

# ORGANIZATION MANUAL

*Medical Staff  
Kettering Medical Center  
Kettering, Ohio*

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# TABLE OF CONTENTS

1	<b>PART 1. FUNCTIONS OF THE MEDICAL STAFF</b> .....	4
2	1.1 GENERAL.....	4
3	1.2 JOB DESCRIPTIONS.....	4
4	<b>PART 2. PROFESSIONAL STAFF COMMITTEES</b> .....	11
5	2.1 DESIGNATION.....	11
6	2.2 MEDICAL EXECUTIVE COMMITTEE.....	11
7	2.3 CREDENTIALS COMMITTEE.....	12
8	2.4 WELLNESS COMMITTEE.....	13
9	2.5 PERFORMANCE IMPROVEMENT COUNCIL.....	15
10	2.6. UTILIZATION REVIEW COMMITTEE.....	17
11	2.7 CLINICAL QUALITY REVIEW COMMITTEE.....	18
12	2.8 PHARMACY & THERAPEUTICS COMMITTEE.....	19
13	2.9 OPERATING ROOM COMMITTEE.....	20
14	<b>PART 3. COMMITTEE MEETING AND PROCEDURES</b> .....	22
15	3.1 Notice of Committee Meetings.....	22
16	3.2 Manner of Action.....	22
17	3.3 Minutes.....	22
18	<b>PART 4. MEDICAL STAFF MEETINGS</b> .....	23
19	4.1 Medical Staff Meetings.....	23
20	4.2 Special Meetings.....	23
21	4.3 Regular Meetings of Clinical Services and Committee.....	23
22	4.4 Quorum.....	24
23	4.5 Attendance Requirements.....	24
24	4.6 Participation by Chief of Staff.....	25
25	4.7 Robert's Rules of Orders.....	25
26	4.8 Rights of Ex Officio Members.....	25
27	<b>PART 5. RULES AND REGULATIONS</b> .....	25
28	1. Out-patient (Ambulatory), Observation and Admission Status.....	25
29	2. Patient Safety.....	28
30	3. Utilization.....	29
31	4. Peer Review.....	29
32	5. Orders.....	33
33	6. Records.....	35
34	7. Consultation.....	44
35	8. Discharge.....	46
36	9. Basic Rules for the Use of Hospital Facilities.....	46
37	10. Emergency Department On-Call Physicians.....	46
38	11. Sources of Patient Care Provided Outside the Hospital.....	47
39	12. Housestaff.....	48
40	13. Professional Liability Action.....	49
41	14. Conduct.....	49
42	15. Disruptive Medical Staff Member.....	49
43	16. Copying of Medical Staff Files.....	50
44	17. Rape Examinations.....	50
45	18. Restraints or Seclusion.....	50
46	19. Pronouncement of Death.....	51
47	20. Use of Investigational/Experimental Drugs or Devices.....	51
48	21. Cancer Staging.....	52
49		

1	<b>PART 6. AMENDMENT</b> .....	53
2	6.1 Amendment.....	53
3	6.2 Responsibilities and Authority.....	53



1 Consults with the Vice President Medical Affairs on matters of special  
2 concern to staff appointees and maintains medical liaison with the Vice  
3 President Medical Affairs to assist in settling grievances and problems of  
4 the staff.  
5

6 **Responsibilities:** Responsible for the enforcement of Medical Staff  
7 Bylaws, Organization Manual, and Credentials Manual for implementation  
8 of sanctions where these are indicated, and for the Medical Staff's  
9 compliance with procedural safeguards in all instances where corrective  
10 action has been recommended against a practitioner.  
11

12 Responsible for all administratively related activities of the Medical Staff,  
13 unless otherwise provided for by the hospital.  
14

15 Responsible in conjunction with the Clinical Service Chiefs for assessing  
16 and recommending to the relevant hospital authority off-site sources for  
17 needed patient care services not provided by the Medical Staff or the  
18 organization.  
19

20 Responsible in conjunction with the Clinical Service Chiefs for the  
21 development and implementation of policies and procedures that guide  
22 and support the provision of services.  
23

24 Responsible in conjunction with the Clinical Service Chiefs for the  
25 recommendations for a sufficient number of qualified and competent  
26 persons to provide care or service.  
27

28 Responsible in conjunction with the Clinical Service Chiefs for the  
29 determination of the qualifications and competence of department or  
30 service personnel who are not licensed independent practitioners and who  
31 provide patient care services.  
32

33 Responsible for participating in the evaluation of existing programs,  
34 services, and facilities of the Hospital and Medical Staff and  
35 recommending continuation, expansion, abridgment or termination of  
36 each.  
37

38 Responsible in conjunction with the Clinical Service Chiefs for participating  
39 in evaluating financial, personnel, and other resource needs for beginning  
40 a new program or service, for constructing new facilities, or for acquiring  
41 new or replacement capital equipment and accessing the relative priorities  
42 of services and needs and allocation of present and future resources.  
43

44 Responsible for appointing the Medical Staff members to the following

1 committees: Credentials (excluding the chair), Utilization Review  
2 Committee, Clinical Quality Review Committee, Performance  
3 Improvement Council except co-chair and its hospital appointees,  
4 Pharmacy & Therapeutics, Operating Room, GI Endoscopy (excluding  
5 chair) and Wellness Committee.  
6

7 **Position Requirements:** The individual occupying this position must meet  
8 the Qualifications of Officers, Medical Staff Bylaws Article IV, Section 2.  
9 Prior successful service as a Department/Clinical Service Chief,  
10 Credentials Committee member, Board member, Medical Executive  
11 Committee member or other similar Medical Staff leadership position is  
12 required. Individuals occupying this position should have education and  
13 training concerning medical administrative activities and Medical Staff  
14 leadership as requested by Hospital Administration and Medical Staff  
15 Services.  
16

## 17 2) Chief-Elect

18  
19 **Reports to:** Chief of Staff and Medical Executive Committee  
20

21 **Position Purpose:** The purpose of this position is to provide continuity in  
22 leadership during times when the Chief of Staff is absent or otherwise  
23 unable to perform his/her assigned functions. The Chief-Elect will be  
24 expected to remain knowledgeable about all Medical Staff issues of  
25 current Medical Staff interest. At the conclusion of the term of the Chief of  
26 Staff, the Chief-Elect will succeed as Chief of Staff.  
27

28 **Accountabilities and Functions:** Assists the Chief of Staff with any  
29 functions specified by the Chief of Staff and the Medical Executive  
30 Committee. Is an ex-officio invitee to the Board of Directors meetings. Is a  
31 member of the Medical Executive Committee and the Risk Management  
32 Committee. Is an invitee to the Professional Practice Committee. Is co-  
33 chair of the Performance Improvement Council. As such, this individual  
34 will be expected to represent the findings and recommendations of the  
35 Performance Improvement Council to the Medical Executive Committee.  
36 (See description of Performance Improvement Council 2.5)  
37

38 **Responsibilities:** Responsible in conjunction with the Clinical Service  
39 Chiefs for continuing surveillance of the professional performance of all  
40 individuals in the Medical Staff who have delineated clinical privileges.  
41

42 Responsible in conjunction with the Clinical Service Chiefs for the  
43 continuous assessment and improvement of the quality of care and  
44 provided services and for the maintenance of quality control programs as

1 appropriate.

2  
3 Co-chairs the Bylaws Committee, when enacted, in conjunction with the  
4 Immediate Past Chief of Staff to foster open communication of Bylaws  
5 changes between the administrative body and medical staff proper.  
6

7 **Position Requirements:** The individual occupying this position must  
8 meet the Qualifications of Officers, Medical Staff Bylaws Article IV, Section  
9 2. Prior successful service as a Department/Clinical Service Chief,  
10 Credentials Committee member, Board member, Medical Executive  
11 Committee member or other similar Medical Staff leadership position is  
12 required. Individuals occupying this position should have received  
13 education and training concerning medical administrative activities and  
14 Medical Staff leadership as requested by Hospital Administration and  
15 Medical Staff Services.  
16

17 **3) Vice Chief, Sycamore Medical Center**

18  
19 **Reports to:** Chief of Staff and the Medical Executive Committee  
20

21 **Position Purpose:** To provide leadership to the Medical Staff who  
22 practice primarily at Sycamore Medical Center (SMC) and promote  
23 effective communication between those physicians, hospital administration  
24 and other members of the Medical Staff leadership.  
25

26 **Accountabilities and Functions:** Assists the Chief Staff as directed by  
27 the Chief of Staff and the Medical Executive Committee for issues relating  
28 to Sycamore Medical Center.  
29

30 Meets regularly with the President for SMC and the physician  
31 representatives for the departments and services lines.  
32

33 Meets regularly with the officers of the Medical Staff to discuss current  
34 concerns and develop plans and goals for SMC within the network.  
35

36 Is responsible to provide written communication at MEC regarding  
37 development of the campus and the delivery of care at SMC as well as  
38 problems and ongoing issues of concern.  
39

40 Is a member of the Medical Executive Committee and attends Quarterly  
41 Medical Staff Meetings.  
42

1 Will assist the Chief of Staff with disciplinary issues, including Medical  
2 Records and Behavioral Concerns, involving providers who practice  
3 primarily at SMC or which occur on the SMC campus.

4  
5 Will assist the Administration at SMC with amending behavior of those  
6 providers who do not fulfill their obligations as outlined in the Bylaws.

7  
8 Will be available to the members of the Medical Staff who practice  
9 primarily at SMC to discuss their hospital related concerns, to assist in  
10 resolution if possible and to bring those concerns back to the Medical Staff  
11 officers and the MEC where warranted.

12  
13  
14 **Position Requirements:** Must meet the Qualifications of Officers as  
15 outlined in the Bylaws. Prior successful service as a Department/Clinical  
16 Service Chief, Medical Staff Committee participation, board member or  
17 similar leadership experience is required.

18  
19 **4) Vice Chief, Medical Staff Credentials Program**

20  
21 **Report to:** Chief of Staff and Medical Executive Committee.  
22 Recommendations are carried forward by the Chief of Staff to the  
23 Professional Practice Committee and then to the Board of Directors for  
24 final approval.

25  
26 **Position Purpose:** To provide oversight for the Credentials Program of  
27 KMC and direction to the hospital Board of Directors in credentialing  
28 members of the Medical Staff. To maintain compliance with the  
29 credentialing policies of the hospital, TJC and applicable law.

30  
31 The goal of the Credentials Program is to minimize potential liability, to  
32 clearly define granted privileges, ascertain the provider's qualifications to  
33 perform granted privileges, periodically review information from legal,  
34 ethical and performance data that impact the provider's privileges and to  
35 minimize the effect of social, economic, political and other non-medical  
36 factors on credentialing.

37  
38 **Accountabilities and Functions:** Together with the VPMA will develop,  
39 edit and maintain, on behalf of the board, a fully documented Credentials  
40 Manual complete with all forms, form letters, policies and procedures,  
41 criteria for clinical privileges and associated policies that are utilized in the  
42 credentials process. Will also assure that each new applicant for Medical  
43 Staff appointment and each existing staff member is aware of existing  
44 pertinent policies and the process to access them in detail should they so

1           desire.

2  
3           Will be responsible for monitoring the processing of all applications for  
4           appointment/reappointment and clinical privileges for the purpose of  
5           assuring that existing Medical Staff policies, TJC standard and state  
6           requirements are followed.

7  
8           Will oversee processing of requests for all appointments to the Medical  
9           and will specifically review those applications that fall outside of guidelines  
10          for “clean” application.

11  
12          Will assist the Chief of Staff in appointing representative members to the  
13          Credentials Committee and will Chair said committee. The purpose of the  
14          committee will be to assist and advise the Vice Chief in all aspects of the  
15          credentials program. The Credentials Committee will meet on an as  
16          needed basis, a minimum of six (6) times per year. Minutes and  
17          recommendations from each meeting will be submitted by the Chair to the  
18          MEC for further presentation to the Professional Practice Committee and  
19          subsequently, the hospital board.

20  
21          The Vice Chief in conjunction with the VPMA is responsible to enable the  
22          Manager to maintain accurate and complete documentation concerning  
23          the entire credentialing process. This includes the maintenance, security,  
24          storage and retrievability of credentials’ files, minutes and other  
25          documents pertaining to the overall credentials program within the hospital  
26          and the processing of individual applications for appointment and clinical  
27          privileges.

28  
29          **Position Requirements:** Individuals occupying this position must meet  
30          the Qualifications of Officers as delineated in Medical Staff Bylaws. Prior  
31          service as a Clinical Service Chief, Board member, Medical Executive  
32          Committee member, or other similar Medical Staff leadership position is  
33          required. Past participation on Credentials Committee is highly  
34          recommended. Specific training is necessary for performance and will be  
35          recommended by the immediate past Credentials Chair.

## 36 37 38   **1.2.2 Medical Staff Clinical Service Chiefs**

39  
40          **Reports to:** Chief of Staff

41  
42          **Position Purpose:** The purpose of this position is to provide leadership to  
43          those clinical services who choose to organize to discuss policies, service  
44          needs, programs, and other issues affecting the provision of patient care

1 by providers in the clinical service.  
2

3 **Reporting Relationship:** Clinical Service Chiefs report directly to the  
4 Chief of Staff, Medical Executive Committee and through written  
5 communication to the credentials committee.  
6

7 **Accountabilities and Functions:** Attend the Medical Executive  
8 Committee and provide formal and informal positions on issues affecting  
9 the provision of patient care by providers in the clinical service. The  
10 service chief is selected by the clinical service to serve a two-year term.  
11

12 **Responsibilities:** as outlined in the Medical Staff Bylaws.  
13

14 **Position Requirements:** Individuals occupying this position must be  
15 Active members of the Medical Staff, having held that position for at least  
16 three (3) years. Board certified within their respective specialty.  
17

### 18 **1.2.3 Assistant Medical Staff Clinical Service Chiefs**

19 **Report to:** Medical Staff Clinical Service Chief  
20

21 **Position Purpose:** The purpose of this position is to assist the respective  
22 Clinical Service Chief to provide leadership to those clinical services who  
23 choose to organize to discuss policies, service needs, programs, and  
24 other issues affecting the provision of patient care by providers in the  
25 clinical service.  
26

27 **Reporting Relationship:** The assistant Clinical Service Chief reports  
28 directly to the respective Clinical Service Chief, and if directed the Chief of  
29 Staff, Medical Executive Committee and/or other appropriate committees.  
30

31 **Accountabilities and Functions:** Regularly attends the Clinical Quality  
32 Review Committee and other committees as appointed in order to provide  
33 formal and informal positions on issues affecting the provision of patient  
34 care by providers in the clinical service. The assistant Clinical Service  
35 Chief is selected by the active members of the respective clinical service  
36 to serve a two-year term.  
37

38 **Responsibilities:** as outlined in the Medical Staff Bylaws.  
39

40 **Position Requirements:** Individuals occupying this position must be  
41 Active member of the Medical Staff, having held that position for at least  
42 three (3) years. Board certification within their respective specialty.  
43  
44



1  
2 **2.3 CREDENTIALS COMMITTEE**  
3

4 **2.3.1 Composition**  
5

6 The Credentials Committee shall be composed of the Vice Chief, Medical Staff  
7 Credentials Program, the immediate past vice chief (ex officio), the immediate  
8 past Chief of Staff (ex officio), the Vice President of Medical Affairs, and a Board  
9 member (ex officio) and representatives from each of the following clinical  
10 services: Anesthesiology, Emergency Medicine, Family Medicine, Internal  
11 Medicine, Medical Imaging, Obstetrics/Gynecology, Orthopedics, Pathology,  
12 Pediatrics, and Surgery. The Vice Chief shall be an elected position. Nomination  
13 and election of the Vice Chief shall occur biannually by the process outlined in  
14 the Bylaws. This person may serve consecutive two-year terms. Member  
15 appointments shall be for terms of three years. The Chief of Staff shall appoint  
16 new clinical service representatives after receipt of nominations from the clinical  
17 service chiefs.  
18

19 **2.3.2 Duties**  
20

- 21 a. The Credentials Committee shall investigate the qualifications of all  
22 applicants for appointment and shall review the Clinical Services  
23 assignments and privileges requested.  
24
- 25 b. At an interval no greater than every twenty-four (24) months, it shall  
26 review all information available on each appointee, including  
27 recommendation from the clinical service chiefs. This information shall be  
28 used for the purpose of determining its recommendations for  
29 reappointment to the Medical Staff, appoints to the clinical Service and for  
30 the granting of clinical privileges. The committee shall transmit its  
31 recommendations in writing, which may be reflected by its minutes, to the  
32 Medical Executive Committee. Where non-reappointment or a change in  
33 clinical service or privileges is recommended, the reason(s) for such  
34 recommendation shall be stated and documented.  
35
- 36 c. The Credentials Committee shall review qualifications of all Allied Health  
37 Professionals, subject to recommendation of the Allied Health  
38 Professionals Council, clinical service chief, prior to their being permitted  
39 access to patients and their medical records, and the committee shall  
40 establish processes as necessary to accomplish this review.  
41
- 42 d. The Credentials Committee shall establish criteria for new procedures,  
43 provided such procedures are approved to be performed at the Hospital

1 and evaluate the qualifications of any practitioner applying for these  
2 privileges.

- 3  
4 e. The Vice Chief of the Medical Staff Credentials Program and/or designee,  
5 shall be available to meet with the Board or its applicable committee on all  
6 recommendations that the Credentials Committee may make. The  
7 Credentials Committee may also create an ad hoc committee to deal with  
8 specific concerns.  
9

### 10 **2.3.3 Meetings, Reports and Recommendations**

11  
12 The Credentials Committee shall meet as often as necessary to accomplish its  
13 duties but at least six (6) times a year. The committee shall maintain a  
14 permanent record of its proceedings and actions, and report its  
15 recommendations to the Medical Executive Committee with a copy to the  
16 President and the Board.  
17

## 18 **2.4 WELLNESS COMMITTEE**

### 19 **2.4.1 Purpose and Meetings**

- 20  
21  
22  
23 a. The Wellness Committee is a Medical Staff oversight committee whose  
24 primary purpose is not to discipline but rather to identify, assist and foster  
25 rehabilitation of impaired Medical Staff members and non-members with  
26 clinical privileges or duties. The Wellness Committee's processes are  
27 separate from the medical staff disciplinary function. An impaired  
28 individual is one who is unable, or potentially unable to practice medicine  
29 with reasonable skill and safety to patients because of physical or mental  
30 illness, including deterioration through the aging process or loss of motor  
31 skills, or excessive use or abuse of drugs including alcohol.  
32  
33 b. The committee serves to educate the Medical Staff and other Kettering  
34 Medical Center staff about health, addressing prevention of physical,  
35 psychiatric or emotional illness and impairment recognition issues specific  
36 to physicians and others with Medical Staff privileges including facilitation  
37 of confidential diagnosis, treatment and rehabilitation from potentially  
38 impairing conditions;  
39  
40 c. The committee will encourage self-referral and referral by other Kettering  
41 Medical Center staff.  
42  
43 d. The committee will examine the evidence for impairment of Medical Staff  
44 members and others with Medical Staff privileges including evaluation of

1 the credibility of a complaint, allegation or concern;

- 2
- 3 e. The committee will facilitate referral of the affected person, if indicated, to
- 4 the appropriate professional internal or external resources for diagnosis
- 5 and treatment of the condition or concern;
- 6
- 7 f. Committee members will seek to maintain confidentiality of the person
- 8 seeking referral or referred for assistance, except as limited by law, ethical
- 9 obligation, or when safety of a patient or staff is threatened;
- 10
- 11 g. The committee will provide support to Medical Staff members with
- 12 impairment while monitoring recovery including safety of patients until the
- 13 rehabilitation or disciplinary process is completed, while maintaining
- 14 confidentiality;
- 15
- 16 h. The committee will report to the Medical Staff leadership instances in
- 17 which a recovering person is providing unsafe treatment to patients.
- 18
- 19 i. The committee will meet at least yearly, and as needed;
- 20
- 21 j. The functions of the committee include reviewing concerns in an orderly
- 22 fashion that have been received by the Chief of Staff and monitoring
- 23 current cases of physician impairment. Concerns about impairment will be
- 24 taken to the next scheduled meeting, or sooner at the discretion of the
- 25 chair. When problems are presented, documentation will be obtained in a
- 26 timely fashion. Suggestions or allegations of physician impairment will be
- 27 investigated in a thorough manner;
- 28
- 29 k. When the committee finds that a formal, professional evaluation is
- 30 necessary to determine whether a problem truly exists, it will carry out an
- 31 intervention in confidence, encouraging the suspected impaired physician
- 32 to voluntarily submit to the evaluation. If necessary, the committee may
- 33 seek the help of the Montgomery County Medical Society Physician's
- 34 Effectiveness Committee and/or the Ohio State Medical Association
- 35 Physician's Effectiveness Program to do an intervention. Any intervention
- 36 will be attended by the Chief of Staff, or his/her designee, who will deliver
- 37 executive decision for definitive action, i.e., requirement of a formal
- 38 evaluation. The physician will be encouraged to take a voluntary leave of
- 39 absence or face precautionary suspension of hospital privileges.
- 40 Immediacy of response for evaluation will depend on the magnitude of the
- 41 perceived problem. If there is still inability to obtain compliance, the
- 42 physician will be reported to the Ohio State Medical Board and to the
- 43 Medical Executive Committee.
- 44

- 1           i.     When a physician comes to the hospital acutely impaired, the Chief of  
2           Staff, Clinical Service Chief or his/her designee, will be notified promptly,  
3           and if appropriate, will remove the physician from the situation that risks  
4           patient care. The Wellness Committee will be notified of this action and  
5           shall investigate and determine whether additional action is required.  
6  
7           m.     The committee is delegated the responsibility of establishing protocols for  
8           the evaluation and treatment of Medical Staff members whose physical or  
9           mental capacity is questioned. Any physical or mental condition, which  
10          would reasonably be expected to impair the practitioner, could subject the  
11          Medical Staff member to investigation. Such investigations are to be  
12          conducted in a confidential and impartial manner.  
13

#### 14   **2.4.2 Composition**

15  
16   The membership of the committee shall consist of ten (10) members. There are eight  
17   (8) members of the Medical Staff, appointed by the Chief of Staff, preferably not service  
18   chairpersons or members of the Medical Executive Committee. There are two (2)  
19   additional members - the Vice President Medical Affairs and the Chief of Staff.  
20  
21

### 22   **2.5 PERFORMANCE IMPROVEMENT COUNCIL**

#### 23   **2.5.1 Purpose and Meetings**

- 24  
25  
26          a.     The Performance Improvement Council is a joint committee that establishes  
27          the PI priorities and provides formal information sharing between the Clinical  
28          Quality Department and the leadership of both Hospital Administration and  
29          Medical Staff. The PIC has the responsibility to charter, oversee and  
30          regularly evaluate PI programs for the organization. The council receives and  
31          acts on summary reports from clinical and administrative committees as well  
32          as functions which track and trend information on monitoring activities. It  
33          makes recommendations for performance improvement and effectively  
34          communicates those recommendations to the professional staff and hospital  
35          groups with related responsibilities as specified in the Performance  
36          Improvement Plan.  
37  
38          b.     PIC oversees organizational efforts to measure, assess and improve clinical  
39          activities at the various levels of organizational leadership, functional area and  
40          clinical service and it is responsible for coordinating efforts to evaluate and  
41          monitor resource consumption and utilization management.  
42  
43          c.     PIC coordinates, prioritizes and monitors the Medical Staff, Hospital and  
44          Medical Education data gathering and analysis components of the Quality

1 Review program performance improvement activities using PDCA  
2 methodology, and coordinates the Medical Staff activities in these areas with  
3 those of the other professional and support services in the Hospital.  
4 Individualized physician/resident data identified through performance  
5 improvement processes will be referred to the Chief of Staff and/or CQRC as  
6 needed for further evaluation according to Medical Staff peer review process.  
7

- 8 d. PIC annually evaluates KMC's overall performance improvement program for  
9 its comprehensiveness, integration, effectiveness and cost efficiency and  
10 revises that plan as needed.
- 11
- 12 e. PIC reviews clinical risk management events, including root cause analyses  
13 of sentinel events, morbidity concerns and aggregate data on significant high  
14 risk events to identify possible patterns and communicate that information to  
15 the professional staff and hospital groups with related responsibilities.
- 16
- 17 f. PIC periodically oversees the development and implementation of hospital  
18 safety programs and an emergency preparedness plan that addresses  
19 disasters, both hospital and community.
- 20
- 21 g. Reviews annual the Hospital Hazard Vulnerability Analysis (HVA) objectives  
22 and scope of the Emergency Operations Plan, Environment of Care, Staffing  
23 Effectiveness, Plan for Patient Care, Patient Safety Plan and the Performance  
24 Improvement Plan.
- 25
- 26 h. PIC establishes formats for the aggregation, display and reporting of data and  
27 findings as well as a system of follow-up to determine that recommended  
28 actions are implemented. It formats and schedules submissions of data and  
29 findings, committee minutes and special reports such that the entire clinical  
30 performance of the organization is monitored, the data is reported in a  
31 structured and comprehensive manner, and appropriate recommendations  
32 can be made based on that data to provide care within our institution of the  
33 highest quality.  
34  
35

36 The Performance Improvement Council meets at least quarterly and as dictated  
37 by need and reports to the Medical Executive Committee and Hospital executive  
38 council.  
39

## 40 41 **2.5.2 Composition**

42  
43 The composition of the Performance Improvement Council will total twenty (20)  
44 members equally representing Medical Staff and administration including the

1 following:

2  
3 Chief-Elect, Medical Staff - Co-chair; Vice President Medical Affairs, Kettering  
4 Medical Center - Co-chair; KMC President; KMC Vice Presidents; President,  
5 Medical Staff; Vice Chief - Sycamore Medical Center.

## 6 7 **2.6. UTILIZATION REVIEW COMMITTEE**

### 8 9 **2.6.1 Purpose**

10 Review and oversee ongoing issues regarding effective utilization of resources,  
11 including case-specific utilization, physician and physician group profiling, unit  
12 and service line trending.

13  
14  
15 a. The Utilization Review Committee is a joint medical/administration council  
16 which develops and amends annually a utilization management plan for  
17 approval by the Medical Executive Committee and Hospital Executive  
18 Council. The plan must apply to all patients regardless of payment source,  
19 outline the confidentiality and conflict of interest policy, and include  
20 provision for at least:

- 21  
22 (1) Review of admissions and medical necessity of admissions,  
23 continued hospital stays and the use of clinical support services;  
24 (2) Discharge planning;  
25 (3) Data collection and reporting requirements;  
26 (4) Use of written, objective, measurable criteria in conducting the  
27 reviews.

28  
29 b. Develop a matrix that would assist the organization with decision making  
30 and tracking including analysis of utilization profiles on a periodic basis  
31 and prepare written evaluations of the utilization review and management  
32 activities on a continuous basis, with a determination of their effectiveness  
33 in allocating resources.

34  
35 c. Review, approve and recommend to Performance Improvement Council  
36 and the Medical Executive Committee all new carepaths and new  
37 associated standing orders and as needed, revisions to existing carepaths  
38 and associated standing orders. The criteria for implementing new  
39 carepaths/standing orders and/or continuing or revising existing  
40 carepaths/standing orders include the following: high volume, high risk,  
41 high cost and/or problem prone diseases or DRG's; recommended or  
42 selected measures pertinent to decision points, outcomes and variations  
43 related to compliance; modifications necessary to support specific level of  
44 locus of guideline implementation; whether the guidelines assist

1 practitioner in making decisions about appropriate health care for specific  
2 clinical circumstances; guidelines based on current professional  
3 knowledge; mechanisms for disseminating information about  
4 implementation of selected guidelines. The provider(s) who use the  
5 guidelines will be a part of the multidisciplinary team who recommend the  
6 carepaths to the Utilization Review Committee.  
7

## 8 **2.6.2 Composition**

9 The Utilization Review Committee will be co-chaired by the Medical  
10 Director for Clinical Quality and by a physician appointed by the Chief of  
11 Staff. The council will have fifteen (15) total members appointed by  
12 administration and by the Chief of Staff as outlined below:  
13

- 14 ▪ Director, Home Care
- 15 ▪ ED Physician
- 16 ▪ Chair, ICU Committee
- 17 ▪ Surgeon
- 18 ▪ Hospitalist
- 19 ▪ Medicine Residency Program Director
- 20 ▪ Finance representative
- 21 ▪ Manager, Case Management
- 22 ▪ Manager, Clinical Documentation
- 23 ▪ Decision Support Staff
- 24 ▪ Director, Patient Access
- 25 ▪ Corporate Compliance representative
- 26 ▪ Vice President, Medical Affairs – committee sponsor  
27

## 28 **2.7 CLINICAL QUALITY REVIEW COMMITTEE**

### 29 **2.7.1 Purpose and Meetings**

30  
31  
32 The committee will identify and determine initial peer review issues and  
33 coordinate, track and trend clinical quality patterns and/or concerns a death  
34 reviews at Kettering and Sycamore Medical Centers.  
35

36 The Clinical Quality Review Committee will:

- 37  
38 a. conduct review of surgical cases which fail to meet predetermined criteria.  
39 These criteria may include: documentation, tissue examination, indications  
40 for surgery and post operative care.  
41
- 42 b. review and evaluate external data as it is necessary to understand the  
43 care that is being examined by the committee.  
44

- 1 c. monitor and assess utilization of blood and blood components, including  
2 evaluation of appropriateness of all blood component transfusions, review  
3 of all confirmed transfusion reactions in a timely manner, conduct review  
4 of ordering practices for blood and blood products, distributing, handling,  
5 and dispensing; administering; and monitoring blood and blood component  
6 effects on patients.  
7

## 8 **2.7.2 Composition**

9  
10 This committee will be appointed by the Chief of Staff to include among others  
11 appropriate assistant Clinical Service Chiefs. It will meet at least quarterly and  
12 as needed and will report its findings to the Medical Executive Committee.  
13

## 14 **2.8 PHARMACY & THERAPEUTICS COMMITTEE**

### 15 **2.8.1 Purpose and Meeting**

- 16  
17  
18 a. Serves as a regulatory and advisory committee to the Medical Staff and  
19 Hospital administration in all matters pertaining to the evaluation, selection  
20 and utilization of medications, including equipment used to prepare and  
21 administer medications;  
22  
23 b. Recommends or assists in the formulation of educational programs  
24 designed to meet the needs of physicians, nurses, pharmacists or other  
25 health care practitioners on matters related to the selection, administration  
26 and monitoring of medication use;  
27  
28 c. Develops and maintains a formulary of drugs accepted for use in the  
29 hospital and provides for its appropriate revisions. The selection and  
30 review of these drugs will be based on objective evaluation of their relative  
31 merit, safety and cost;  
32  
33 d. Establishes programs and procedures that help ensure cost effective drug  
34 therapy using indicators of patient outcome in their assessment;  
35  
36 e. Reviews adverse drug reactions and develop programs to minimize their  
37 occurrence;  
38  
39 f. Collects data, monitors and recommends process improvement to the  
40 institution and the Medical Staff, regarding the procurement, storage and  
41 distribution; prescribing or ordering; preparing and dispensing;  
42 administering; and monitoring the effects on patients of medications used  
43 in the hospital and enteral nutrition products in the hospital;  
44

- 1 g. Reviews medication errors and determine actions which should be taken  
2 to minimize their occurrence;
- 3
- 4 h. Develops a medication safety program for the institution that incorporates  
5 The Joint Commission's National Patient Safety Goals and  
6 recommendations from accrediting bodies into a plan that promotes safe  
7 medication administration and reduces preventable medication errors;  
8
- 9 i. Recommends to the Medical Staff and institution policies regarding  
10 nutrition care issues.
- 11
- 12 j. Establishes priorities for ongoing assessment of medication used in the  
13 Hospital.
- 14
- 15 k. Monitors the Anticoagulation Management program for efficiency and  
16 effectiveness;
- 17
- 18 l. Reports regularly to the Performance Improvement Council and  
19 recommends short term projects to improve acutely identified issues.  
20
- 21 m. Reports to MEC those items that require approval and independent  
22 participation by the medical staff.  
23

## 25 **2.8.2 Composition**

- 26
- 27 a. The Pharmacy & Therapeutics Committee is a joint Medical Staff/hospital  
28 committee. Its membership consists of representatives from the Medical  
29 Staff, nursing, pharmacy, nutrition services and other health care  
30 providers. The chair shall be appointed by the Chief of Staff and the  
31 members appointed jointly by the Chief of Staff and the Hospital executive  
32 committee. The number of members will not exceed twenty (20).  
33
- 34 b. The committee may appoint subcommittees as needed and the chair or  
35 director of pharmacy may invite non-members to attend as needed.  
36
- 37 c. The P & T Committee will meet at least quarterly and reports to both PIC  
38 and MEC as appropriate.  
39

## 41 **2.9 OPERATING ROOM COMMITTEE**

### 43 **2.9.1 Purpose and Meetings**

1 a. Operating Room Committee shall be responsible for the following: the  
2 Operating Rooms (OR), the Post Anesthesia Care Units (PACU), the  
3 Ambulatory Surgery Center (ASC), the Pre Admission Testing (PAT)  
4 services including the "Pre-Operative Clinic", and the Central Sterile  
5 Processing (collectively PeriOperative Services) at Kettering and  
6 Sycamore Medical Centers:

- 7
- 8 (1) review, revise and develop policies and procedures for the  
9 operating room and PACU;
  - 10
  - 11 (2) recommend policy revisions to Medical Executive Committee for  
12 approval;
  - 13
  - 14 (3) monitor compliance with operating room and PACU policies;
  - 15
  - 16 (4) monitor and evaluate effectiveness of operating room policies  
17 including patient safety issues.
  - 18
  - 19 (5) upon request provide comments to the credentials committee  
20 regarding physicians use of the operating room and PACU;
  - 21
  - 22 (6) review and prioritize requests for capital equipment, instruments  
23 and medical supplies;
  - 24
  - 25 (7) serve as liaison for clinical services;
  - 26
  - 27 (8) foster performance improvement activities;
  - 28
  - 29 (9) review and comply with regulatory and accrediting agencies.
  - 30

31 b. The chair of the Operating Room Committee may in urgent situations:

- 32
- 33 (1) resolve disputes among surgeons or between surgeons and  
34 hospital personnel;
  - 35
  - 36 (2) enforce the policies of the operating room and PACU;
  - 37
  - 38 (3) interpret policies of the operating room and PACU, if necessary,  
39 between meetings of the OR committee.
  - 40

41 The Operating Room Committee will meet no less than quarterly or as needed and  
42 report to the Performance Improvement Council, KMC Hospital Executive Council, and  
43 to the Medical Executive Committee, as appropriate.

1 **2.9.2 Composition**

2  
3 The chair and representatives from the following clinical services are jointly  
4 appointed by the Chief of Staff and KMC Hospital executive council: Anesthesia,  
5 cardiovascular-thoracic, neurosurgery, ob/gyn, ophthalmology, orthopedics,  
6 otolaryngology, plastic surgery, urology, and vascular surgery. Hospital  
7 representation may include the following: Director of Peri-Operative Services,  
8 Hospital President, Chief Nursing Officer, Chief Financial Officer, Scheduling,  
9 Senior Executive Officer, Vice President – Medical Affairs, Vice President,  
10 Clinical Services – Sycamore Medical Center, Surgery Business Manager,  
11 Clinical Operations Director, ASC-PACU Manager, PAT-SDM-GI, and Sycamore  
12 OR Manager. Total Medical Staff and hospital representation will not exceed  
13 thirty (30) members.

14  
15 **PART 3. COMMITTEE MEETING AND PROCEDURES**

16  
17 **3.1 Notice of Committee Meetings**

18  
19 Written notice of any regular or special committee meeting not held pursuant to  
20 resolution will be provided to all persons entitled to be present thereafter not less than  
21 ten (10) days before the date of such meeting. Personal attendance at a meeting  
22 constitutes a waiver of notice of such meeting, except when a person attends a meeting  
23 for the express purpose of objecting, at the beginning of the meeting, to the transaction  
24 of any business because the meeting was not duly called or convened.

25  
26 **3.2 Manner of Action**

27  
28 Except as otherwise specified, the action of a majority of the members present and  
29 voting at a meeting at which a quorum is present is the action of the group. In unusual  
30 circumstances action may be taken without a meeting by the Staff, service or committee  
31 by presentation of the question to each member eligible to vote, in person or by mail,  
32 and their vote returned to the chair of the group or to the president in the case of a Staff  
33 vote. Such vote shall be binding so long as the question is voted on by at least the  
34 number of voting members of the group that could constitute a quorum.

35  
36 **3.3 Minutes**

37  
38 Minutes of all meetings, except as noted in the bylaws, shall be prepared and include a  
39 record of attendance and the vote taken on each matter. Minutes are to be signed by  
40 the presiding chair or officer, forwarded to the Medical Executive Committee or the  
41 parent committee in the case of a subcommittee and presented to the attendees at a  
42 subsequent meeting for acceptance. Minutes shall be made available, upon request to  
43 and at the discretion of the president, to any Active Staff member who functions in an  
44 official capacity within the Hospital so as to have a legitimate interest in them. When

1 access is approved, it shall be afforded in a manner consistent with the confidentiality  
2 policies of the Hospital concerning Medical Staff minutes and activities. A permanent  
3 file of the minutes of each meeting shall be maintained.  
4  
5

## 6 **PART 4. MEDICAL STAFF MEETINGS**

7

### 8 **4.1 Medical Staff Meetings**

9

- 10 a. The Medical Staff shall meet quarterly throughout the medical staff year.  
11 One of these will be designated by the MEC as an annual meeting.  
12 Written notice of these meetings shall be sent at least seven (7) days in  
13 advance to all appointees and shall also be conspicuously posted.  
14
- 15 b. The primary objective of the meetings shall be to report on the activities of  
16 the Medical Staff and to conduct other business as may be on the agenda.  
17 Written minutes of all meetings shall be prepared and recorded.  
18

### 19 **4.2 Special Meetings**

20

- 21 a. The Chief of Staff may call a special meeting of the Medical Staff at any  
22 time. The Chief of Staff shall call a special meeting within twenty (20)  
23 days after receipt of a written request signed by not less than ten percent  
24 (10%) or fifty (50) members, whichever is less, of the active medical staff,  
25 or upon resolution by the Medical Executive Committee. Such request or  
26 resolution shall state the purpose of the meeting. The Chief of Staff shall  
27 designate the time and place of any special meeting.  
28
- 29 b. Written or printed notice stating the time, place, and purpose of any  
30 special meeting of the Medical Staff shall be conspicuously posted and  
31 shall be sent to each member of the Medical Staff at least ten (10) days  
32 before the date of such meeting. The attendance of a member of the  
33 Medical Staff at a meeting shall constitute a waiver of notice of such  
34 meeting. No business shall be transacted at any special meeting, except  
35 that stated in the notice of such meeting.  
36
- 37 c. A special meeting of any committee or clinical service may be called by  
38 the chair, clinical service chief, medical director, or a medical staff officer.  
39

### 40 **4.3 Regular Meetings of Clinical Services and Committee**

41

42 Regular meetings shall be those clinical service meetings as well as medical staff  
43 and/or hospital committees that are identified in the Bylaws and related manuals.

1 Committees may, by resolution, provide the time for holding regular meeting  
2 without notice other than such resolution.

3  
4 Each clinical service is required to have a minimum of four meeting a year.

5  
6 Each committee of the Medical Staff shall hold its first meeting of the calendar  
7 year at a time and place designated by the Chief of Staff subject to review by the  
8 Medical Executive Committee. The Chief of Staff or each committee chair shall  
9 establish a time for regular meetings, shall select a recorder to record minutes of  
10 meetings, and shall adopt such rules of procedure necessary to accomplish the  
11 purposes for which the committee was established.  
12

#### 13 14 **4.4 Quorum**

15  
16 **4.4.1 Medical Staff Meetings.** Those Active staff members present.

17  
18 **4.4.2 Medical Executive Committee.** Fifty percent (50%) of the voting  
19 members of the committee. If the clinical service representative attends  
20 less than 50% of these meetings, the clinical service will be asked to  
21 nominate a replacement.  
22

23 **4.4.3 Credentials Committee.** Minimum of five (5) medical staff members.

24  
25 **4.4.4 Performance Improvement Committee.** A minimum of three (3) medical  
26 staff members.  
27

28 **4.4.5 Committee/Clinical Service Meetings.** Those active members present.  
29

#### 30 **4.5 Attendance Requirements**

31  
32 **4.5.1 Meeting Attendance.** All members of the Medical Staff are encouraged  
33 to attend meetings of the Medical Staff. Meeting attendance is required  
34 for active Medical Staff members. At a minimum, each active medical  
35 staff member is required to attend at least fifty percent (50%) of clinical  
36 service meetings and fifty percent (50%) of the quarterly medical staff  
37 meetings. Meeting attendance will not be used as the sole criteria by the  
38 Credentials Committee in evaluating physicians, podiatrists, psychologists,  
39 and dentists at the time of reappointment. Active Medical Staff members  
40 who do not meet attendance requirements will be subject to assignment to  
41 probationary status and other corrective or administrative disciplinary  
42 measures as determined by the Medical Executive Committee. Meeting  
43 attendance will be considered by the Credentials Committee in evaluating  
44 practitioner at the time of reappointment.

1  
2 **4.5.2 Attendance by members of the Medical Executive, Credentials, and**  
3 **Performance Improvements Committees.** Members of the Medical  
4 Executive Committee, Credentials Committee, and Performance  
5 Improvement Council, are expected to attend at least fifty percent (50%) of  
6 the meetings held. The Medical Executive Committee may require  
7 Medical Staff meeting attendance on any Medical Staff, joint Medical  
8 Staff/hospital committee or clinical service meetings.  
9

10 **4.6 Participation by Chief of Staff**

11  
12 The Chief of Staff and/or any representative assigned by the Chief of Staff may  
13 attend any committee or clinical service meetings of the medical staff.  
14

15 **4.7 Robert's Rules of Orders**

16  
17 The latest edition of Robert's Rules of Orders shall prevail at all meetings of the  
18 Medical Staff, Medical Executive Committee and clinical service meetings unless  
19 waived, except that the chair may vote at any meeting.  
20

21 **4.8 Rights of Ex Officio Members**

22  
23 Except as otherwise provided in the Bylaws and related manuals, persons  
24 serving as ex officio members of a committee shall have all rights and privileges  
25 as regular members.  
26  
27

28 **PART 5. RULES AND REGULATIONS**

29  
30 **1. Out-patient (Ambulatory), Observation and Admission Status**

- 31  
32 a. Provisional Diagnosis and Status: No patient shall be admitted to the  
33 Hospital until a provisional diagnosis has been stated and the consent of  
34 the admitting physician, or his alternate, secured. It is the attending  
35 practitioner's responsibility, which may be delegated to the case manager  
36 if allowed by the third party administrator, to correctly assign on the initial  
37 order sheet the patient's appropriate status, such as out-patient  
38 (ambulatory), observation or admission. Case manager to notify  
39 practitioner of the patient's admission status. Justification for the  
40 assignment of status should reflect Medical Staff approved criteria.  
41  
42 b. Patients: The Hospital shall accept patients suffering from all types of  
43 diseases except those whose medical needs are beyond the scope of  
44 care provided at a facility of Kettering Medical Center. Patients presenting

1 to a facility of Kettering Medical Center for treatment outside the hospital's  
2 scope of service will be stabilized and transferred to another appropriate  
3 facility.

- 4  
5 c. Protection of Other Persons: Practitioners admitting patients shall be held  
6 responsible for giving such information as may be necessary to assure the  
7 protection of other patients and personnel from those who are a source of  
8 danger from any cause whatever or to assure the protection of the patient  
9 from self-harm.

10  
11 This Hospital has the obligation of minimizing the risk of hazards and  
12 safeguarding all patients, visitors and personnel. Therefore, when any  
13 patient whose mental or physical condition causes him/her to be disturbing  
14 and/or unsafe to himself, other patients, and personnel of this hospital, the  
15 patient will be transferred to a private room, at his/her own expense. This  
16 transfer will be discussed with and approved by the attending physician. In  
17 case of disagreement, the appropriate Clinical Service Chief will be  
18 contacted, and if a mutual decision with the attending physician cannot be  
19 rendered, a Medical Staff officer or designee, shall be consulted and a  
20 final disposition made.

21  
22 When transferred to a private room, the patient must have twenty-four  
23 hour supervision, also at his/her own expense. If unable to afford the cost  
24 of special duty nursing, relatives or others acceptable to the attending  
25 physician and the vice president patient care of the medical center may be  
26 permitted to attend the patient. These individuals must remain with the  
27 patient continuously. If the above procedures are not acceptable to the  
28 physician, patient, or his/her family the physician will be obligated to  
29 transfer the patient from the Hospital or the patient and/or family may sign  
30 the patient out of the Hospital against medical advice. The Vice President  
31 of Patient Care or administrator-on-call should be notified when such a  
32 transfer is indicated.

- 33  
34 d. Transfer of Service: Patient transfer from the admitting physician's care to  
35 another physician is arranged by agreement of current attending physician  
36 and receiving physician whether the transfer is requested by the patient or  
37 patient's surrogate or by the attending physician.

38  
39 To complete a patient transfer of service the attending physician must  
40 order a transfer of service with appropriate documentation of reasons for  
41 transfer in the physician progress notes as well as the receiving physician  
42 documenting acceptance of the patient transfer in the physician progress  
43 notes and orders.

1 e. Assignment of Cases:  
2

3 (1) Service patients shall be attended by members of the Medical Staff  
4 and shall be assigned by the clinical service concerned in the  
5 treatment of the disease which necessitated admission. No  
6 physician shall receive compensation for the attendance of any  
7 patient whose admission is authorized as public or a part-paid  
8 patient except where public funds are legally provided for or where  
9 specific contracts have been arranged for provided professional,  
10 medical or surgical care.

11  
12 (2) It is expected that private patients shall be attended by their own  
13 physician. All physicians with clinical privileges are required to  
14 provide continuity of care to all patients in their practice for whom  
15 they are responsible, and to provide care that is effective, safe,  
16 patient and family centered, efficient, timely and within the  
17 parameters of granted privileges. In the event that a  
18 physician plans to be away from the hospital for a scheduled  
19 absence (e.g. vacation, absences for personal reasons, but not  
20 including a leave of absence as defined in medical staff governing  
21 documents), such physician shall make adequate arrangements  
22 prior to departure to provide physician coverage for his/her private  
23 patients that are inpatients or who may present to the Emergency  
24 Department while the physician is away on such planned absence.  
25 The physician, unless in a group practice in which all practitioners  
26 have common privileges or are in a designated call coverage group  
27 made known in advance to the medical staff services department,  
28 shall notify the Medical Staff Services Department and the  
29 Emergency Department of such period of scheduled absence,  
30 and shall identify the covering physician who shall have similar  
31 Medical Staff privileges, who has agreed in writing to provide this  
32 coverage, and who shall be located within the hospital's geographic  
33 service area and close enough to fulfill their responsibilities to  
34 provide timely care for the private physician's inpatients and/or the  
35 private physician's Emergency Department patients. If the  
36 physician is also scheduled to be on-call during the scheduled  
37 absence, he/she must also provide backup on-call coverage with  
38 another physician who meets the above criteria, and shall notify the  
39 departments as identified above and other hospital  
40 areas/departments as may be required in the bylaws, other related  
41 governing documents and/or medical staff/hospital policies. In the  
42 case of the patient requiring admission who has no attending  
43 physician on staff and does not elect or is unable to choose one,  
44 he/she shall be referred to the appropriate clinical service on-call

1 physician.

2  
3 (3) Physicians to whom these unattached patients are referred have a  
4 responsibility to provide care to the patient at least once for the  
5 problem for which the patient was referred, regardless of ability to  
6 pay and to provide continued care or secure referral to proper  
7 available care provider.

8  
9 (4) Physicians, who assume medical care responsibility for these  
10 unattached patients, are expected to respond to a request from the  
11 Emergency Department to provide consultative or in-hospital care  
12 in a timely fashion, to meet patient medical care needs.

13  
14 (5) All patients who are placed in a hospital bed as inpatient or  
15 observation status are required to be seen by the admitting or  
16 consulting physician in a timely fashion with documentation of that  
17 visit in the medical record. Patients transferred or admitted to an  
18 ICU shall be seen by the attending or consulting physician within a  
19 time frame consistent with the clinical condition of the patient,  
20 usually no longer than twelve (12) hours. Patients placed in a non-  
21 ICU bed as out-patient (ambulatory), observation status or  
22 admission, shall be seen by the admitting or consulting physician  
23 within a time frame consistent with the clinical condition of the  
24 patient, but within twenty-four (24) hours. All patients, with the  
25 exception of normal newborns and residential patients in Kettering  
26 Behavioral Medicine Center, require daily patient visits by the  
27 attending physician or his/her covering physician and these visits  
28 must be documented in the progress notes as a part of usual care.  
29 Medical student progress notes will not be a part of the medical  
30 record until they are signed by a supervising resident or physician.  
31 To provide appropriate continuity of care for patients who are  
32 hospitalized by physicians other than the patient's primary care  
33 physician, the attending is responsible to communicate, when  
34 appropriate, with the primary care physician regarding the patient's  
35 hospital course and the plan of care post hospitalization.

36  
37 **2. Patient Safety**

38  
39 Kettering Medical Center and the Kettering Medical Center's Medical Staff have a  
40 responsibility to promote patient safety and medical error reduction. This is  
41 accomplished through the identification and prevention of medical errors through  
42 the prospective analysis and re-design of vulnerable patient systems, the  
43 promotion of a culture of non-punitive reporting, and the responsibility to tell a  
44 patient if he or she has been harmed by the care provided. Each medical staff

1 member is expected to participate in the patient safety program at KMC by  
2 actively supporting and following the KMC policies and procedures related to  
3 providing safe medical care, including the KMC's Patient Safety Performance  
4 Improvement initiatives and Patient Safety Culture Survey approved by the  
5 Medical Executive Committee, TJC patient safety goals and recommendation,  
6 prevention of sentinel events and informing patients and their families about  
7 unanticipated outcomes of care.  
8

### 9 **3. Utilization**

- 10
- 11 a. The history and physical and progress note must document the patient's  
12 clinical course in sufficient detail to provide a reasonable understanding of  
13 the patient's evolving condition, diagnoses, treatment and plan of care. In  
14 addition, the note must provide sufficient information regarding the  
15 severity of illness and/or intensity of service that requires continued use of  
16 hospital resources.  
17
- 18 b. Medical Staff members are required to provide appropriate diagnoses or  
19 clinical indications to justify diagnostic tests and therapeutic interventions  
20 performed by medical center departments.  
21
- 22 c. Admissions prior to the day of surgery will be permitted if the medical  
23 condition warrants acute hospital admission criteria. If prior approval for  
24 surgery or admission is required by the payor, the Medical Staff member is  
25 responsible (whenever possible) for obtaining such approval prior to  
26 surgery or admission.  
27
- 28 d. If approval for performance of any procedures is required by the third party  
29 payor, such approval must be obtained prior to performance of that  
30 procedure.  
31
- 32 e. It is the practitioner's responsibility to abide by the stipulations made by  
33 the payor for patient services as long as these requirements are  
34 consistent with the Bylaws and Organization Manual of the Medical Staff  
35 and consistent with appropriate standards of care.  
36
- 37 f. Periodic review of the appropriateness of patient care may be made by the  
38 staff of clinical management. Deviations from Medical Staff approved  
39 criteria will be referred to the utilization physician reviewer.  
40

### 41 **4. Peer Review**

42  
43 The peer review function for physicians, licensed independent practitioners, and  
44 those with delineated clinical privileges will be performed with intention to

1 safeguard practitioner confidentiality and to promote objective and unbiased  
2 considerations. The purpose of all peer review is to promote excellent clinical  
3 outcomes and the safety of our patients and staff. Peer review is to be done with  
4 the intention to identify and improve processes which may impair the ideal  
5 delivery of clinical care. Its intent is performance improvement and not  
6 indictment of individuals. Issues of disruptive behavior are not addressed via  
7 peer review (refer to Part 5, Rules and Regulations of this manual). Peer review  
8 is a necessary element of professionalism and all members of the Medical Staff  
9 are expected to actively participate in the process, when requested. Situations  
10 may arise when professionals outside our Medical Staff may be asked to  
11 participate in the peer review process. In this event, the practitioner will be  
12 appraised of this need and will be invited to nominate unbiased individuals for  
13 consideration. When a determination is made of a type 2 or type 3 issue, the  
14 practitioner will be given written notification within 30 days.

15  
16 If a subcommittee is appointed to look into this matter by the Medical Executive  
17 Committee or the Chief of Staff, the subcommittee members will follow the  
18 following guidelines:

- 19  
20 1. Any predetermined review by which criteria are established to evaluate a  
21 diagnosis, treatment outcome, procedure or other parameter must not be  
22 exclusively directed at one physician, and should include all practitioners  
23 involved in the same. This procedure does not preclude an investigation  
24 of an individual practitioner based upon a specific complaint.
- 25  
26 2. Once the initial chart review indicates further inquiry is necessary, the  
27 practitioner involved should be notified in writing that a review will take  
28 place.
- 29  
30 3. The Medical Executive Committee will maintain a file for each investigation  
31 containing the written complaint and all relevant correspondence, clinical  
32 records, and committee minutes. The practitioner who is the subject of  
33 investigation, upon reasonable notice to the Medical Executive Committee,  
34 will be permitted to review all the documents in the file at the Medical Staff  
35 Services Department, except for the written complaint and except for the  
36 witness statements and notes made by the peer review team members  
37 regarding the witness interviews. The file documents are confidential and  
38 are subject to the privileges from disclosure to the persons outside the  
39 review proceedings (Ohio Rev. Code Section 2305.251). The physician  
40 may not retain the file documents or make copies thereof.
- 41  
42 4. Minutes shall be maintained by the investigating committee which should  
43 be in writing and identify any deviation from the appropriate standard of  
44 care. When such is the case, the practitioner will be notified and asked to

1 respond. When a practitioner's response satisfies the committee, or for  
2 other reasons the committee feels that no action is appropriate, the  
3 investigation will be terminated with a positive comment and an  
4 appropriate letter is sent to the practitioner.

5  
6 5. When the investigation reveals a significant deviation from the appropriate  
7 standards of care or if for other reasons the investigating committee feels  
8 that further action is necessary, the affected practitioner shall be invited to  
9 meet with the committee to discuss the case(s). The chair of the  
10 committee should make efforts to see that each member of the committee  
11 reviews the complete file so they are well informed before the meeting.  
12 This should include comparing any internal reviewer's report with the  
13 patient charts in question. If the matter is resolved at this level, the review  
14 will be terminated with a positive comment and a letter to that effect sent  
15 to the practitioner.

16  
17 6. If the majority of the committee is still not satisfied after meeting with the  
18 physician, it can refer the matter and the complete file back to the Medical  
19 Executive Committee with or without recommendation. The Medical  
20 Executive Committee will act at that point, based on the recommendation,  
21 or otherwise send the file to an outside reviewer. External peer review  
22 initiated by request, which is approved by Medical Executive Committee,  
23 from any one of the following:

- 24 Medical Staff Clinical Service
- 25 Clinical Quality Review Committee (CQRC)
- 26 Medical Executive Committee
- 27 Clinical Service Chief
- 28 Chair of CQRC
- 29 Chief of Staff
- 30 President of KMC or designee

31  
32  
33 Indication for an external review include but are not limited to the  
34 following:

- 35
- 36 1) Ambiguity when dealing with vague or conflicting recommendations
- 37 from committee review(s) where conclusions from the review could
- 38 impact a practitioner's membership or privileges;
- 39
- 40 2) Lack of internal expertise, when no one on the medical staff has
- 41 adequate expertise in the clinical procedure or area under review;
- 42
- 43 3) When the medical staff needs an expert witness for a fair hearing,
- 44 for evaluation of a credential file or for assistance in developing a

1 benchmark for quality monitoring;  
2

- 3 4) To promote impartiality in peer review. The Medical Executive  
4 Committee or Board of Directors may require external peer review  
5 in any circumstance deemed appropriate by either of the bodies. If  
6 referred to an outside reviewer, upon receipt of the latter's report, if  
7 the Medical Executive Committee is satisfied, the review will be  
8 terminated with a positive comment and the letter is sent to the  
9 physician. If not satisfied, the Medical Executive Committee will  
10 decide on an appropriate action as set forth in the bylaws.

11  
12 Peer review issues will ultimately be classified in the following types:  
13

14  
15 Type I: Issues related to documentation (administrative or clerical)  
16

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

19 Ib: Issues that have the potential or actually impact  
20 patient care and/or failure to comply with  
21 administrative or regulatory standards (i.e. H & P not  
22 complete, not present on chart prior to procedure,  
23 thus leading to delayed procedure and/or  
24 cancellation)  
25

26 Type II: Minor deviations related to reasonably prudent standard of  
27 care (lesser severity (i.e. resulting in temporary harm or  
28 prolonged hospitalization and/or treatment)  
29

30 IIa: Patient care issues that could have affected outcome,  
31 less than desired care that did NOT result in an actual  
32 adverse outcome. (i.e.: "near miss" events)  
33

34 IIb: Same as IIa above, but in which patient complication  
35 or adverse outcome actually occurred.  
36

37 Type III: Major deviations related to reasonably prudent standard of  
38 care (lesser severity (i.e. death or major permanent loss of  
39 function)  
40

41 IIIa: Major events that could have resulted in drastic  
42 adverse outcome, (i.e: wrong site surgery)  
43

1 IIIb: Same as IIIa above, but which actually resulted in an  
2 adverse outcome.  
3

4 Identification of potential Type 1 issues may be from case managers,  
5 health information services personnel, medical director clinical quality,  
6 Vice President Medical Affairs, or by an member of the Medical Executive  
7 Committee.  
8

9 Identification of potential Type 2 or Type 3 issues may arise from any of  
10 the following: complaints by patients, written complaints by hospital or  
11 Medical Staff, routine chart and outcome reviews by members of the  
12 Quality Department, routine chart review by appropriate hospital staff  
13 and/or committees, routine review of clinical outcomes and documentation  
14 statistics, or by focused practitioner practice evaluation as requested by  
15 Clinical Service Chief, Medical Executive Committee, or the Professional  
16 Practice Committee of the Board of Directors.  
17

18 A practitioner who has received a Type 2 or Type 3 determination will be  
19 notified in writing and given the opportunity to appeal the decision. This  
20 appeal may be in writing or in person. Appeals should be directed to the  
21 chair of the Clinical Quality Review Committee, the Clinical Service Chief  
22 or the Chief of Staff.  
23

24 The aggregate data from Type 1, Type 2, and Type 3 issues will be  
25 reviewed as indicated and during the biennial reappointment and  
26 recredentialing process of the Medical Staff.  
27  
28  
29

#### 30 **4.1 Focused Professional Practice Evaluation and Ongoing Professional** 31 **Practice Evaluation** 32

33 The medical staff is responsible for monitoring and evaluating a practitioner's  
34 professional performance. In doing so, the medical staff conducts both Focused  
35 Professional Practice Evaluations (FPPE) and Ongoing Professional Practice  
36 Evaluations (OPPE) as outlined in the Medical Staff Services Policies as  
37 approved by the Medical Executive Committee.  
38

#### 39 **5. Orders** 40

- 41 a. All inpatients must have orders upon admission provided by a member of  
42 the Medical Staff with clinical privileges or a non-member with appropriate  
43 clinical privileges within the scope of his/her licensure.  
44

- 1           b.     Written Orders: All orders for diagnostic procedures, treatment or  
2 medication shall be in writing or directly entered in the electronic medical  
3 record or physician order entry system. Orders written by credentialed  
4 members of the Medical Staff are the preferred method of order entry.  
5 Telephone, electronic and verbal orders may be necessary to meet patient  
6 care needs in an expeditious manner. All orders given by a medical  
7 professional must be authenticated within 48 hours by either the  
8 prescribing practitioner or another practitioner responsible for the care of  
9 the patient. All orders, including verbal orders, must be dated, timed and  
10 authenticated. Telephone and verbal orders shall be accepted and carried  
11 out when dictated to credentialed personnel within the scope of their  
12 licensure, certification or registration including RNs, and respiratory care,  
13 imaging, laboratory, social services, rehabilitation therapists, pharmacy,  
14 nutrition services, EEG (electroencephalogram) and EKG  
15 (electrocardiogram) limited to their respective disciplines. Direct telephone  
16 or verbal orders are to be written down and then read back to the ordering  
17 physician (except in an emergency or during a procedure when repeating  
18 back the order is adequate). Orders received over the telephone shall be  
19 accepted from credentialed KMC Medical Staff or residents if the ordering  
20 physician's identity is not in doubt and the orders are read back to the  
21 physician and confirmed. Faxed orders may be accepted if the fax is  
22 signed by the ordering physician and the sending fax site is identified.  
23 Orders may be accepted via email or two-way pager services if sent  
24 through a KMC approved site or another secure site and the ordering  
25 physician is clearly identified. Orders received from physicians via any of  
26 the above means will be transcribed into the record and verified by  
27 signature or electronic verification.  
28  
29  
30           c.     Routine Orders: Routine orders may be formulated by a physician or a  
31 group to meet the needs of their patients. Routine orders may not replace  
32 or cancel those written orders for specific patients. These orders shall be  
33 signed by the attending physician or the consultant who wishes to institute  
34 them.  
35  
36           d.     Stop-Orders: Stop-orders shall be applied to certain specified categories  
37 of drugs, and nursing service or pharmacy will notify attending physicians  
38 when such stop-orders have been applied.  
39  
40           e.     Unusual Orders: When a nurse receives an order for a medication in  
41 unusual circumstances, or in dosage beyond that usually prescribed, or in  
42 excess of that listed in reference books or package inserts, he/she may  
43 verify the order with the Hospital pharmacist. If the Hospital pharmacist  
44 concurs with the physician's order, then the dosage ordered should be

1 given. If the hospital pharmacist considers the order wrong in dosage, the  
2 attending physician is notified of this opinion by the pharmacist. If the  
3 attending physician does not change the order, then the nurse shall  
4 consult with the chief of the clinical service who will then consult with the  
5 attending physician, and a joint decision will be rendered. If necessary,  
6 the Chief of Staff shall be consulted and a final disposition made. If the  
7 nurse is unwilling to carry out the order for personal, professional or legal  
8 reasons, he/she shall refer the order to the appropriate director of nursing  
9 for resolution.

## 10 11 12 **6. Records**

### 13 **Content, Review and Evaluation**

- 14  
15
- 16 **a. Content:** A complete medical record of a patient in admission,  
17 observation or ambulatory status shall include when not otherwise  
18 excluded, identification data; chief complaint(s); history of present illness;  
19 past history; social history; family history; review of systems; relevant  
20 physical examination; provisional diagnosis; medical or surgical treatment;  
21 operative report; pathological findings; progress notes; multidisciplinary  
22 notes and flow sheets; medication administration records; special reports  
23 such as consultations, clinical laboratory, imaging reports, and a discharge  
24 summary including discharge diagnoses. Autopsy reports must be  
25 included in those cases in which an autopsy is performed. No medical  
26 record shall be stored until it is complete except by instruction of the Chief  
27 of Staff or Vice President Medical Affairs. Physical examinations will  
28 include relevant body systems as indicated by the patient's medical  
29 histories including chief complaint; present illness; past, social and family  
30 history; and review of systems. Routine screening preventative physical  
31 examinations such as breast exams, pelvic exams, rectal exams,  
32 neurological exams and fundoscopic eye exams are encouraged but not  
33 required for a completed medical record, unless indicated by the patient's  
34 history.
- 35
- 36 **b. Legibility:** Members of the medical staff and others with clinical  
37 privileges or duties, have a responsibility to make legible entries into the  
38 medical record. The medical staff has a legibility policy to assure all  
39 individuals having access to patient medical records can read information  
40 contained within the medical record. Violations will receive progressive  
41 corrective action including notification, education (including possible  
42 remedial handwriting programs), and suspension(s) for incomplete  
43 medical records.
- 44

1           **c. Non-Medical Comments:** Criticism, impertinent and inappropriate  
2 comments, drawings or language, or personal attacks against Staff  
3 members, Hospital personnel or the Hospital and its policies shall not  
4 appear in the medical record. Any questioned violation of this rule shall be  
5 referred to a committee consisting of the officers of the Medical Staff and  
6 the Vice President of Medical Affairs for interpretation, judgment, and  
7 action. If warranted, this committee shall refer the incident to the Medical  
8 Executive Committee for review and recommendation.

9  
10           **d. History and Physical:** A current complete history and physical (H & P)  
11 examination consists of the following required elements: chief complaint,  
12 history of present illness, past history, social history, family history, review  
13 of systems, relevant physical examination, impression and plan of care.  
14 For those patients for which a surgery/procedure is to be performed, the H  
15 & P must include indications for surgery as documented by the operating  
16 surgeon. A complete H & P examination shall be placed on the patient's  
17 chart or dictated within twenty-four (24) hours after admission.

18  
19           The H & P examination records are the responsibility of the attending  
20 physician and properly documented by signature, date and time. Medical  
21 student H & P examination will not be part of the medical record unless  
22 they are written and signed by a supervising resident or attending  
23 physician. Medical student dictation will not be transcribed by Kettering  
24 Medical Center.

25  
26           The H & P must be completed and documented by one of the following  
27 practitioners:

- 28                   ▪     Doctor of medicine or osteopathy
- 29                   ▪     Doctor of podiatric medicine (in accordance with Ohio State  
30 law and as indicated in the Credentials Manual)
- 31                   ▪     Doctor of dental surgery or of dental medicine (in  
32 accordance with Ohio State law and as indicated in the  
33 Credentials Manual)
- 34                   ▪     Physician Assistants
- 35                   ▪     Nurse Practitioners

36  
37  
38           Should the H & P be provided by a non-credentialed practitioner (i.e.  
39 patient's primary care practitioner), then an update meeting the required  
40 contents of the H&P as defined in this section must be completed and  
41 documented by a licensed practitioner who is appropriately credentialed  
42 and privileged in accordance with medical staff bylaws and other related  
43 manuals.

1                   Medical H & P

2                   A current complete medical H & P is one completed within (thirty) 30 days  
3                   prior to admission and updated within twenty-four (24) hours after  
4                   admission.

5  
6                   When the admission H & P has been dictated but not yet transcribed and  
7                   on the chart, an admission note which adequately describes the patient's  
8                   condition, diagnoses and plan of care shall be placed on the chart within  
9                   24 hours of admission when the H & P is not on the chart.

10  
11                   Surgical H & P

12                   A current complete surgical H & P is one completed within (thirty) 30 days  
13                   prior to the surgery/procedure and has been updated by the operating  
14                   surgeon within 24 hours prior to the surgery/procedure. Update to indicate  
15                   the following: H & P was reviewed, the patient was examined, and that  
16                   “no change” has occurred in the patient’s condition since the H & P was  
17                   completed or any changes in the patient’s condition must be documented  
18                   in the update note and placed in the patient’s medical record within 24  
19                   hours of admission, but prior to surgery/procedure requiring anesthesia.

20  
21                   If the practitioner finds that the H & P done before admission is  
22                   incomplete, inaccurate, or otherwise unacceptable, the practitioner  
23                   reviewing the H & P, examining the patient, and completing the update  
24                   may disregard the existing H & P and conduct and document in the  
25                   medical record a new H & P within 24 hours after admission or  
26                   registration, but prior to surgery or a procedure requiring anesthesia.

27  
28  
29  
30                   Ambulatory/Outpatient H & P

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

- 38                   **e. Anesthesia/Procedural Sedation:** Outpatients undergoing surgery or  
39                   procedures under any anesthesia or procedural sedation except local  
40                   anesthesia without any pre-operative medication require a history and  
41                   physical.  
42  
43                   **f. Pre-Operative/Pre-procedure Record:** Emergencies excepted, patients

1 shall not be taken to the operating room/or procedure room unless the  
2 medical record contains a signed and witnessed informed consent form,  
3 plan of care for surgery/or procedure and anesthesia/or procedural  
4 sedation and an acceptably current history and physical. In emergency  
5 conditions, an acceptable history and physical for preoperative purposes  
6 may be limited to major significant conditions requiring immediate  
7 surgery/procedure. A history and physical examination is acceptable to  
8 meet the requirement prior to surgery/procedure if performed within (thirty)  
9 30 days prior to the surgery/ procedure and is also updated within 24  
10 hours prior to the surgery/procedure for any significant interval changes.  
11 Surgery/procedure time may be forfeited on the authority of the  
12 surgery/procedure room committee as outlined in the operating/procedure  
13 room policy, when the starting of the operation/procedure is delayed for  
14 more than fifteen (15) minutes  
15

- 16 **g. Pre-Operative Attestation:** To assist the patient in providing informed  
17 consent, the privileged Medical Staff individual performing surgery or  
18 procedures shall provide a plan of care for the patient including informing  
19 the patient and/or appropriate surrogate(s) regarding the need for,  
20 benefits, alternative options, risks and potential complications associated  
21 with the operative procedure.  
22

23 To assist the patient in providing informed consent, the licensed  
24 independent practitioner responsible for managing the patient's care,  
25 treatment, and services (or his/her designee) shall inform the patient  
26 and/or appropriate surrogate(s) regarding the potential benefits, risks, and  
27 side effects of the patient's proposed care, treatment and services, the  
28 likelihood of the patient achieving his or her goals and any potential  
29 problems that might occur during recuperation. This informed consent  
30 process includes a discussion about reasonable alternatives to the  
31 patient's proposed care, treatment and services. The discussion  
32 encompasses risks, benefits and side effects related to the alternatives  
33 and the risks related to not receiving the proposed care, treatment and  
34 services. Risks and benefits associated with blood transfusion when  
35 blood or blood components may be needed with an operative procedure  
36 are also discussed. Documentation of risks, benefits and alternatives  
37 must be present in the patient record. The informed consent policy  
38 outlines the details of the process.  
39

40 To assist the patient in providing informed consent, the Medical Staff  
41 member or CRNA providing anesthesia or procedural sedation shall  
42 provide an anesthesia or procedural sedation plan of care including  
43 documenting patient American Society of Anesthesiology (ASA)  
44 classification and informing the patient and/or appropriate surrogate(s) the

1 need for, benefits, alternative options, risks, and potential complications  
2 associated with anesthesia or procedural sedation prior to administration  
3 of pre-operative medication.  
4

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

- 12 • the names(s) of the licensed independent practitioner(s) who  
13 performed the procedure and his or her assistant(s)
- 14 • the name of the procedure
- 15 • findings of the procedure
- 16 • a description of the procedure
- 17 • any estimated blood loss
- 18 • any specimens removed
- 19 • the postoperative diagnosis

20  
21 **i.** When the original or a hard copy of the full operative report is not placed  
22 in the medical record immediately after surgery or high-risk procedure, a  
23 progress note of the operation or procedure is entered immediately. This  
24 immediate postoperative/procedure note, completed before the patient is  
25 transferred to the next level of care, includes the same elements outlined  
26 above.

27  
28 All tissues and foreign material surgically removed, unless specifically  
29 excluded by the Medical Executive Committee, shall be sent to the  
30 Hospital pathologist who shall make such examination, as he/she shall  
31 consider necessary, to arrive at a pathological diagnosis and to issue a  
32 signed report, which shall become a permanent part of the patient's  
33 record.

34  
35 **j. Discharge Summary:**

- 36  
37 (1) To facilitate continuity of care, a discharge summary containing at a  
38 minimum the reasons for hospitalization, significant findings,  
39 procedures performed and treatments rendered, the final  
40 diagnoses, the patient's condition at discharge and instructions to  
41 the patient and/or appropriate surrogate(s) will be included in a  
42 completed medical record. For normal newborns, uncomplicated  
43 deliveries, or patients whose admitted hospital stay is less than 48

1 hours with uncomplicated care, a discharge progress note, which  
2 includes the condition at discharge, discharge instructions, and  
3 follow up care, may be substituted for a discharge summary. A  
4 discharge progress note may also be used to satisfy the discharge  
5 summary requirements for the initial hospitalization when a patient  
6 is transferred to another KMC facility.  
7

8 (2) Any multi-service patient (one whose medical care is provided by  
9 more than one specialist or attending practitioner) shall have a  
10 single discharge summary, which includes all areas of care. The  
11 attending physician will be responsible for the discharge summary.  
12

13 (3) The discharge summary is to include the future care of the patient.  
14

15 **k. Completion of Records - Requirements:**  
16

17 (1) History and physical, discharge summary, consultation and  
18 operative/procedure note shall be authenticated with a handwritten  
19 or electronic signature. Rubber stamp signatures are not  
20 acceptable for authentication. Electronic, verbal or telephone  
21 orders must be authenticated within 48 hours.  
22

23 (i) Completion: Charts must be accurately and legibly  
24 completed within fourteen (14) days from allocation date.  
25 Charts are complete only after dictated reports and required  
26 entries are signed, dated and timed within required  
27 timeframes; merely dictating before the deadline is not  
28 sufficient. Charts may be identified as incomplete prior to  
29 discharge if required elements are not performed as  
30 mandated by the stricter rule of medical staff manuals,  
31 hospital policy or accrediting and/or regulatory agencies.  
32 Examples of such incomplete records would be lack of an  
33 immediate post-operative note and failure to authenticate  
34 electronic, verbal or telephone orders within 48 hours.  
35

36 (ii) Legibility: Members of the Medical Staff and others with  
37 clinical privileges have a responsibility to make legible  
38 entries into the patient's medical record. It is the hospital's  
39 expectation to assure that all individuals having access to  
40 patient medical records can read information contained  
41 within the medical record. Violators will receive progressive  
42 corrective actions including notification, education (including  
43 possible remedial handwriting programs) and potential  
44 suspension for incomplete medical records.

1  
2 (iii) Notice: Notification of suspension of hospital privileges for  
3 incomplete or delinquent medical records will be given to the  
4 practitioner either verbally, by certified r/r/mail, or by  
5 receipted facsimile. For records that are not able to be  
6 completed within the fourteen day period due to extenuating  
7 circumstances (e.g. illness, vacation) a prior waiver with time  
8 extension may be requested from the officers listed below.  
9

10 Administrative suspension of privileges for incomplete or  
11 delinquent medical records results in the affected physician  
12 not being able to admit or write orders for new patients; but  
13 does not in any way remove the physician's responsibilities  
14 for call coverage, for patients already under his/her care in  
15 the Hospital or the for the provision of services which have  
16 been scheduled prior to the suspension and which cannot be  
17 appropriately rescheduled.  
18

19 Suspension of physicians who supervise other dependent  
20 allied health practitioners (AHPs) such as APN's or PA's,  
21 may result in the AHP's privileges being suspended as well if  
22 there are no other collaborating or supervising physicians.  
23

24 Any physician whose hospital privileges have been  
25 suspended because of incomplete or delinquent records, or  
26 portions thereof, may in the event of unusual or extenuating  
27 circumstances obtain authority to care for or admit a specific  
28 patient from the Chief of Staff or designee, Chief-Elect, Vice  
29 Chief – KMC Sycamore, Vice Chief, Medical Staff  
30 Credentials Program, or the Vice President of Medical  
31 Affairs. The approving officer and physician shall both notify  
32 the admissions office of the nature of the special  
33 circumstances prior to the admission of the patient. For  
34 removal from administrative suspension prior to curing  
35 medical records deficiencies, physicians may submit a plan  
36 of compliance and petition for restoration to one of the above  
37 officers. Upon approval of the plan, the officer will contact  
38 the Health Information Management Department to restore  
39 such physician's admitting and ordering privileges.  
40

41 (iv) A practitioner who has received three suspension letters  
42 during any consecutive 12-month period, and who again has  
43 become delinquent or anyone who has been under  
44 suspension for 2 consecutive weeks without an excused

1 waiver will be assessed a fine of \$500.00 in addition to the  
2 imposition of the administrative suspension. Reinstatement  
3 of clinical privileges cannot occur until the physician  
4 completes all delinquent and incomplete records and pays  
5 the fine to the Medical Staff Services Department. If  
6 privileges are reinstated, any single subsequent delinquency  
7 or not completing the medical records as required during the  
8 same consecutive 12-month period will result in a fine of  
9 \$1000.00, administrative suspension, and the physician will  
10 be required to present an acceptable corrective action plan  
11 in person to medical executive committee. If clinical  
12 privileges are reinstated, any subsequent noncompliance in  
13 either completing and authenticating all medical records in  
14 the same consecutive 12-month period will result in  
15 immediate termination of both medical staff membership and  
16 clinical privileges. Notice of such termination will be sent by  
17 certified/return receipt mail, and reasonable attempts will be  
18 made to contact the practitioner personally. Signature of  
19 receipt of the notice or documentation of the date of the  
20 personal contact will constitute completion of the notification  
21 process. The practitioner who is so terminated will not be  
22 eligible for the appeal process and will need to reapply to the  
23 medical staff for membership and clinical privileges. For  
24 patient safety reasons, and in order to not jeopardize the  
25 continuity of patient care, in the event of such imminent  
26 termination, the Chief of Staff or his/her designee may  
27 intervene to permit the practitioner to have a limited  
28 extension of membership with privileges restricted to caring  
29 for currently hospitalized patients and for patients previously  
30 scheduled for procedures or admission. Following the  
31 discharge of the last patient, the administrative termination  
32 will take effect.

- 33  
34 (v) Practitioners who resign while under suspension will be  
35 designated as "Resigned: NOT in good and regular standing"  
36 status and will be so reported by the medical staff services  
37 department in any future queries to the medical staff  
38 regarding status.

39  
40 A suspension for failure to complete medical records lasting  
41 31 days or more may be reportable to the National  
42 Practitioner Data Bank and the State licensing board if such  
43 failure is determined through a professional review action  
44 with final finding to relate to professional competence or



1 the permission of the attending physician or his/her physician designee,  
2 and with permission of patient or patient's representative, may review the  
3 medical record of a currently hospitalized patient.  
4

## 5 **7. Consultation**

6  
7 a. General - The responsibility for patient care rests with the attending  
8 physician but consultation is recommended when there is a reasonable  
9 doubt as to the diagnosis and/or treatment. Consultation is required when  
10 the patient needs care which is beyond the attending physician's scope of  
11 Medical Staff approved privileges.  
12

13 b. Medical Staff members are expected to respond to requests for  
14 consultations in a timely fashion that meets patient care demands and the  
15 need for appropriate utilization of services. Medical Staff member  
16 requesting consultation will be responsible to provide appropriate clinical  
17 information and time-to-response expectations on the order sheet.  
18 Guidelines for time-to-response expectations are as follows:  
19

- 20 1) Emergency consultations: 30-60 minutes (e.g., surgery, post-  
21 anesthesia recovery unit, ICU, emergency department)
- 22 2) Urgent consultations: 4 hours (e.g., ICU)
- 23 3) Routine consultations: 24 hours (e.g., general medical-surgical  
24 floor)  
25

26 Physician to physician contact is the preferred way of initiating all  
27 consultations, but is required for emergency and urgent consultations.  
28

29 c. Consultation with other members of the Active and Courtesy Staff shall be  
30 sought as appropriate in order to provide the best possible care for  
31 Hospital's patients  
32

33 d. If circumstances are such as to render consultation undesirable or  
34 unnecessary, consultation shall not be performed and the reasons thereof  
35 shall be entered in the progress notes of the clinical record.  
36

37 e. Kettering Medical Center patients with substance abuse issues are  
38 encouraged to be referred in consultation to a Medical Staff member with  
39 substance abuse expertise or referred to an external community based  
40 substance abuse service.  
41

42 f. Specific issues regarding consultation:  
43

- 44 (1) For Mentally Incompetent Patients and/or Minors

1  
2 In cases involving physical or mental pathology where pregnancy  
3 would be detrimental to life or health, a sterilization procedure may  
4 be performed at the request of the patient and:

- 5  
6 (i) The court-appointed guardian or parent(s), when both exist;  
7 or  
8  
9 (ii) The court-appointed guardian or parent(s), when only one  
10 exists.  
11  
12 (iii) A signed consent is required by the patient and,  
13  
14 (iv) A written consultation from two physicians, one practicing in  
15 the specialty in which the primary disease occurred is  
16 required.

17  
18 (2) Abortion

- 19  
20 (a) Abortion will be performed only for medical reasons  
21 pertaining or relating to the mother and will require  
22 agreement of two consultants:  
23  
24 (i) From the clinical service which relates to the medical  
25 reason, and  
26  
27 (ii) From another OB-GYN physician on the Active Staff  
28 not associated in practice with the surgeon doing the  
29 abortion.  
30  
31 (b) No abortion will be performed after 24 weeks, by dates or  
32 any Level II ultrasound, for any fetal reasons.

33  
34 No abortion will be performed for fetal reasons other than  
35 anencephaly, Potter's syndrome (renal agenesis), severe  
36 hypoplastic lungs, and condition verified by ultrasound  
37 and/or other lab evaluation with written documentation on  
38 the chart prior to procedure. (This does not pertain to known  
39 fetal demise where an evacuation of the uterine contents is  
40 indicated.)

- 41  
42 (c) Qualification: The consultant must be a member of the  
43 Medical Staff, well qualified to give an opinion in the field in  
44 which his/her opinion is sought. Medical Staff privileges in

1 the field concerned is the usual accepted evidence of  
2 qualifications.

3  
4 (d) The Consultation: A satisfactory consultation includes  
5 examination of the patient, review of the chart, and a written  
6 report of the findings and recommendations signed by the  
7 consultant which is made a part of the record. Pre-surgical  
8 consultation reports, at least in brief form, shall be recorded  
9 prior to the operation.

10  
11 (e) Administrative Request for Consultation: In circumstances  
12 of grave urgency or when consultation is required by rules of  
13 the Hospital, the Hospital administrator shall at all times  
14 have the right to call in a consultant after conference with the  
15 Chief of Staff or an available member of the Medical  
16 Executive Committee.

17  
18 **8. Discharge**

19 Patients shall be discharged only by order of the attending physician or his/her  
20 designated alternate.

21  
22 **9. Basic Rules for the Use of Hospital Facilities**

23  
24 All privileges are contingent upon the practitioner's abiding by all applicable  
25 hospital and departmental policies and compliance with accreditation and  
26 regulatory requirements. Failure to abide by these policies and requirements will  
27 subject the practitioner to potential disciplinary action. The respective medical  
28 director and/or Clinical Service Chief may recommend to the Chief of Staff  
29 disciplinary action, including summary suspension, if appropriate. The Medical  
30 Executive Committee will consider the action of the Chief of Staff at its next  
31 meeting and make recommendations in accordance with Medical Staff  
32 disciplinary policy.

33  
34  
35 **10. Emergency Department On-Call Physicians**

36  
37 Members of the Medical Staff have an obligation to work with the hospital  
38 administration to provide coverage of emergency medical conditions arising  
39 within or presenting to our facility as required by law. The Emergency On-Call  
40 list is developed by Medical Staff Services in conjunction with the Officers of the  
41 Medical Staff, the Clinical Service Chiefs and the Hospital Administration and is  
42 separate for KMC and SMC/KBMC  
43

1 The Emergency On-Call Physician list is intended to provide urgent and  
2 emergent consultation to patients in our facilities either seeking care in the ED or  
3 within the hospital proper for admitted patients with emergent needs. The call list  
4 for KMC applies to Kettering Medical Center and the Kettering Emergency  
5 Department. The call list for SMC applies to Sycamore Medical Center, Kettering  
6 Behavioral Medicine Center and the Sycamore Emergency Department. Time  
7 constraints for Urgent and Emergent responses are further defined in this  
8 document. The call lists will be available on the hospital Intranet.

9  
10 If there are discrepancies, administrative or reimbursement concerns, it is the  
11 responsibility of the currently listed on call physician to see to the emergent need  
12 of the patient first and deal with the non-clinical issues secondarily. If an on call  
13 physician is unavailable for duty on the day that they are specified for call, it is  
14 their responsibility to find and report to the Medical Staff Office and/or the  
15 Emergency Department, a suitable on-call replacement physician.

16  
17 On-Call physicians must respond to Emergency requests for evaluation in a  
18 timely fashion and provide stabilization and/or emergent definitive treatment as  
19 requested by the Emergency Physician or Attending Physician without regard to  
20 insurance status or payment capability. Emergency patients referred to the  
21 provider in the out patient setting will also receive initial stabilizing care without  
22 regard to immediate payment capability.

23  
24 A patient or appropriate surrogate may request a transfer to another hospital. If  
25 stabilization and/or definitive treatment of the medical condition of an individual is  
26 not available within the current hospital, the patient may be transferred to an  
27 appropriate facility with certification by the physician that the medical benefits of  
28 the transfer outweigh the risks and is in the best interest of the patient. An on  
29 call physician may not request that a patient be transferred to a second hospital  
30 for the physician's convenience only.

## 31 32 **11. Sources of Patient Care Provided Outside the Hospital**

33  
34 Medical Executive Committee will approve contractual sources of patient care  
35 provided by entities outside the Hospital. A written agreement defining the  
36 nature and scope of patient care will include providing care in a timely fashion  
37 and consistent performance of patient care processes according to appropriate  
38 accreditation standards. Expectations for the performance of contracted services  
39 will be met by verification that all licensed independent practitioners who will be  
40 providing patient care, treatment and services have appropriate privileges by  
41 providing a copy of the list of privileges to the hospital when requested. Written  
42 agreements will specify that the contracted organization will ensure that all  
43 contracted services provided by licensed independent practitioners will be within  
44 the scope of their privileges. The written agreement will also include the

1 expectation that consistent performance of patient care processes must be  
2 provided according to appropriate accreditation and regulatory standards.

## 3 4 **12. Housestaff**

5  
6 Housestaff physicians (MD or DO) who are members of a KMC or affiliated  
7 postdoctoral education program approved by the ACGME or AOA, will be  
8 supervised for all clinical activities by a physician with privileges at Kettering  
9 Medical Center, according to Hospital policies, including the KMC Housestaff  
10 Policy Manual. KMC affiliated House Staff educational programs' policies  
11 regarding supervision must be consistent with KMC Housestaff Policy Manual.  
12 Housestaff with unrestricted State Medical Board of Ohio license or equivalent  
13 may provide direct inpatient and/or outpatient medical care within the scope of  
14 their licensure with appropriate supervision. The supervising physician is  
15 responsible for fostering an environment in which housestaff members under  
16 their supervision acquire the requisite skill and training to practice within a  
17 specialty. Concurrently, the supervising physician has the responsibility for  
18 assuring that there is no difference or adverse variation in the quality of care  
19 provided when a housestaff member treats a patient. The supervising  
20 physician's name will be documented on all patients' medical records whose care  
21 is provided as a part of a post-graduate training program. Delegated clinical  
22 responsibilities are defined in the Housestaff Policy Manual for all levels of post-  
23 graduate training and are based on a system of graded authority which includes  
24 direct observation and knowledge of the house staff member's education,  
25 experience, skills and abilities. Documentation in the medical record by  
26 housestaff member and supervising physician is confirmation that supervision  
27 has taken place. When housestaff members episodically see patients which are  
28 not assigned to a teaching panel, the patient's attending physician, after being  
29 notified by the housestaff member, assumes the responsibility for the residents'  
30 supervision. The supervising physician will countersign the following documents:  
31 the history and physical, the discharge summary, the operative/surgical report,  
32 and the consultation report. The supervising physician will also be responsible  
33 for completing the medical record in a timely manner in situations where the  
34 housestaff member may not complete his/her responsibilities in regard to the  
35 medical record.

36  
37 The Graduate Medical Education Committee (GMEC) must communicate to the  
38 MEC and the Hospital Board of Directors about the safety and quality of patient  
39 care provided by, and the related educational and supervisory needs of, its  
40 participants in professional graduate education programs including both KMC  
41 and affiliated programs.  
42

1 **13. Professional Liability Action**

2  
3 Each individual with clinical privileges at Kettering Medical Center will notify  
4 Medical Staff services within thirty (30) days of a final settlement or judgment of a  
5 professional liability action. It is recommended that individuals with clinical  
6 privileges notify the risk management office of Kettering Medical Center if they  
7 are aware that a professional liability action involving Kettering Medical Center  
8 has been filed or is likely to be filed.  
9

10 **14. Conduct**

11  
12 Unprofessional and unethical conduct and the violation of this Organizational  
13 Manual or Hospital policy may be grounds for disciplinary action.  
14

15 All members of the Medical Staff are required to abide by the Code of Conduct  
16 Policy and the terms of the Notice of Privacy Practices prepared and distributed  
17 to patients as required by the federal Health Insurance Portability and  
18 Accountability Act of 1996 Regulations.  
19

20 It is the desired culture of the medical staff that all medical staff members  
21 conduct themselves in a professional manner at all times, one that promotes  
22 patient safety and the delivery of competent, quality care; fosters a congenial  
23 working environment and does not disrupt the operations of the hospital.  
24

25 Members of the Medical Staff will abide by the Code of Conduct Policy.  
26 Violations in conduct will be evaluated and acted upon as delineated in the  
27 Bylaws.  
28  
29

30 **15. Disruptive Medical Staff Member**

31  
32 The stated goal of the Medical Staff is to ensure professional behavior at all  
33 times that promotes patient safety and the delivery of competent quality care,  
34 fosters a congenial working environment and does not disrupt the operations of  
35 the hospital. Any and all reports of disruptive behavior are taken seriously.  
36

37 Disruptive Behavior in all personnel within the hospital will be addressed in  
38 accordance with policies which are similar in goals for both the employees and  
39 the members of the Medical Staff. It is the intention of the Hospital  
40 Administration and this Medical Staff that these policies are enforced in a firm,  
41 fair and equitable manner. Any form of retaliation against the person(s) bringing  
42 complaint will not be tolerated.  
43

1 Disruptive behavior by Medical Staff members will be dealt with by the Vice  
2 President for Medical Affairs, clinical service chief, and/or Chief of Staff. The  
3 report of the behavior will be documented, the incident investigated and  
4 appropriate actions will be taken. Collegial intervention is outlined in the Code of  
5 Conduct Policy and corrective actions are delineated in the Bylaws. Behavior  
6 that creates a risk for immediate harm may result in summary suspension of  
7 Medical Staff membership and clinical privileges pending further investigation.  
8 As appropriate, the VPMA may choose to involve the hospital Executive team  
9 when disruptive behavior poses risk to the hospital. Consultation with the  
10 Physician Wellness Committee and outside resources may also be utilized.

## 11 **16. Copying of Medical Staff Files**

- 12
- 13
- 14 a. Members of the Medical Staff may inspect their own credentialing files in  
15 the presence of a Medical Staff officer, the Vice President Medical Affairs,  
16 or the Manager, Medical Staff Services.
- 17
- 18 b. Access to or copies of related and appropriate portions of the credentialing  
19 file may be provided for legitimate reasons with the approval of the Chief  
20 of Staff or Vice President of Medical Affairs and/or designee. A release of  
21 liability of the Medical Center and the Medical Staff may be required. For  
22 more than three (3) pages, the standard Medical Center copying fee will  
23 apply.
- 24

## 25 **17. Rape Examinations**

26

27 Rape Examination is a formal legal collection of evidence when the allegation of  
28 sexual assault has occurred. Emergency Department physicians and nurses are  
29 specifically trained in this procedure. Patients presenting to the Emergency  
30 Department from the outpatient environment or the inpatient setting with a  
31 request for Rape Examination will be evaluated, evidence collected and medical  
32 treatment offered as dictated in the ED Policy Manual. If a SANE (Sexual  
33 Assault Nurse Examiner) professional is available, the evidence collection and  
34 exam may be deferred to that person. Medical treatment of injury or infection is  
35 addressed by the ED Physician or may be assumed by the patient's private  
36 physician in attendance at the time of the evaluation.

37

## 38 **18. Restraints or Seclusion**

39

40 It is the desired culture of the Medical Staff to avoid the use of physical and  
41 chemical restraints with proactive situation management. Should a need for  
42 short term restraint arise, the processes delineating their use are clearly outlined  
43 in hospital policy. It is the responsibility of the Medical Staff member to be aware  
44 of and abide by this policy.

1  
2 **19. Pronouncement of Death**  
3

4 Only a licensed physician may pronounce a patient dead. The physician need  
5 not personally examine the body. A resident, nurse, paramedic or other  
6 competent observer may report findings on the telephone and the physician  
7 make the death pronouncement. The physician pronouncing the patient is  
8 responsible for completing the Death/Autopsy form on all hospital deaths. The  
9 Death Certificate is a state form and must be signed by a fully licensed physician  
10 or coroner. Ideally this should be a physician with an established physician-  
11 patient relationship who is familiar with the patient's history. In general, this is  
12 the presiding attending physician for an admitted patient, the physician of record  
13 or the physician predominantly involved in the current care of the patient for out  
14 patients.  
15

16  
17 The following deaths require reporting to the coroner: accidental deaths,  
18 homicidal deaths, suicidal deaths, occupational deaths; deaths while confined;  
19 therapeutic deaths; death during anesthesia induction or the immediate post-  
20 anesthesia period; death during or following diagnostic or therapeutic  
21 procedures; death due to administration of drug, vaccine or other substance;  
22 "medical malpractice"; abortion-related death; special circumstances ("delayed  
23 death"); any death about which there is doubt, question or suspicion; any  
24 unattended death at home or in a public or outdoor place. Any doubt regarding  
25 reportable cases should be referred to the coroner's office for clarification.  
26 Documentation of contacts and the identity of the physician agreeing to take  
27 responsibility is required on the data of deceased in the medical record.  
28

29  
30 **20. Use of Investigational/Experimental Drugs or Devices**  
31

32 Physician must obtain KHN Institutional Review Board approval prior to using any  
33 investigational/experimental drugs or devices for research studies or emergency  
34 use. Industry-sponsored research studies may be submitted to a KHN-approved  
35 central IRB for review. All IRB submissions begin initially with the KHN  
36 Innovation Center who will assist with preparation and submission to the IRB.  
37 Investigational/experimental drugs or devices are defined as any non-FDA  
38 approved drug/device or a drug/device used in a research study. Institutional  
39 Review Board (IRB) approval is for protection of patients' rights and does not  
40 imply credentials beyond those approved by the Medical Staff. Investigational  
41 procedures may need to be processed through the usual credentialing process.  
42 The granting of Medical Staff privileges for new procedures that are necessary to  
43 use these investigational/experimental devices will follow the Medical Staff  
44 process for privileging described in the Credentials Manual.

1  
2 Research Studies: To obtain IRB approval of a research study of an  
3 investigational/experimental drugs or devices, contact KHN Innovation Center for  
4 assistance in preparing and submitting a protocol, informed consent form, and  
5 other required documents to the IRB Office for approval. Investigational  
6 procedures may need to be processed through the usual credentialing process  
7 as well.  
8

9 Emergency Use: Emergency use is defined as the use of an  
10 investigational/experimental drug or device on a human subject in a life-  
11 threatening situation in which no standard acceptable treatment is available and  
12 in which there is not sufficient time to obtain IRB approval for its use. A written  
13 request, usually in letter form, that includes the risks, benefits, and consent,  
14 signed by the requesting physician, stating the life-threatening situation or one-  
15 time need and, the absence of standard acceptable treatment, is submitted to the  
16 IRB Office with the assistance of the KHN Innovation Center. The IRB Chair or  
17 designee will review the request and approve or disapprove its use. In  
18 accordance with FDA Regulation 21 CFR 50.23 and CFR 56.104, the protocol  
19 and consent form are reviewed and approved by the IRB Committee within five  
20 (5) working days of initial approval. The standard guidelines for obtaining  
21 informed consent apply.  
22

23 Patients currently on research protocols from Kettering Medical Center or other  
24 institutions who are admitted, must follow Pharmacy Department Policy covering  
25 investigational drug procedures.  
26

27 When the IRB receives a request from a physician for an emergency use of an  
28 investigational/experimental drug or device, the IRB must examine each case to  
29 ensure itself and the institution that the emergency use was justified and  
30 compliant with FDA regulations 21 CFR 50.23 and CFR 56.104.  
31

## 32 **21. Cancer Staging**

33

34 All newly diagnosed cancers will be staged by the managing physician (defined  
35 as the treating physician, usually the surgeon, medical oncologist, or radiation  
36 oncologist) using the American Joint Commission on Cancer-TMN staging format  
37 or a format approved by the KHN Network Cancer Committee. The staging will  
38 be entered on a form adopted by the Cancer Committee and the completion of  
39 the staging will be required to complete the medical record on the patient. Cases  
40 that cannot be staged will be so indicated on the staging form with a reason why  
41 it cannot be staged.

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**PART 6. AMENDMENT**

**6.1 Amendment**

This Medical Staff Organization Manual may be amended, revised or repealed, in whole or in part, by resolution approved by 2/3 vote of voting members present at the Medical Executive Committee. Any changes must be recommended to the Professional Practice Committee of the Board of Directors and become effective upon approval by the board of directors.

**6.2 Responsibilities and Authority**

The procedure outlined in the Medical Staff Bylaws shall be followed in the adoption and amendment of this Medical Staff Organization Manual, provided that the Medical Executive Committee may act for the Staff in making the necessary recommendations.

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**CERTIFICATION OF ADOPTION AND APPROVAL**

Adopted by the Medical Executive Committee on  
July 21, 2009

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Shachi Rattan, MD  
Chief of Staff

Approved by the Board of Directors on  
August 6, 2009 after receipt of a recommendation by the  
Medical Executive Committee

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Roy Chew  
Secretary