order is adequate) to the ordering Practitioner who shall verify that the read back is correct prior to the implementation of the order. Documentation of all telephone/verbal orders includes the time the telephone/verbal order was received, and the date and names of the authorized individuals who gave, received, recorded, and implemented the orders. Orders received over the telephone shall be accepted from ordering Practitioners only if the identity of such is not in doubt. Faxed orders may be accepted if the fax is signed by the ordering Practitioner and the sending fax site is identified. Orders received from Practitioners via any of the above means will be entered into the medical record by authorized Hospital staff and dated, timed,

and authenticated promptly by the ordering Practitioner. Medical records containing telephone and verbal orders lacking authentication within the established time frame may be considered immediately delinquent.

4.5.3 In some instances, the ordering Practitioner may not be able to authenticate an order, including a verbal/telephone order (*e.g.,* the ordering Practitioner gives a verbal order which is entered in the medical record and then is off duty for the weekend or an extended period of time). In such cases, another Practitioner responsible for the patient's care can authenticate the order, including a verbal/telephone order, of the ordering Practitioner. All Practitioners responsible for the patient's care are expected to have knowledge of the patient's hospital course, medical plan of care, condition, and current status. When a Practitioner other than the ordering Practitioner authenticates an order, that Practitioner assumes responsibility for the order as being complete, accurate and final.

4.5.4 Inpatient orders issued by authorized APPs must be: within the APP's scope of practice, permitted by/in accordance with the Clinical Privileges granted to the APP; consistent with the APP's standard care arrangement or supervision agreement, as applicable; and, in accordance with all applicable laws, rules, regulations, accreditation standards, these Rules & Regulations, and Hospital and Medical Staff policies. APP orders are not required to be countersigned unless otherwise required by these Rules & Regulations, applicable laws, rules, regulations, accreditation standards, the APP's supervising or collaborating Practitioner, or applicable Hospital/Medical Staff policies and procedures.

4.5.5 Orders for outpatient services from Practitioners and APPs who are licensed in Ohio, with or without Privileges at the Hospital, may be accepted in accordance with the requirements set forth in the applicable Hospital policy, as such policy may be amended from time to time.

4.6. RECORDS

4.6.1 Content

(A) 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, include: 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 orders; nursing notes; reports of treatment; medication records; vital signs, and other information necessary to monitor the patient's condition.

4.6.2 Legibility

(A) Practitioners and APPs with Clinical Privileges have a responsibility to make legible entries into the medical record. The Medical Staff has legibility expectations to assure all individuals having access to patient medical records can read information contained within the medical record. Non-compliance may result in progressive action with respect to the Practitioner/APP including notification, education (including possible remedial handwriting programs), automatic suspension(s) for incomplete medical records, and/or formal corrective action.

4.6.3 Non-Medical Comments

(A) Criticism, impertinent and inappropriate comments, drawings or language, or personal attacks against other Practitioners/APPs, 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 CMO for interpretation, judgment, and action pursuant to the applicable Medical Staff policy/procedure. If warranted, they may refer the incident to the Medical Executive Committee for review and recommendation.

4.6.4 History and Physical

(A) A medical history and physical examination (H&P) will be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(B) An updated examination of the patient, including any changes in the patient's condition, will be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the H&P is completed within 30 days before admission or registration.

(C) A current complete 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 surgery/a 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.

(D) 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.

(E) An osteopathic musculoskeletal examination is required as an integral part of the H&P performed by osteopathic Physicians on their hospitalized patients unless contraindicated. The reason for omitting the musculoskeletal examination is documented in those cases where this examination is contraindicated.

(F) The H&P records are the responsibility of the attending Practitioner. H&Ps shall be properly documented, and authenticated, dated, and timed. Medical student H&Ps will not be part of the medical record.

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

(1) Doctor of medicine or osteopathy

(2) Oral Surgeon (if privileged to do so by the Hospital for his/her patients as indicated in the Credentials Policy Manual)

(3) Authorized APPs (*e.g.,* physician assistant, certified nurse practitioner, *etc.*) if privileged to do so by the Hospital and in accordance with Ohio law (*e.g.,* within scope of practice, *etc.*)

(a) H&P's completed and documented by an authorized APP must be reviewed and countersigned, dated, and timed by the attending Practitioner.

(H) A Dentist, Podiatrist, or Psychologist with appropriate Privileges is responsible for completion and documentation of a dental, podiatric, or psychological history and examination as further detailed in the Credentials Policy Manual.

(I) Should the H&P be completed by a Practitioner with or without appointment/Privileges at the Hospital (*i.e.,* patient's primary care Practitioner) within 30 days before Hospital admission or registration, then an updated H&P meeting the required content as defined in this section must be completed and documented by a Practitioner or APP who is appropriately privileged at the Hospital as follows:

(1) The update shall indicate the following: the H&P was reviewed, the patient was examined, and whether any changes have occurred in the patient's condition since the H&P was initially 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 after admission or registration, but prior to surgery or a procedure requiring anesthesia services.

(2) If the Practitioner/APP finds that the H&P done before admission is incomplete, inaccurate, or otherwise unacceptable, the Practitioner/APP reviewing the initial 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 services.

(J) Ambulatory/Outpatient H&P

(1) Ambulatory patients who are undergoing procedures requiring moderate sedation or anesthesia require a complete H&P on the chart.

(2) Only a pertinent note concerning the nature of the disease process leading to the procedure and the intended procedure is necessary in other cases. Other pertinent positive findings, such as drug allergies and serious pre-existing disease/conditions, should also be noted.

(K) Anesthesia/Moderate Sedation

(1) Outpatients undergoing surgery or procedures under any anesthesia or moderate sedation, except local anesthesia without any pre-operative medication, require an H&P.

4.6.5 Pre-Operative/Pre-procedure Record

(A) 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/moderate sedation, and an acceptable current H&P. In emergency situations when there is no time to record the complete H&P, an acceptable H&P may be limited to an admission or progress note describing the major significant conditions requiring the immediate surgery/procedure, a brief history, appropriate physical findings, and the preoperative diagnosis recorded in the medical record before surgery. 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.

4.6.6 Informed Consent

(A) To assist the patient in providing informed consent, the Practitioner performing the surgery or procedure 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. Risks and benefits

associated with blood transfusion, when blood or blood components may be needed with an operative procedure, are also discussed.

(B) To assist the patient in providing informed consent, the Practitioner responsible for managing the patient's care, treatment, and/or services 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/or services, the likelihood of the patient achieving treatment 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/or 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/or services. Documentation of risks, benefits, and alternatives must be present in the patient record.

(C) The Hospital Informed Consent Policy, as such policy may be amended from time to time, outlines the details of the informed consent process.

(D) To assist the patient in providing informed consent, the Practitioner or CRNA providing anesthesia or moderate sedation shall provide an anesthesia or moderate 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 moderate sedation prior to administration of pre-operative medication.

4.6.7 Anesthesia Documentation

(A) 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.

(B) An intra-operative anesthesia record shall be maintained.

(C) 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.

4.6.8 Surgical Record

(A) All operations or procedures performed in the Hospital shall be described in full in the electronic medical record.

(B) The operative/procedure report must be in sufficient detail to provide necessary clinical information and must be entered immediately into the patient's medical record upon completion of the operative or high-risk procedure unless an interim operative/procedure progress note is immediately entered in the medical record before the patient is transferred to the next level of care in which case the full operative/procedure report may be completed within twenty-four (24) hours after the surgery/procedure.

(1) An interim operative/procedure progress note includes the same (albeit abbreviated) elements as set forth in (C) below for the full operative/procedure report.

(C) The operative/procedure report must include the following elements:

(1) Patient name and hospital identification number

(2) Date/time of surgery/procedure

(3) Name(s) of surgeon(s)/Practitioner(s) performing the procedure(s) and other assistants/practitioners who performed surgical tasks (even when performing those tasks under supervision)

(4) Name of the procedure(s) performed

(5) Findings of the procedure(s) including complications, if any

(6) Description of the procedure(s)/technique(s) including the type of anesthesia administered

(7) Estimated blood loss

(8) Specimens/tissues removed or altered

(9) Pre-operative/pre-procedure diagnosis

(10) Post-operative/post-procedure diagnosis

(11) Names of surgeons/Practitioners (other practitioners) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/Practitioner. Significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues.

(12) Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

(D) The operative/procedure report/interim note must be dated, timed, and signed by the surgeon/Practitioner who performed the surgery/high risk procedure.

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

4.6.9 Discharge Summary

(A) 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. The discharge summary must be completed within seven (7) days after discharge.

(B) 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 Kettering Health Network facility.

(C) 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.

(1) The attending Practitioner will be responsible for the discharge summary.

(a) Preparation of the discharge summary may be delegated by the attending Practitioner to an APP who is caring for the patient provided that such delegation is within the APP's scope of practice, permitted by/in accordance with the Clinical Privileges granted to the APP; consistent with the APP's standard care arrangement or supervision agreement, as applicable; and, in accordance with all applicable laws, rules, regulations, accreditation standards, these Rules and Regulations, and Hospital and Medical Staff policies.

(b) The individual who writes the discharge summary must authenticate, date, and time their entry. Additionally, for delegated discharge summaries, the Practitioner responsible for the patient during the patient's Hospital stay must co-

authenticate, date, and time the discharge summary to verify its content.

4.6.10 Completion of Records - Requirements:

(A) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with Hospital policies and procedures. Rubber stamp signatures are not acceptable for authentication of entries in the medical record. Verbal or telephone orders must be authenticated within forty-eight (48) hours.

(B) Charts must be accurately and legibly completed within seven (7) days from allocation date/quality documentation clarification requests. 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 documented 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 verbal or telephone orders within forty-eight (48) hours after issuance.

(C) After 21 days from discharge, notification of automatic suspension of Privileges for incomplete or delinquent medical records will be given to the Practitioner either verbally, by Special Notice, or by receipted facsimile. An extension due to extenuating circumstances (*e.g.,* illness, vacation) may be requested by the Practitioner from the Medical Staff officer(s).

(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 automatic suspension and which cannot be appropriately rescheduled (See Section 10.5.2 of the Medical Staff Bylaws).

(E) Automatic suspension of Practitioners who supervise or collaborate with APPs may result in the APP's Privileges being automatically suspended as well if the APP has no other collaborating or supervising Practitioners.

(F) Any Practitioner whose Privileges have been automatically 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 (that does not otherwise meet the exceptions set forth in Section 10.5.2 of the Bylaws) from the Chief of Staff or the CMO.

The approving Medical Staff/Hospital leader and Practitioner shall notify the hospitalization office of the nature of the special circumstances prior to the admission of the patient. For removal of the automatic suspension prior to curing medical records deficiencies, Practitioners must submit a plan of compliance and petition for restoration to the Chief of Staff or CMO. Upon approval of the plan, the Chief of Staff or CMO will contact the Health Information Management Department to restore such Practitioner's admitting and ordering Privileges.

(G) A Practitioner who has received three (3) automatic suspensions during any consecutive 12-month period and who subsequently has incomplete or delinquent medical records; or, a Practitioner who has been under automatic suspension for two (2) consecutive weeks without an approved extension will have his/her Medical Staff appointment and Privileges automatically terminated. Notice of any automatic 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 whose Medical Staff appointment and Privileges are automatically 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 may intervene to defer the automatic termination in order to permit the Practitioner to conclude caring for currently hospitalized patients and for patients previously scheduled for procedures or admission consistent with Section 10.5-2 of the Medical Staff Bylaws. Following the discharge of the last patient, the automatic termination will take effect.

(H) The Privileges of a Practitioner that are automatically suspended for delinquent medical records shall be automatically reinstated upon the Practitioner's completion of the incomplete records, or portions thereof.

(I) A Practitioner whose Medical Staff appointment and Privileges have been automatically terminated as a result of delinquent medical records must reapply for Medical Staff appointment and Privileges at the Hospital. If the Practitioner is subsequently regranted Medical Staff appointment and Privileges, any single subsequent automatic suspension for medical record completion during the following consecutive 12-month period will result in an automatic termination of Medical Staff appointment and Privileges. The Practitioner will thereafter be required to present an acceptable corrective action plan for consideration for reapplication for Medical Staff appointment and Privileges.

(J) A suspension (pursuant to the formal corrective action procedure set forth in the Medical Staff Bylaws) for failure to complete medical records 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 a Practitioner's professional competence or conduct, and adversely affects or could adversely affect a patient's health or welfare.

4.6.11 Ownership of Medical Records

(A) 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.

(B) 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.

4.6.12 Access to Records

(A) 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.

(B) 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 held Privileges and attended such patients in the Hospital.

(C) Review of medical records is limited to Practitioners, APPs, 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.

(D) Practitioners on the Medical Staff who have the permission of the patient or the patient's legal representative may review the medical record of a currently hospitalized patient. Practitioners not on the Medical Staff, with the written permission of the patient or patient's legal representative, may obtain a copy of the patient's medical record for review.

4.7. CONSULTATION

4.7.1 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. If the attending Practitioner and the consultant disagree on management of a patient, a second opinion must be ordered.

4.7.2 Medical Staff Appointees with appropriate Privileges 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 Practitioner 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 and is required for emergent and urgent consultations.

4.7.3 Consultation shall be sought as appropriate in order to provide the best possible care for the Hospital's patients.

4.7.4 Care of patients in the intensive care unit requires management by or consultation with a Physician board certified or board eligible in critical care.

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

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

4.7.7 The consultant must be an Appointee of the Medical Staff with appropriate Privileges who is well qualified to give an opinion in the field in which his/her opinion is sought.

4.7.8 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 an operation.

4.7.9 In circumstances of grave urgency or when consultation is required by rules of the Hospital/Medical Staff, the Hospital President 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.

4.8. DISCHARGE

4.8.1 Patients shall be discharged only by a signed or co-signed order of the attending Practitioner or covering Practitioner.

4.8.2 Authorized APPs may accept and document a verbal/telephone discharge order issued by the attending/covering Practitioner in accordance with the procedure set forth in Section 4.5-2.

4.9. BASIC RULES FOR THE USE OF HOSPITAL FACILITIES

4.9.1 The exercise of Privileges is contingent upon the Practitioner's/APP's abiding by the Medical Staff Bylaws and other related Manuals, all applicable policies, and compliance with accreditation standards, and applicable laws, rules, and regulatory requirements. Failure to do so may subject the Practitioner or APP to corrective action in accordance with the process set forth in the Medical Staff Bylaws or APP Manual, as applicable.

4.10. EMERGENCY ON-CALL PRACTITIONERS

4.10.1 Appointees of the Medical Staff with Privileges have an obligation, as set forth in the Medical Staff Bylaws, 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. Practitioners may be on-call at multiple Kettering Health Network hospitals as long as there are plans to provide alternate coverage should more than one facility require emergent services at one time.

4.10.2 The Emergency On-Call list is intended to provide urgent and emergent consultation to patients seeking care in the Emergency Department or within the Hospital and its affiliated units. Time constraints for urgent and emergent responses are further defined in Section 4.7. The Emergency On-Call list will be available on the Hospital Intranet.

4.10.3 If there are discrepancies, administrative, or reimbursement concerns, the currently listed on-call Practitioner on the Emergency On-Call list is responsible for the emergent needs of the patient first and may then 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, that individual is responsible to report to the Medical Staff Office and/or the Emergency Department a suitable on-call replacement Practitioner with appropriate Clinical Privileges.

4.10.4 Emergency Department patients will receive initial stabilizing care without regard to immediate payment capability. Emergency on-call Practitioners must respond to emergent requests from the Emergency Department Physician for evaluation of Emergency Department patients in a timely fashion and provide stabilization and/or emergent definitive care, treatment, and/or services without regard to insurance status or payment capability.

4.10.5 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 a 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 this 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 EMTALA Transfer form.

4.10.6 An on-call Practitioner may direct a licensed physician assistant (PA) or Advanced practice registered nurse (APRN) (whom the Practitioner supervises or collaborates with and consistent with the PA's or APRN's respective scope of practice and Clinical Privileges at the Hospital) as the on-call Practitioner's representative to appear at the Hospital and provide further assessment or stabilizing treatment to an individual. This determination should be based on the individual's medical needs and the capabilities of the Hospital, the applicable State scope of practice laws, the Medical Staff governing documents, and applicable Hospital policies and procedures. Notwithstanding the foregoing, the designated on-call Practitioner is ultimately responsible for providing the necessary services to the individual in the Emergency Department/Hospital, regardless of who makes the in-person appearance. Furthermore, in the event that the treating Practitioner disagrees with the on-call Practitioner's decision to send a representative and requests the actual appearance of the on-call Practitioner, then the on-call Practitioner is required under EMTALA to appear in person. Both the Hospital and the on-call Practitioner who fails or refuses to appear in a reasonable period of time may be subject to sanctions for violation of the EMTALA statutory requirements.

4.11. CONTRACTED PATIENT CARE SERVICES

4.11.1 The Medical Executive Committee will review and make recommendations for contractual sources of patient care provided by entities outside the Hospital.

4.11.2 A written agreement defining the nature and scope of patient care services will include providing care in a timely fashion and expectations of consistent performance of patient care processes according to appropriate accreditation standards.

4.11.3 Expectations for the performance of contracted services will be met by verification that all Practitioners and APPs who will be providing contracted patient care, treatment, and services for patients at the Hospital (or a provider-based location thereof) must request and be granted appropriate Privileges by the Hospital prior to providing such contracted services.

4.11.4 Written agreements will specify that the contracted organization will ensure that all contracted services provided by Practitioners and APPs will be within the scope of their Privileges as granted to them by the Hospital. The written agreement will also include the expectation that consistent performance of patient care processes must be provided according to applicable standards of care, appropriate accreditation standards, and applicable laws, rules, and regulatory requirements.

4.12. HOUSE STAFF PHYSICIANS

4.12.1 This section (and the corresponding references to House Staff Physicians in this Manual) is/are applicable to Kettering Medical Center and Sycamore Medical Center only.

4.12.2 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.

(A) House Staff Physicians with a current, valid training certificate from the State Medical Board of Ohio may provide inpatient and/or outpatient medical care in the course of their residency training program/clinical rotations within the scope of their training certificate and with appropriate supervision.

(B) House Staff Physicians with an unrestricted State Medical Board of Ohio license who meet designated qualifications may request moonlighting Privileges to provide direct inpatient and/or outpatient medical care outside of their residency training program within the scope of their licensure with appropriate supervision.

4.12.3 The supervising Physician is responsible for fostering an environment in which House Staff Physicians 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 Physician 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 Physician's education, experience, skills, and abilities.

4.12.4 Documentation in the medical record by a House Staff Physician and supervising Physician is confirmation that supervision has taken place. When House Staff Physicians episodically see patients which are not assigned to a teaching panel, the

patient's attending Physician, after being notified by the House Staff Physician, assumes the responsibility for the resident's supervision.

4.12.5 To the extent permitted by and consistent with the House Staff Policy Manual, residency program policies and procedures, and applicable laws, rules, and regulations, House Staff Physicians may perform the following tasks consistent with the requirements set forth in these Medical Staff Rules and Regulations and applicable Hospital policies and procedures:

(A) Accept and document verbal/telephone orders including, but not limited to, admission and discharge orders issued by the admitting or attending Practitioner.

(B) With the exception of admission and discharge orders, issue orders for care, treatment, and services.

(C) Assist with preparation of medical H&P (and updates thereto).

(D) Review, and document in, the medical records of those patients for whom the House Staff Physician is providing care, treatment, and/or services.

(E) Assist with preparation of consultation reports, operative/procedure reports, and discharge summaries, as applicable.

4.12.6 The supervising Physician will review and countersign the following documentation prepared by a House Staff Physician: all orders, the H&P (and updates thereto), the operative/high risk procedure report, the consultation report, and the discharge summary.

4.12.7 The supervising Physician will also be responsible for completing the medical record in a timely manner in situations where the House Staff Physician may not complete his/her responsibilities in regard to the medical record.

4.13. PROFESSIONAL LIABILITY ACTION

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

4.14. CODE OF CONDUCT/NOTICE OF PRIVACY PRACTICES

4.14.1 All Practitioners and APPs are required to abide by the Practitioner/APP Code of Conduct 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.

4.15. DISRUPTIVE PRACTITIONERS/APPS

4.15.1 Issues of disruptive behavior by Practitioners/APPs are addressed in accordance with the applicable procedure set forth in the Medical Staff Bylaws.

4.16. ACCESS TO PEER REVIEW FILES

4.16.1 Information regarding access to peer review files will be addressed in the Medical Staff Peer Review/Professional Practice Evaluation Policy.

4.17. RAPE EXAMINATIONS

4.17.1 Rape examination is a formal legal collection of evidence when an allegation of sexual assault has occurred. Emergency Department Physicians and nurses are specifically trained in this procedure. Patients presenting to the Emergency Department 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.

4.17.2 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.

4.18. RESTRAINTS

4.18.1 The Medical Staff will 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, as such policy may be amended from time to time.

4.19. PRONOUNCEMENT OF DEATH

4.19.1 Only a licensed Physician may pronounce a patient dead. The Physician need not personally examine the body. A nurse, paramedic, or other competent observer (*e.g.,* House Staff Physician, *etc.*), as defined by applicable Ohio law, may report findings on the telephone for the Physician to make the death pronouncement. The Physician pronouncing the patient dead is responsible for completing the death/autopsy form. The death certificate is a state form and must be signed by the Physician who attended the decedent or by the coroner or medical examiner, as appropriate, within 48 hours after the death or fetal death. 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.

4.19.2 Deaths shall be reported to the coroner as required by applicable Ohio laws, rules, and regulations. Any doubt regarding reportable cases should be referred to the coroner's office for clarification.

4.20. USE OF INVESTIGATIONAL/EXPERIMENTAL DRUGS/DEVICES

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

4.20.2 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.

4.20.3 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 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.

4.20.4 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.

4.20.5 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.

4.21. CANCER STAGING

4.21.1 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 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 include rationale on the staging form.

4.22. FOCUSED PROFESSIONAL PRACTICE EVALUATION

4.22.1 The Medical Staff's focused professional practice evaluation ("FPPE") process is set forth in detail in the Medical Staff Peer Review/Professional Practice Evaluation Policy.

4.22.2 FPPE shall be implemented for all: (a) Practitioners/APPs requesting initial Privileges; (b) existing Practitioners/APPs requesting new Privileges during the course of an appointment/Privilege period; and, (c) in response to concerns regarding a Practitioner's/APP's ability to provide safe, high quality patient care. The FPPE period shall be used to determine the Practitioner's/APP's current clinical competence and ability to perform the requested Privileges.

4.23. ONGOING PROFESSIONAL PRACTICE EVALUATION

4.23.1 Upon conclusion of the FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all Practitioners and APPs with Privileges at the Hospital.

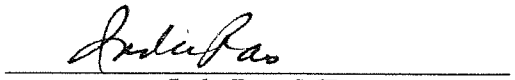
4.23.2 The Medical Staff's OPPE process is set forth, in detail, in the Medical Staff Peer Review/Professional Practice Evaluation Policy and requires the Hospital/Medical Staff to gather, maintain, and review data on the performance of all Practitioners and APPs with Privileges on an ongoing basis.

ARTICLE 5
ADOPTION, AMENDMENT OR REPEAL

This Medical Staff Organization and Functions 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
February 18, 2020



Indu Rao, MD
Chief of Staff

Approved by the Board of Directors
after receipt of a recommendation by the
Medical Executive Committee
February 24, 2020

Wally Sackett
President/CEO