FRIDAY, APRIL 6, 2018
GOVERNANCE COMMITTEE MEETING

Janet B. Reid
Timothy P. Smucker
Erin P. Hoeflinger
Hiroyuki Fujita
Lydia A. Lancaster
Alan VanderMolen
Alex Shumate (*ex officio*)

Location: Longaberger Alumni House
Mount Leadership Room

Time: 8:00-9:45am

ITEMS FOR DISCUSSION

1.	*Student Trustee Selection Process - Dr. Lancaster*	8:00-8:10am
2.	*Trustee Development - Dr. Reid*	8:10-8:20am
3.	*Board Office Update - Dr. Thompson*	8:20-8:30am
4.	*Report on Departing Trustees and Election of Officers (verbal) - Dr. Reid, Mr. Shumate*	8:30-8:45am

ITEMS FOR ACTION

5.	Reappointment of a Charter Trustee - Mr. Shumate	8:45-8:50am
6.	Ratification of Committee Appointments - Mr. Shumate	8:50-8:55am
7.	Amendments to the *Bylaws and Rules and Regulations of the Medical Staffs* of University Hospitals and Arthur G. James Cancer Hospital - Dr. Thompson	8:55-9:00am
	Executive Session	9:00-9:30am

2018 Graduate Student Trustee Candidates
Five Finalists

Janice Bonsu · *Columbus, Ohio*

Seeking: Doctor of Medicine

Background Education: Master of Public Health, Global Health, University of Pennsylvania; Bachelor of Science, Neuroscience, Johns Hopkins University

Background Highlights: Orr Family Fund Scholar, Fulbright Program Alternate-Finalist (2017), Penn Center for Global Health Travel Award (2016), Current Senator for College of Medicine on Inter-professional Council, research assistant for Center for Injury Research and prevention at Children's Hospital of Pennsylvania

Jane Dewire ·

Seeking: Doctor of Medicine

Background Education: Master of Science, Physiology and Biophysics, Georgetown University; Bachelor of Arts, Latin, concentration in Pre-Medicine, Georgetown University

Background Highlights: Med Student Research Assistant for Quality and Patient Safety Summer Research and Bariatric Research Assistant at OSU WMC, M1:M2 Mentor, Women in Medicine Mentor, Secretary for The Cape May Fund, President of LGBTQ+ and Allies in Medicine, Treasurer for Students for a National Health Program

Garrett Dowd · *Silver Lake, Ohio*

Seeking: MS & PhD, Control Systems and Cognitive systems

Background Education: Self-Driving Car Nanodegree, Udacity; MS, Technology Entrepreneurship, University College London (UK Fulbright Recipient); BS, Mechanical Engineering, University of Akron

Background Highlights: Special projects experience for Hyperloop Transportation Technologies (Los Angeles), Project lead for Glyde Global (London, UK), F Factor Finalist, Leader of UCL Startup Ecosystem Trek, Hackathon Mentor (Cambridge, UK), Former member of the University Akron Board of Trustees, 2018 University Fellow (OSU), 2017 Founders of the Future member

Ann Morrison ·

Seeking: PhD in Vision Science

Background Education: MS, Vision Science, Ohio State; Doctor of Optometry, Ohio State; BS, Biology, Kennesaw State University

Background Highlights: Clinical Instructor in the College of Optometry, Consultant for Welch Allyn Vision Screening Advisory Board, American Academy of Optometry Fellow, Numerous research projects in College of Optometry, President of Graduate Organization for Vision Science, former president of Epsilon Psi Epsilon Optometric Fraternity, Terrance N. Ingraham Pediatric Optometry Residency Award (2016)

Ana Sucaldito · *Jamestown, North Carolina*

Seeking: PhD in Public Health

Background Education: BS, Behavioral/Systems Neuroscience, Ohio State

Background Highlights: Undergraduate Research Assistant for the Institute for Behavioral Medical Research, Founder/President of KindCarts Service Initiative at the James Cancer Hospital, Staff Mentor/Advisor for MUNDO (Multicultural Understanding through Non-traditional Discovery Opportunities) at OSU, General member of Ohio Union Activities Board Grad/Prof, Co-chaplain of Sphinx Senior Honorary (2017), Dean's Distinguished University Fellowship (2017)

THE CHRONICLE
of Higher Education

Back to Special Report

LEADERSHIP & GOVERNANCE

How to Bring New Board Members Up to Speed

By Kathryn Masterson | MARCH 18, 2018

PREMIUM

Isaiah Tanenbaum

Trustee training needs to be effective and fast, says Cathy Trower, a consultant for nonprofit boards. "Having people sitting silent is not good," she says. "It can lead to disengagement."

When board governance goes wrong, it can go very wrong.

Among recent high- profile scandals and embarrassments: the University of Virginia board's firing its president and then rehiring her. University of Illinois trustees' pushing for politically connected applicants. Penn State's oversight failures in the Sandusky child-sex-abuse scandal. Sweet Briar College's announcing it was closing, then reopening after a legal challenge. Most recently, trustees at Michigan State under fire for their handling of the Larry Nassar case.

Short of scandal, poor governance can lead to turnover in college presidents or a slow decline, with better-run institutions passing you by. Fewer and fewer institutions can take their future for granted, so it's ever more important to prepare trustees well and give them the tools and support to succeed at the job.

Colleges face routine fiscal and competitive pressures, and they encounter frequent crises around free speech, academic freedom, Title IX, and other issues. Boards are urgently necessary to help guide institutions strategically through those choppy waters.

Rigorous Trustee Orientation Is Crucial to Good Governance

Board members must understand their responsibilities, and feel connected and engaged, from the start.

- 8 Tips to Get New Trustees Up and Running ✔ PREMIUM
- What One Trustee Wishes He Had Known Going In

"The job has gotten bigger, wider, deeper, and more complex," says Richard D. Legon, president of the Association for Governing Boards of Universities and Colleges. "You want a consequential board that will add value."

But to have such a board, a college needs to get trustees up to speed quickly. They face a steep learning curve, says Cathy A. Trower, a consultant for nonprofit boards who was a trustee at Wheaton College, in Massachusetts, and worked with Wheaton to assess its board.

"Having people sitting silent is not good," she says. "It can lead to disengagement." And a board's disengagement can fester, resulting in members' skipping meetings, ducking tough questions, and rubber-stamping the business at hand. It can also mean loss of revenue if disenchanted trustees choose to make their philanthropic gifts elsewhere.

On the other hand, overengagement, too, can be problematic. Trustees are not supposed to get into the day-to-day management of an institution but rather leave that to the president and senior staff.

How can colleges quickly get trustees into the rhythm of the work? According to a 2016 survey by the governing-boards association, a majority of colleges — 82 percent of private institutions and 54 percent of public — have mandatory orientation for new trustees. Twelve percent of private-college boards and 24 percent of public have an optional one.

The quality of those orientations varies, says Brian C. Mitchell, past president of Bucknell University and Washington & Jefferson College. He consults with colleges and has co-written a book called *How to Run a College: A Practical Guide for Trustees, Faculty, Administrators, and Policymakers.*

Often, he says, a session consists of a readout of the processes of a college that doesn't put them in the context of higher-education trends. Board meetings tend to be similar, with time spent on backward-looking reports from different departments rather than trends and analyses predictive of where a college might head.

"You don't have pieces of the puzzle that you're putting together," he says. The result is a board acting on an incomplete picture.

AGB and consultants like Mitchell and Trower are seeing a growing interest, from colleges and new trustees alike, in improving these orientations and the overall training process for new board members.

When Mary Zygala Schleyer joined Wheaton's board nine years ago, it took new trustees about two years to feel comfortable speaking up, she says. They were overloaded with information at the beginning, and it was hard to retain. They were on their own to figure out the culture of the board, the people on it, and how things really worked. It took her more than a year, she says, to learn everyone's name, and she was hesitant to speak up in meetings.

Now Wheaton has a more extensive orientation, says Schleyer, who leads the Wheaton board's governance committee. The program includes pairing a new trustee with a mentor who can help navigate the board's complexities and culture, arranging multiple

check-ins with new trustees over time, and providing information on finances, fund raising, and so on, broken down into more manageable chunks.

"People have to hit the ground running and get as smart as possible as quick as possible," says Monique Lee Bahadur, a Wheaton trustee who is in charge of new-trustee orientation.

The board has also built in more-informal opportunities, like gathering for a glass of wine in a hotel lobby after board meetings. That helps trustees get to know one another, especially those who are not alumni and may feel excluded. Schleyer says it was those informal gatherings that helped her feel part of the board. The collegiality and trust fostered there bring a level of comfort when it's time to speak candidly on important issues. "Often what happens outside meetings is as important as what happens during meetings," she says.

In order to maximize their value to a college and president, Legon says, trustees need to have a clear understanding of what their roles and responsibilities are — and what they aren't. Ideally, that education starts before a trustee even agrees to join a board, and continues through orientation, the first year, and beyond.

"Really, trustees should never stop learning," Legon says.

Kevin Fitzsimons

President Michael Drake speaks during a board meeting at Ohio State U., where a longstanding program provides mentors to new board members.

Every board is different, and methods of educating and integrating new trustees vary, too. Like the institutions they oversee — public or private, large or small, liberal-arts or tech-centered — each board has its own culture, history, expectations, and demands. What they all share is their responsibility as fiduciaries. Their collective trust is to protect the future of the institution, overseeing how it spends its money and hires its leader.

G. Gabrielle Starr, president of Pomona College, understands the source of the temptation to get enmeshed in the details. Board members care deeply about an institution — why else would they give their time and money? They also have areas of expertise, usually one of the reasons they are recruited in the first place. But the best adage, Starr says, is "Nose in, fingers out." Be nosy about how things at your institution are run, but keep your paws out of the daily operation.

Board members might want to get involved in decisions about admissions or marketing in particular, because many come from business backgrounds and are used to running things, says Legon, of the governing-boards association. They are not accustomed to shared governance, and understanding it is a key part of their education.

David A. Greene, president of Colby College, has made one of his institution's goals to outgovern the competition. From his perspective, a strong, strategic board is crucial, helping Colby make nimble, bold decisions to better position itself. Strategic goals include helping to revitalize Watertown, the former Maine mill town where Colby is located. The college is also emphasizing the humanities and its liberal-arts core and bringing in partners in the sciences.

When a new chair of the board was taking over, two years ago, Colby brought in a consultant who helped trustees rework their orientation program. What had been an informal process was changed to a formal one that includes a primer on college facts and finances, mentorship arrangements, and documents spelling out expectations and responsibilities. Those include attending all meetings, leading in gift-giving, and reviewing and approving broad strategies. What they're not supposed to do is speak for the college or meddle in day-to-day management.

It's not just trustee orientation that changed. The board also reorganized its committees to be less tied to a specific departments and more wide-reaching and strategic, Greene says — for example, a new committee on people and programs. The board also does its more routine work through phone calls, so that time during the three board meetings a year is reserved for the meatier issues that benefit more from face-to-face discussion.

The new approach, says Eric Rosengren, Colby's board chair and head of the Boston Fed, allows trustees to tackle the Watertown revitalization, plans for which include building a boutique hotel and a downtown dorm. "We want to have a community that is as vibrant as the school," he says.

Potential new members are told they are "coming onto a train that is already moving" in terms of the president's vision. The board also selects people who are comfortable working in collegial consensus environments.

"I think it's made people much more comfortable to speak up at an earlier stage than they would have," says Rosengren.

As Colby has learned, one of the best ways to help new trustees understand a board and the college it serves is to assign them an experienced mentor.

Mentors check in with their mentees before and after meetings, especially a trustee's first, to see if they have questions. A mentor can also be a safe person to talk with in private, answering questions a newcomer might be too embarrassed to ask in public. The mentor can explain roles and personalities and the board's culture.

"You can't figure that out in an orientation," says Trower, the consultant and author of several books on college governance. "You have to get immersed in that room and watch the dynamics." That might mean figuring out who has power and influence and why, or if certain topics prompt a defensiveness in administrators or are considered taboo.

Mentors can also act as a gentle check if a board member is getting inappropriately immersed in management details.

Ohio State University has had a longstanding mentor program for its board. Even the two student trustees — an undergraduate and a graduate student who serve two years instead of the other trustees' nine — have mentors, says Blake Thompson, vice president for government affairs and board secretary. Mentors and mentees often develop friendships as well.

At Wheaton, the board changed how it paired up mentors and mentees, says Bahadur, the trustee in charge of new members' orientation. Previously, Wheaton would pair up a new trustee with someone she or he had something in common with. Now the governance committee looks to find pairings of people with different experiences, backgrounds, or personalities that may complement each other's and offer each a different perspective.

For instance, the committee has paired alumni with current parents, to get someone who has a deep history of Wheaton with someone who is relatively new to the community; a former tech executive with a consumer-health businesswoman; and alumni from different generations, say, a woman who graduated in the 1970s and a man who graduated in the 2000s.

In each of those examples, Bahadur says, "we aim to thoughtfully pair new trustees and mentors, not to have peas in a pod, as it's so important and beneficial for them to share different perspectives."

Like everything else in the higher-ed landscape, says Mitchell, the consultant and former college president, trustee training must become more efficient and sophisticated. The days of what he calls "mom and pop" governance are over.

This article is part of:
Rigorous Trustee Orientation Is Crucial to Good Governance

A version of this article appeared in the March 23, 2018 issue.

THE CHRONICLE
of Higher Education

LEADERSHIP & GOVERNANCE

8 Tips to Get New Trustees Up and Running

By Kathryn Masterson | MARCH 18, 2018

✔ PREMIUM

New trustees have a steep learning curve. Here is how some colleges introduce them to the work and life of the institution.

Require a solid orientation. Cathy A. Trower, a consultant to boards and author of several books on college governance, says orientation should include discussions about shared governance, the college's business model, academic cornerstones like tenure and academic freedom, and the most pressing issues in higher education, including access and affordability, free speech, preventing sexual misconduct, and diversity and inclusion. She suggests that orientation also include discussion about the two major problems that the college's board has grappled with in the past year. That fosters "honest dialogue right at the start with big issues," she says.

Spend as much time as possible with faculty and students, says G. Gabrielle Starr, president of Pomona College. At Pomona, trustees have the opportunity to meet and talk to students at annual retreats. That also helps build empathy and trust, she says. Other institutions may have trustees dine with faculty or students, attend a class, or go on a student-led campus tour.

Rigorous Trustee Orientation Is Crucial to Good Governance

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- How to Bring New Board Members Up to Speed
  ✔ PREMIUM
- What One Trustee Wishes He Had Known Going In

Bring trustees to campus in between board meetings. At Ohio State University, for example, new trustees come and spend a series of days in between board meetings doing deep dives into the academic and operational sides of the university, including research centers, student organizations, facilities, and finance. Some trustees sit in on classes. "The more trustees know and engage, the more vested they are," says Blake Thompson, board secretary at Ohio State.

Create opportunities for new board members to get to know seasoned ones. At Wheaton College, in Massachusetts, new trustees are invited to a summer retreat before their first board meeting in the fall. During the retreat, they usually explore one issue in depth (diversity on the board, for example). Then trustees informally gather and talk in the lobby of the hotel where they are staying. Such occasions grew, says one trustee, Mary Zygala Schleyer, out of feedback from departing trustees who said they felt out of the loop as non-alumni.

Set clear written expectations up front. Richard D. Legon, president of the Association of Governing Boards of Universities and Colleges, says he has heard from numerous trustees who say they were not given the full picture of what the position would mean when they were approached about joining. If a college really wants someone, it might give a soft sell about the role and the time commitment. But, he says, that doesn't help anyone in the long run. Colby College developed a document listing roles and responsibilities, including philanthropic expectations and guidelines to discourage trustees from micromanaging.

Give trustees time to check out various committees before deciding which ones they would like to work on. Ohio State does this, with new trustees rotating through six different committees, like academic affairs and student life, master planning and facilities, and audit and compliance. At Pomona, trustees don't have an assigned committee for the first year, so they can decide where they'd most like to make an impact. Sometimes it's not the area most closely linked to their profession, Starr says.

Create midpoint check-ins. At Wheaton, the board's leadership checks in with new trustees and their mentors at about the six-month mark to sound them out on their experiences and expectations. It can be a good time to catch and fix any problems early — if they have questions, if there's something a new trustee feels she needs to do the job better, or if the new member is having problems with attendance or doing the reading before meetings. Board members also have an interview with a member of the governance committee two years into their term to evaluate their work and give them an opportunity to reflect on what they'd like to see happening on the board. Mentors are also required to check in with their mentees.

Fine-tune as needed. Collect feedback from trustees about what has worked well and what hasn't in orientation. Use that information to make improvements for the next group of new trustees. Emory University looks for ways to maximize busy trustees' time and best present the large amount of information. While there's no perfect orientation, the university is always seeking to improve, says Allison K. Dykes, Emory's vice president and board secretary. Emory tried orientations that lasted two days or were stretched out over a month, and now fits everything into one long day. Trustees wanted to "knock it all

out at once," Dykes says. The day ends with a dinner with the board chair and university president, reinforcing the most important messages they want trustees to walk away with.

This article is part of:
Rigorous Trustee Orientation Is Crucial to Good Governance

A version of this article appeared in the March 23, 2018 issue.

THE OHIO STATE UNIVERSITY

Boards of Trustees Office
Overview and Organizational Functions

Board Office Overview

- The university is governed by a board of 20 trustees responsible for oversight of academic programs, budgets and administration, and employment of faculty and staff.
- The secretary of the Board of Trustees shall be the custodian of and responsible for the preservation of all official records and minutes of the board; provide oversight for the development and execution of the board agenda; be the custodian of the university seal and its imprint; and perform all other duties customary to the office or as assigned.
- The Board of Trustees office partners with senior leaders and units across the university, including the offices of the president, Academic Affairs, Human Resources, University Communications, Advancement, Legal Affairs, Business & Finance and Administration & Planning to support and implement the strategic work of the board.

Strategy & Engagement	Communications & Information Management	Executive Operations	General Administration	Fiscal Operations
Partners with secretary to engage trustees and coordinate strategic work of the board	Partners with secretary and associate secretary to manage board information and communications	Provides operational/logistical support for secretary related to board and Govt Affairs offices	Provides operational, administrative and logistical support for the office	Partners with secretary and associate secretary to guide the fiscal direction of the office
• Provides crucial trustee/former trustee outreach (e.g., memos, announcements) and engagement (e.g., onboarding, scheduling, problem solving) • Develops/implements strategic themes for board meetings • Identifies priorities and spearheads creation of agendas for Governance Committee and Wexner Medical Center Board • Leads Quality and Professional Affairs Committee meetings • Serves as team lead for all events (e.g., football games, bowl trips, holiday parties, trustee dinners) • Cultivates/maintains essential relationships with senior leaders, board committee liaisons and the president's and provost's offices • Coordinates special honors given at board meetings (e.g., Student Recognition Awards) • Oversees operations across all functions of the office • Serves as contact for Ethics Commission, Board of Regents	• Writes and/or edits board communications and materials, including agendas, background materials, talking points, scripts, briefings, emails, minutes, media notices, resolutions, presentations, reports, etc. • Collects/reviews all board meeting materials, partnering with subject matter experts to confirm/improve information • Develops/maintains board website content • Manages content in Diligent • Serves as point person for special projects to support strategic work • Establishes project timelines to improve overall efficiency • Partners with secretary to develop curriculum for governance-related classes • Mentors student office staff • Responsible for shared drive file organization • Coordinates Resolution in Memoriam and emeritus faculty notification processes • Serves as lead for publishing binders and bound volumes	• Provides comprehensive executive assistance for secretary (e.g., travel, correspondence, scheduling) • Provides executive assistance for trustees, as requested • Supports secretary/trustee interactions • Assists secretary in managing responsibilities and maintaining relationships related to positions with Govt Affairs and external boards • Serves as point person for catering at board events • Provides logistical support for board meetings and events	• Provides fiscal assistance (e.g., reconciliation, invoicing, deposits, eRequests, travel) • Manages office operations and provides customer service (e.g., answering phones, greeting guests, sorting mail) • Supervises student office staff • Manages the diploma request fulfillment process • Coordinates supply orders, parking arrangements, deliveries and board meeting logistics (e.g., AV, lodging, seating) • Provides logistical support for events (e.g., football, dinners) • Coordinates ticket fulfillment, delivery, invoices, payments • Responsible for filing rule changes with the state • Works with student staff to transcribe, format and index meeting minutes/appendices • Assists with preparing, proofreading and archiving board meeting materials • Tracks trustee attendance • Manages document retention and archiving for the office	*In conjunction with her role in the Office of the President …* • Serves as senior fiscal officer and HRP for the board office • Provides strategic fiscal leadership for the office, as well as general budget, audit and compliance oversight • Supervises fiscal support provided by GA staffer • Plans, develops and implements policies, processes and procedures for all financial functions • Oversees financial activities and provides counsel on strategic and operational financial matters • Ensures adherence to appropriate internal controls and compliance with established policies and procedures • Provides short- and long-term financial planning
Jessica Eveland *Associate Secretary*	**Amy McKay** *Director of Special Projects*	**Rebekah Berry** *Executive Assistant*	**Amber Poindexter** *Administrative Specialist*	**Melissa DeAngelo** *Finance Director*

April 6, 2018

REAPPOINTMENT OF A CHARTER TRUSTEE

Synopsis: Approval of the reappointment of James D. Klingbeil as a Charter Trustee to the Board of Trustees, is proposed.

WHEREAS the Board of Trustees established the position of Charter Trustee at its meeting on February 6, 2009, acknowledging that the establishment of such a position had the potential of further strengthening the governance capacity of the board; and

WHEREAS the Ohio State University is one of the premier public land-grant institutions in the country and, in execution of its mission, embraces education on a state, national and global scale; and

WHEREAS the complex and multi-faceted nature of the university — in its mission, its character, its constituencies and its financing — calls for extraordinary leadership at the highest levels; and

WHEREAS the governance of the university would be well-served by Charter Trustees whose attributes include but are not limited to diverse cultural, geographic, business, professional, public service and civic backgrounds; and

WHEREAS the board added a number of guidelines, including the following:

> Charter Trustees shall be non-Ohio residents and shall be chosen on the basis of the following attributes: Ohio State alumna/alumnus or friend of the university; success in his or her chosen field or profession; state, national or international prominence; ability to advocate for higher education; expertise in areas deemed critical to the university; and willingness and ability to offer counsel; and

WHEREAS James D. Klingbeil of San Francisco, California, is a distinguished alumnus of The Ohio State University, and has a record of extraordinary service to the university through his philanthropy and dedication to the Foundation Board; by a career of significant accomplishment as founder of the Klingbeil Company and current position as chairman of Klingbeil Capital Management; and by his expertise in areas critical to the mission of the university and to the work of the Board of Trustees proven to be an exemplary embodiment of all of those qualities deemed most desirable in a Charter Trustee:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves the reappointment of James D. Klingbeil as a Charter Trustee to serve a second three-year term commencing June 6, 2018.

The Ohio State University
Board of Trustees

April 6, 2018

RATIFICATION OF COMMITTEE APPOINTMENTS 2018-19

BE IT RESOLVED, That the Board of Trustees hereby approves that the ratification of committee appointments for 2018-19 are as follows:

Academic Affairs and Student Life:
Clark C. Kellogg, Chair
Cheryl L. Krueger, Vice Chair
Janet B. Reid
Timothy P. Smucker
Erin P. Hoeflinger
Abigail S. Wexner
Hiroyuki Fujita
Alan A. Stockmeister
H. Jordan Moseley
James D. Klingbeil
JANET PORTER
Richard K. Herrmann (faculty member)
Alex Shumate (ex officio)

Finance:
Michael J. Gasser, Chair
Brent R. Porteus, Vice Chair
W. G. "Jerry" Jurgensen
Jeffrey Wadsworth
Alexander R. Fischer
John W. Zeiger
Lydia A. Lancaster
Alan VanderMolen
Alex Shumate (ex officio)

Advancement:
Erin P. Hoeflinger, Chair
Alan VanderMolen, Vice Chair
Clark C. Kellogg
Cheryl L. Krueger
Brent R. Porteus
Alexander R. Fischer
Abigail S. Wexner
Alan A. Stockmeister
Lydia A. Lancaster
JANET PORTER
Nancy J. Kramer
Craig S. Bahner
KRISTIN L. WATT (Alumni Assn member)
Georganne M. Shockey (Alumni Assn member)
James F. Dietz (Foundation Board member)
Gifford Weary (Foundation Board member)
Alex Shumate (ex officio)

Audit and Compliance:
Timothy P. Smucker, Chair
W. G. "Jerry" Jurgensen, Vice Chair
Michael J. Gasser
Jeffrey Wadsworth
Hiroyuki Fujita
John W. Zeiger
H. Jordan Moseley
James D. Klingbeil
Lawrence A. Hilsheimer
Amy Chronis
Craig S. Morford
Alex Shumate (ex officio)

Governance:
Janet B. Reid, Chair
Timothy P. Smucker, Vice Chair
Erin P. Hoeflinger
Hiroyuki Fujita
Lydia A. Lancaster
Alan VanderMolen
Alex Shumate (ex officio)

Talent and Compensation:
W. G. "Jerry" Jurgensen, Chair
Janet B. Reid, Vice Chair
Michael J. Gasser
Erin P. Hoeflinger
Hiroyuki Fujita
John W. Zeiger
Lydia A. Lancaster
JANET PORTER
Alex Shumate (ex officio)

Master Planning and Facilities:
Alexander R. Fischer, Chair
James D. Klingbeil, Vice Chair
Brent R. Porteus
Alan A. Stockmeister
H. Jordan Moseley
Robert H. Schottenstein
Alex Shumate (ex officio)

RATIFICATION OF COMMITTEE APPOINTMENTS 2018-19 (CONT'D)

Wexner Medical Center:
Leslie H. Wexner, Chair
Janet B. Reid
W. G. Jurgensen
Cheryl L. Krueger
Abigail S. Wexner
JANET PORTER
David B. Fischer
Stephen D. Steinour
Robert H. Schottenstein
Alex Shumate (ex officio, voting)
Michael V. Drake (ex officio, voting)
Bruce A. McPheron (ex officio, voting)
Michael Papadakis (ex officio, voting)
K. Craig Kent (ex officio, non-voting)
L. Arick Forrest (ex officio, non-votIng)
David P. McQuaid (ex officio, non-voting)
Mark E. Larmore (ex officio, non-voting)
Andrew M. Thomas (ex officio, non-voting)
Elizabeth O. Seely (ex officio, non-voting)
Susan D. Moffatt-Bruce (ex officio, non-voting)
Mary A. Howard (ex officio, non-voting)
William B. Farrar (ex officio, non-voting)
Martha C. Taylor (ex officio, non-voting)
Amanda N. Lucas (ex officio, non-voting)

AMENDMENTS TO THE *BYLAWS AND RULES AND REGULATIONS OF THE MEDICAL STAFF* OF UNIVERSITY HOSPITALS

Synopsis: The amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals are recommended for approval.

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by a joint University Hospitals and James Bylaws Committee on October 9, 2017; and

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff Administrative Committee on December 13, 2017; and

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff on January 5, 2018; and

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on March 27, 2018; and

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals were approved by the Wexner Medical Center Board on April 4, 2018:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves the attached amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The Ohio State University Hospitals.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

Bylaws of the Medical Staff
The Ohio State University Hospitals
Chapter 3335-43

3335-43-01 Medical staff name.

No change.

3335-43-02 Purpose.

The purpose of the self-governing, democratically organized medical staff, which is accountable to the Ohio state university Wexner medical center board for the quality of care provided to the patients of the Ohio state university hospitals, shall be:

(A) - (D) No change.

(E) To govern medical staff and credentialed practitioners these bylaws are not intended to and shall not create any contractual rights between the Ohio state university Wexner medical center and any practitioner. Any and all contracts of affiliation, association or employment shall control contractual and financial relationships between the Ohio state university Wexner medical center and such practitioners.

(Board approval dates: 6/7/2002, 2/2/2007, 9/19/2008, 4/8/2011, 11/7/2014)

3335-43-03 Patients.

No change.

3335-43-04 Membership.

(A) Qualifications

(1) No change.

(2) All members of the medical staff of the Ohio state university hospitals shall, except as specifically provided in these bylaws, be members of the faculty of the Ohio state university college of medicine, or in the case of dentists, of the Ohio state university college of dentistry. ~~, and shall,~~ All members, except for physician scholar medical staff, shall be duly licensed or certified to practice in the state of Ohio. Members of the limited staff shall possess a valid training certificate, or an unrestricted license from the applicable state board based on the eligibility criteria defined by that board. All members of the medical staff and limited staff and licensed health care professionals with clinical privileges shall comply with provisions of state law and the regulations of the state medical board or other state licensing board if applicable. Only those physicians, dentists, and practitioners of psychology and podiatry who can document their education, training, experience, competence, adherence to the ethics of their profession, dedication to educational and research-goals, and ability to work with others with sufficient adequacy to assure the Wexner medical center board and the board of trustees of the Ohio state university that any patient treated by them at university hospitals will be given the high quality of medical care provided at university hospitals, shall be qualified for membership on the medical staff of the Ohio state university hospitals.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

All applicants for membership, clinical privileges, and members of the medical staff must provide basic health information to fully demonstrate that the applicant or member has, and maintains, the ability to perform requested clinical privileges. The chief medical officer of the medical center, medical directors, the department chairperson, the credentialing committee, the medical staff administrative committee, the quality and professional affairs committee of the Ohio state university Wexner medical center board, or the Ohio state university Wexner medical center board may initiate and request a physical or mental health evaluation of an applicant or member. Such request shall be in writing to the applicant. All members of the medical staff and licensed health care professionals will comply with medical staff and the Ohio state university policies regarding employee and medical staff health and safety; uncompensated care; and will comply with appropriate administrative directives and policies to avoid disrupting those operations of the Ohio state university hospitals which adversely impact overall patient care or which adversely impact the ability of the Ohio state university hospitals employees or staff to effectively and efficiently fulfill their responsibilities. All members of the medical staff and licensed health care professionals shall agree to comply with bylaws, rules and regulations, and policies and procedures adopted by the medical staff administrative committee and the Wexner medical center board, including but not limited to policies on professionalism, behaviors that undermine a culture of safety, annual education and training (list approved by the medical staff administrative committee and maintained in the chief medical officer's office), conflict of interest, HIPAA compliance, and access and communication guidelines. Medical staff members and licensed health care professionals with clinical privileges must also comply with the university integrity program requirements including but not limited to billing, self-referral, ethical conduct and annual education. Medical staff members and licensed health care professionals with clinical privileges must immediately disclose to the chief medical officer and the department chairperson the occurrence of any of the following events: a licensure action in any state, any malpractice claims filed in any state or an arrest by law enforcement.

(3) All members of the medical staff and credentialed providers must maintain continuous uninterrupted enrollment with all governmental health care programs.

(a) It shall be the duty of all medical staff members and credentialed providers to promptly inform the chief medical officer and the corporate credentialing office of any investigation, action taken, or the initiation of any process which could lead to an action taken by any governmental programs.

(b) Exclusion of any medical staff member or ~~licensed health care professional~~credentialed provider from participation in any federal or state government program or suspension from participation, in whole or part, in any federal or state government reimbursement program, shall result in immediate lapse of membership on the medical staff of the Ohio state university hospitals and the immediate lapse of clinical privileges at the Ohio state university hospitals as of the effective date of the exclusion or suspension. Medical staff members may submit a request to resign their medical staff membership to the Chief Medical Officer in lieu of automatic termination. The resignation in lieu of automatic termination shall be discussed at the next credentialing committee and medical staff administrative committee in order to provide recommendations to the Quality and Professional Affairs Committee of the Wexner Medical Center Board. A final determination should be decided by the Quality and Professional Affairs Committee at its next regular meeting.

(c) If the medical staff member's or credentialed provider's ~~licensed health care professional's~~ participation in ~~these~~ all governmental programs is fully reinstated, the affected medical staff member or ~~licensed health care professional~~credentialed provider shall be eligible to apply for

membership and clinical privileges at that time. ~~It shall be the duty of all medical staff members and licensed health care professionals to promptly inform the chief medical officer of any action taken, or the initiation of any process which could lead to such action taken by any of these programs.~~

(4) – (7) No change.

(B) – (F) No change.

(G) Resumption of clinical privileges following leave of absence.

(1) A member of the medical staff or credentialed provider shall request a leave of absence in writing for good cause shown such as medical reasons, educational and research reasons or military service to the chief of clinical service and the chief medical officer. Such leave of absence shall be granted at the discretion of the chief of the clinical service and the chief medical officer provided, however, such leave shall not extend beyond the term of the member's or credentialed provider's current appointment. A member of the medical staff or credentialed provider who is experiencing health problems that may impair his or her ability to care for patients has the duty to disclose such impairment to his or her chief of clinical department and the chief medical officer and the member or credentialed provider shall be placed on immediate medical leave of absence until such time the member or credentialed provider can demonstrate to the satisfaction of the chief medical officer that the impairment has been sufficiently resolved and can request for reinstatement of clinical activities. During any leave of absence, the member or credentialed provider shall not exercise his or her clinical privileges, and medical staff responsibilities and prerogatives shall be inactive.

(2) The member or credentialed provider must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and quality and professional affairs committee of the Wexner medical center board. The credentials committee, the chief medical officer, the chief of the clinical service or the medical staff administrative committee shall have the authority to require any documentation, including advice and consultation from the member's or credentialed provider's treating physician or the committee for practitioner health that might have a bearing on the medical staff member's or credentialed provider's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member or credentialed provider must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.

(3) All members of the medical staff or credentialed providers who take a leave of absence for medical or non-medical reasons must be in good standing upon resumption of clinical activities. No member shall be granted leave of absence in excess or his or her current appointment and the usual procedures for appointment and reappointment, including deadlines for submission of application as set forth in this rule, will apply irrespective of the nature of the leave. Absence extending beyond his or her current term or failure to request reinstatement of clinical privileges shall be deemed a voluntary resignation from the medical staff and of clinical privileges, and in such event, the member or credentialed provider shall not be entitled to a hearing or appeal.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

3335-43-05 Peer review and corrective action.

(A) Informal peer review.

(1) All medical staff members agree to cooperate in informal peer review activities that are solely intended to improve the quality of medical care provided to patients at the Ohio state university hospitals.

(2) Information indicating a need for informal review, including patient complaints, disagreements, questions of clinical competence, inappropriate conduct and variations in clinical practice identified by the clinical departments or divisions and medical staff committees shall be referred to the chair of the practitioner evaluation committee.

~~The practitioner evaluation committee chair or his or her designee will consult with the affected medical staff member and obtain information or opinions from knowledgeable persons within the medical center as well as external peer review consultants pursuant to criteria outlined in these bylaws.~~

(3) The practitioner evaluation committee chair or his or her designee may obtain information or opinions from medical staff members or credentialed providers as well as external peer review consultants pursuant to criteria outlined in these bylaws. The information or opinions from the informal peer review may be presented to the practitioner evaluation committee or another designated peer review committee.

~~(2)~~(4) Following the assessment by the practitioner evaluation committee chair or his or her designee, the practitioner evaluation committee may make recommendations for educational actions of additional training, sharing of comparative data or monitoring or provide other forms of guidance to the medical staff member to assist him or her in improving the quality of patient care. Such actions are not regarded as adverse, do not require reporting to any governmental or other agency, and do not invoke a right to any hearing.

~~(3)~~(5) At the conclusion of the evaluation, the practitioner evaluation committee chair or his or her designee submits a report to the applicable clinical department chief and the chief medical officer. The chief of the clinical department and the chief medical officer shall evaluate the matter to determine the appropriate course of action. They shall make an initial written determination on whether:

~~(1)~~ (a) The matter warrants no further action;

~~(2)~~ (b) Informal resolution under this paragraph is appropriate. The chief of the clinical department and the chief medical officer shall determine whether to include documentation of the informal resolution in the medical staff member's file. If documentation is included in the member's file, the affected member shall have an opportunity to review it and may make a written response which shall also be placed in the file. Informal review under this paragraph is not a procedural prerequisite to the initiation of formal peer review under paragraph (B) of this rule; or

~~(3)~~ (c) Formal peer review under paragraph (B) of this rule is warranted.

(6) In cases where the chief of the clinical department and chief medical officer cannot agree on the need for formal peer review, the matter shall be submitted for formal peer review and determined as set forth in paragraph (B) of this rule.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

(B) Formal peer review.

(1) – (4) No change.

(5) The formal peer review committee shall investigate every request and shall deliver written findings and recommendations for action to the chief of the clinical department. ~~within 30 days.~~ The formal peer review committee may recommend a reduction, suspension or revocation of the medical staff member's clinical privileges or other action as it deems appropriate. In making its recommendation the formal peer review committee may consider, relevant literature and clinical practice guidelines, the opinions and views expressed throughout the review process, information or explanations provided by the member under review, and other relevant information. Prior to making its report, the committee shall afford the medical staff member against whom the action has been requested an opportunity for an interview. At such interview, the medical staff member shall be informed of the specific actions or omissions alleged to constitute grounds for formal peer review and shall be given copies of any statements, reports, opinions or other information compiled at prior stages of the proceedings. The medical staff member may furnish written or oral information to the formal peer review committee at this time and shall be given an opportunity to discuss, explain, or refute the allegations and to respond to any statements, reports or opinions previously compiled in the proceedings. However, such interview shall not constitute a hearing, but shall be investigative in nature. The medical staff member shall not be represented by an attorney at this interview. The written findings and recommendations for action are expected to be submitted within 90 days, unless an extension is deemed necessary by the committee.

(6) Upon receipt of the written report and recommendation from the formal peer review committee, the chief of the clinical department shall ~~within seven days~~ make his or her own written recommendation for corrective action and forward that recommendation along with the findings and recommendations of the formal peer review committee to the chief medical officer.

(7) The chief medical officer shall ~~have ten days to~~ decide whether to accept, reject or modify the recommendation of the chief of the clinical department. If the chief medical officer decides the grounds are not substantiated, the chief medical officer will notify the formal peer review committee, the chief of the clinical department, the person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

If the chief medical officer finds the grounds for the requested corrective action are substantiated, the chief medical officer shall promptly notify the affected medical staff member of that decision and the corrective action that will be taken. This notice shall advise the affected medical staff member of his or her right to request a hearing before the medical staff administrative committee pursuant to rule 3335-43-06 of the Administrative Code and shall also include a statement that failure to request a hearing in the timeframe prescribed in this rule shall constitute a waiver of rights to a hearing and to an appeal on the matter and the affected medical staff member shall also be given a copy of the rule 3335-43-06 of the Administrative Code. This notification and an opportunity to exhaust the administrative hearing and appeal process shall occur prior to the imposition of the proposed corrective action unless the emergency provisions outlined in paragraph (D) of this rule apply. This written notice by the chief medical officer shall be sent certified return receipt mail to the affected medical staff member's last known address as determined by university records.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

(8) – (9) No change.

(C) – (D) No change.

(E) Automatic suspension and termination.

(1) – (2) No change.

(3) Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer, shall result in immediate and automatic suspension of a medical staff member's appointment and privileges until such time as proof of appropriate insurance coverage is furnished. In the event such proof is not provided within ten days of notice of such suspension, the medical staff member or credentialed provider shall be deemed to no longer comply with medical staff requirements under 3335-43-04 and automatically relinquish ~~voluntarily terminated~~ his or her appointment and privileges.

(4) Upon exclusion, debarment, or other prohibition from participation in any state or federal health care reimbursement program, or a federal procurement or non-procurement program, the medical staff member's appointment and privileges shall ~~be~~ immediately and automatically terminate, unless resignation in lieu of automatic terminations is permitted to rule 3335-43-04(A)(3). ~~suspended until such time as the exclusion, debarment, or prohibition is lifted.~~

(5) – (9) No change.

(F) No change.

3335-43-06 Hearing and appeal process.

(A) Right to hearing and to an appeal.

(1) When a member of the medical staff who has exhausted all remedies under paragraphs (E) and (F) of rule 3335-43-04 of the Administrative Code on appointment or reappointments; or under rule 3335-43-05 of the Administrative Code for corrective action; or who has been summarily suspended under paragraph (D) of rule 3335-43-05 of the Administrative Code, ~~or who receives notice of proposed action that will adversely affect membership on the medical staff or the exercise of clinical privileges (see paragraph (A)(6) of rule 3335-73-04 of the Administrative Code),~~ the staff member shall be entitled to an adjudicatory hearing.

(2) A medical staff member shall not be entitled to a hearing under the following circumstances:

(a) Denial by the Wexner medical center board to grant a waiver of board certification for a medical staff member.

(b) Termination of a medical staff member because of exclusion from participation in any government reimbursement program.

(c) Voluntary withdrawal of a medical staff application.

(d) Failure to submit a reappointment application.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

(e) A leave of absence extending beyond current appointment or failure to request reinstatement of clinical privileges following a leave of absence.

(f) Actions or recommendations resulting from an informal peer review.

(g) Termination of courtesy B medical staff appointments upon approval by the Wexner medical center board.

(3) No change.

(B) - (E) No change.

3335-43-07 Categories of the medical staff.

The medical staff of the Ohio state university hospitals shall be divided into seven categories: physician scholar medical staff; attending medical staff; courtesy A medical staff; courtesy B medical staff; community affiliate medical staff; consulting medical staff; and limited staff. Medical staff members who do not wish to obtain any clinical privileges shall be exempt from the requirements of medical malpractice liability insurance, DEA registration, demonstration of recent active clinical practice during the last two years and specific annual education requirements as outlined in the list maintained in the chief medical officer's office, but are otherwise subject to the provisions of these bylaws.

(A) Physician scholar medical staff.

(1) Qualifications: The physician scholar medical staff shall be composed of those faculty members of the colleges of medicine and dentistry who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature. This medical staff category includes but is not limited to emeritus faculty members. Nominations may be made to the chair of the credentialing committee who shall present the candidate to the medical staff administrative committee for approval.

(2) Prerogatives: Members of the physician scholar medical staff have access to the Ohio state university hospitals and shall be given notice of all medical staff activities and meetings. Members of the physician scholar medical staff shall enjoy all rights of an attending medical staff member except physician scholar members shall not possess clinical privileges.

(3) Physician scholar medical staff must have either a full license or an emeritus registration by the state medical board of Ohio.

(B) – (D) No change.

(E) Limited staff.

Limited staff are not considered full members of the medical staff, do not have delineated clinical privileges and do not have the right to vote in general medical staff elections. Except where expressly stated, members of the limited staff are bound by the terms of these bylaws, the rules and regulations of the medical staff, and the limited staff agreement.

(1) Qualifications

No change.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

(2) Responsibilities:

(a) - (d) No change.

(f) Appeal by a member of the limited staff of probation, lack of ~~reappointment~~ promotion, suspension or termination for failure to meet expectations for professional growth or failure to display appropriate humanistic qualities or failure to successfully complete any other competency as required by the accreditation standards of an approved training program will be conducted and limited in accordance with written guidelines established by the respective department or training program and approved by the ~~medical~~program director and the Ohio state university hospitals graduate medical education committee as delineated in the limited staff agreement and by the graduate medical education policies.

Alleged misconduct by a member of the limited staff, for reasons other than failure to meet expectations of professional growth as outlined above, shall be handled in accordance with rules 3335-43-05 and 3335-43-06 of the Administrative Code.

(3) Failure to meet reasonable expectations.

~~Failure to meet reasonable expectations may result in sanctions including but not limited to probation, lack of reappointment, suspension or termination.~~ Termination of employment from the limited staff member's residency or fellowship training program ~~limited staff member status~~ shall result in automatic termination of the limited staff member's ~~residency or fellowship~~ appointment pursuant to these bylaws.

(4) Temporary appointments. No change.

(5) Supervision.
Limited staff members shall be under the supervision of an attending or courtesy A medical staff member. Limited staff members shall have no privileges as such but shall be able to care for patients under the supervision and responsibility of their attending or courtesy A medical staff member. The care they extend will be governed by these bylaws and the general rules and regulations of each clinical department. The practice of care shall be limited by the scope of privileges of their attending or courtesy A medical staff member. Any concerns or problems that arise in the limited staff member's performance should be directed to the attending or courtesy A medical staff member or the director of the training program.

(a) Limited staff members may ~~admit and~~ write admission, discharge and other orders for the care of patients under the supervision of the attending or courtesy A medical staff member.

(b) All records of limited staff member cases must document involvement of the attending or courtesy A medical staff member in the supervision of the patient's care to include co-signature of the admission order, history and physical, operative report, and discharge summary.

(F) - (H) No change.

(I) Clinical privileges.

(1) Delineation of clinical privileges. No change.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

(2) Temporary privileges:

(a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed health care professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of the chief of the clinical department, and approval by the chief medical officer. The chief medical officer ~~acting as a member and on behalf of the Wexner Medical Center board,~~ has been delegated responsibility by the Wexner medical center board to grant approval of temporary privileges. The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines. Prior to granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient-care need, and shall be granted for a period not to exceed one hundred twenty days.

(3) – (11) No change.

3335-43-08 Organization of the medical staff.

No change.

3335-43-09 Elected officers of the medical staff of the Ohio state university hospitals.

(A) – (D) No change.

(E) Election of officers.

(1) – (3) No change.

(4) The committee's nominees shall be submitted to all voting members of the attending staff no later than ~~March~~ May first of the election year.

(5) – (6) No change.

(F) – (G) No change.

3335-43-10 Administration of the medical staff of the Ohio state university hospitals

(A) Chief medical officer.

The chief clinical officer functions as the chief medical officer as referred to herein these bylaws. The chief medical officer is the senior medical officer for the medical center with the responsibility and authority for all health and medical care delivered at the medical center. The chief medical officer is responsible for overall quality improvement and clinical leadership throughout the medical center, physician alignment, patient safety and medical staff development. The appointment, scope of authority, and responsibilities of the chief medical officer shall be as outlined in the Ohio state university Wexner medical center board bylaws.

(B) Chief quality and patient safety officer.

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

The chief quality and patient safety officer of the Ohio state university Wexner medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer~~. for administrative and operational issues and has an independent reporting relationship to the executive vice president for health sciences regarding quality data and patient safety events~~. The chief quality officer works collaboratively with clinical leadership of the medical center, including the director of medical affairs for the James cancer hospital, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

(C) – (E) No change.

(F) Credentialing committee of the hospitals of the Ohio state university:

(1) Composition:

The credentialing responsibilities of medical staff are delegated to the credentialing committee of the hospitals of the Ohio state university, the composition of which shall include representation from the medical staff of each health system hospital.

The credentialing committee of the hospitals of the Ohio state university shall be appointed by the chief medical officer. The chief of staff, director of medical affairs ~~or~~ and medical directors of each ~~health system~~ hospital shall make recommendations to the chief medical officer for representation on the credentialing committee of the hospitals of the Ohio state university.

The credentialing committee of the hospitals of the Ohio state university shall meet at the call of its chair, who shall be appointed by the chief medical officer of the health system.

(2) Duties:

(a) – (d) No change.

(e) To make recommendations to the medical staff administrative committee through the ~~chief medical officer~~ chairperson of the credentialing committee regarding appointment applications and initial requests for clinical privileges. Such recommendations shall include the name, status, department (division), medical school and year of graduation, residency and fellowships, medical-related employment since graduation, board certification and recertification, licensure status as well as all other relevant information concerning the applicant's current competence, experience, qualifications, and ability to perform the clinical privileges requested;

(f) – (m) No change.

(3) No change.

(G) – (M) No change.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

UH Bylaws Committee: 10.09.2017
MSAC: 12.13.2017
Medical Staff Vote: 01.05.2018
Quality & Professional Affairs: 3.27.2018
MC Board: 4.04.2018
UBOT: 4.06.2018

3335-43-11 History and physical.

No change.

3335-43-12 Meetings and dues.

(A) Meetings.

The medical staff of the Ohio state university hospitals shall conduct scheduled meetings twice yearly. Notice of the meeting shall be sent to all medical staff at least two weeks prior to the meeting. Attendance is encouraged, but shall not be a requirement for continued medical staff membership and clinical privileges. Special and/or electronic meetings of the medical staff may be called at the option of the medical staff administrative committee.

3335-43-13 Amendments and adoption.

No change.

3335-43-14 Rules of construction.

No change.

APPENDIX I

No change.

APPENDIX II

No change.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

Quality and Professional Affairs: 3.28.18
MC Board: 4.4.18
UBOT: 4.6.18

MEDICAL STAFF RULES AND REGULATIONS
The Ohio State University Hospitals

Updated September 2, 2016

84-01 Ethical pledge.

No change.

84-02 Admission procedures.

No change.

84-03 Attending assignment.

No change.

84-04 Consultations.

No change.

84-05 Privileges for giving orders.

No change.

84-06 Death and autopsy procedures.

No change.

84-07 Disaster plan.

No change.

84-08 Emergency care.

No change.

84-09 Surgical case review.

No change.

84-10 Tissue disposition.

No change.

84-11 Committees and policy groups.

No change.

Quality and Professional Affairs: 3.28.18
MC Board: 4.4.18
UBOT: 4.6.18

MEDICAL STAFF RULES AND REGULATIONS
The Ohio State University Hospitals

Updated September 2, 2016

84-12 Medical records.

(A)(1) – (5) No change.

(6) Records storage and security.

In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one years for minors and ten years for adults. In the case of readmission of the patient, all records or copies thereof from the past ten/twenty-one years shall be available for the use of the attending medical staff member or other health care providers.

(7) – (10) No change.

84-13 Operating room committee.

No change.

84-14 Pharmacy and therapeutics committee.

No change.

84-15 Transfusion and isoimmunization committee.

No change.

84-16 Standards of practice.

No change.

84-17 Mechanism for changing rules and regulations.

No change.

84-18 Adoption of the rules and regulations.

No change.

84-19 Sanctions.

No change.

AMENDMENTS TO THE *BYLAWS AND RULES AND REGULATIONS OF THE MEDICAL STAFF* OF THE ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: The amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute are recommended for approval.

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by a joint University Hospitals and James Bylaws Committee on October 9, 2017, and the James Bylaws Committee on December 1, 2017; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by the James Medical Staff Administrative Committee on December 8, 2017; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by the James Medical Staff on December 22, 2017; and

WHEREAS the proposed amendments to the *Bylaws and the Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by the Quality and Professional Affairs Committee of the Wexner Medical Center Board on March 27, 2018; and

WHEREAS the proposed amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The James Cancer Hospital were approved by the Wexner Medical Center Board on April 4, 2018:

NOW THEREFORE

BE IT RESOLVED, That the Board of Trustees hereby approves the attached amendments to the *Bylaws and Rules and Regulations of the Medical Staff* of The James Cancer Hospital.

The James

THE OHIO STATE UNIVERSITY
COMPREHENSIVE CANCER CENTER

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

Bylaws of the Medical Staff of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute Chapter 3335-111

3335-111-01 Medical staff name.

No changes.

3335-111-02 Purpose.

(E) To govern medical staff credentialed practitioners and these Bylaws are not intended to and shall not create any contractual rights between the Ohio state university Wexner medical center and any practitioner. Any and all contracts of affiliation, association or employment shall control contractual and financial relationships between the Ohio state university Wexner medical center and such practitioners.

3335-111-03 Patients.

No changes.

3335-111-04 Membership.

(A) Qualifications.

(1) Membership on the medical staff of the CHRI is a privilege extended to doctors of medicine, osteopathic medicine, dentistry, and to practitioners of psychology and podiatry who consistently meet the qualifications, standards, and requirements set forth in the bylaws, rules and regulations of the medical staff, and the board of trustees of the Ohio state university. Membership on the medical staff is available on an equal opportunity basis without regard to race, color, creed, religion, sexual orientation, national origin, gender, age, handicap, genetic information or veteran/military status. Doctors of medicine, osteopathic medicine, dentistry, and practitioners of psychology and podiatry in faculty and administrative positions who desire medical staff membership shall be subject to the same policies and procedures as all other applicants for the medical staff.

(2) All members of the medical staff of the CHRI, except ~~community associate attending staff~~physician scholar medical staff, shall be members of the faculty of the Ohio state university college of medicine, or in the case of dentists, of the Ohio state university college of dentistry, and shall be duly licensed or certified to practice in the state of Ohio. Members of the limited staff shall possess a valid training certificate, or an unrestricted license from the applicable state board based on the eligibility criteria defined by that board. All members of the medical staff and limited staff and licensed health care professionals with clinical privileges shall comply with provisions of state law and the regulations of the respective state medical board or other state licensing board if applicable. Only those physicians, dentists, and practitioners of psychology and podiatry who can document their education, training, experience, competence, adherence to the ethics of their profession, dedication to educational and research goals and ability to work with others with sufficient adequacy to assure the Wexner medical center board and the board of trustees of the Ohio state university that any patient treated by them at the CHRI will be given high quality medical care provided at CHRI, shall be qualified for

eligibility for membership on the medical staff of the CHRI. ~~Except for community associate staff,~~ CHRI medical staff members shall also hold appointments to the medical staff of the Ohio state university hospitals for consulting purposes. Loss of such appointment shall result in immediate termination of membership on the CHRI medical staff and immediate termination of clinical privileges as of the effective date of the Ohio state university hospitals appointment termination. This consequence does not apply to an individual's suspension for completion of medical records. If the medical staff member regains an appointment to the Ohio state university hospitals medical staff, the affected medical staff member shall be eligible to apply for CHRI medical staff membership at that time. All applicants for membership, clinical privileges, and members of the medical staff must provide basic health information to fully demonstrate that the applicant or member has, and maintains, the ability to perform requested clinical privileges. The director of medical affairs of the CHRI, the medical director of credentialing, the department chairperson, the credentialing committee, the medical staff administrative committee, the quality and professional affairs committee of the Ohio state university Wexner medical center board, or the Ohio state university Wexner medical center board may initiate and request a physical or mental health evaluation of an applicant or member. Such request shall be in writing to the applicant.

(3) All members of the medical staff and licensed health care professionals will comply with medical staff and the CHRI policies regarding employee and medical staff health and safety, provision of uncompensated care, and will comply with appropriate administrative directives and policies which, if not followed, could adversely impact overall patient care or may adversely impact the ability of the CHRI employees or staff to effectively and efficiently fulfill their responsibilities. All members of the medical staff and licensed health care professionals shall agree to comply with bylaws, rules and regulations, and policies and procedures adopted by the medical staff administrative committee and the Wexner medical center board, including but not limited to policies on professionalism, behaviors that undermine a culture of safety, annual education and training (list approved by the medical staff administrative committee and maintained in the chief medical officer's office), conflict of interest, HIPAA compliance and access and communication guidelines. Medical staff members and licensed health care professionals with clinical privileges must also comply with the university integrity program requirements including but not limited to billing, self referral, ethical conduct and annual education.

(4) All members of the medical staff and credentialed providers must maintain continuous uninterrupted enrollment with all governmental healthcare programs. This includes any federal and state government programs.

(a) It shall be the duty of all medical staff members and credentialed providers to promptly inform the chief medical officer and the corporate credentialing office of any investigation, action taken, or the initiation of any process which could lead to an action taken by any governmental program.

(b) Exclusion of any medical staff member or ~~allied health professional~~ credentialed provider from participation in any federal or state government program or suspension from participation, in whole or in part, in any federal or state government reimbursement program, shall result in immediate lapse of membership on the medical staff of the CHRI and the immediate lapse of clinical privileges at the CHRI as of the effective date of the exclusion or suspension. Medical staff members may submit a request to resign their medical

staff membership to the Chief Medical Officer in lieu of automatic termination. The resignation in lieu of automatic termination shall be discussed at the next credentialing committee and medical staff administrative committee in order to provide recommendations to the Quality and Professional Affairs Committee of the Wexner Medical Center Board. A final determination should be decided by the Quality and Professional Affairs Committee at its next regular meeting.

~~(a)~~(c) If the medical staff member's or ~~allied health professional's~~ credentialed provider's participation in ~~these~~ all governmental programs is fully reinstated, the affected medical staff member or ~~allied health professional~~ credentialed provider shall be eligible to apply for membership and clinical privileges at that time. ~~It shall be the duty of all medical staff members and allied health professionals to promptly inform the director of medical affairs or medical director of credentialing of any action taken, or the initiation of any process, which could lead to such action taken by any of these programs.~~

(5) - (6) No Changes.

~~(7) Applicants for community associate attending medical staff category, practicing in a CHRI unit at another hospital, must have and maintain clinical privileges and active medical staff membership at that hospital~~.

(8) - (10) No Changes.

(B) Application for membership.

No Changes.

(C) Terms of appointment.

Initial appointment to the medical staff, except for the honorary category, shall be for a period not to exceed twenty-four months. An appointment or grant of privileges for a period of less than twenty-four months shall not be deemed an adverse action. During the first six months of the initial appointment, except medical staff appointments without clinical privileges, appointees shall be subject to focused professional practice evaluation (FPPE) in order to evaluate the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization pursuant to these bylaws. FPPE requires the evaluation by the clinical department chief with oversight by the credentials committee and the medical staff administrative committee. ~~In the case of community associate attendings, receipt of the positive evaluation provided by the clinical department chief in the primary hospital in which they hold privileges is required.~~

The provisional appointee identifies the primary hospital. Following the six month FPPE period, the clinical department chief may: (1) recommend the initial appointee to transition to ongoing professional practice evaluation (OPPE), which is described later in these bylaws to the medical staff administrative committee; (2) extend the FPPE period, which is not considered an adverse action, for an additional six months not to exceed a

total of twelve months for purposes of further monitoring and evaluation; or (3) terminate the initial appointee's medical staff membership and clinical privileges. In the event that the medical staff administrative committee recommends that an adverse action be taken against an initial appointee, the initial appointee shall be entitled to the provisions of due process as outlined in these bylaws.

(D) Professional ethics.

No Changes.

(E) Procedure for appointment.

(1) - (3) No Changes.

(4) The clinical department chief shall be responsible for investigating and verifying the character, qualifications and professional standing of the applicants by making inquiry of the primary source of such information and shall within thirty days of receipt of the completed application, submit a report of those findings along with a recommendation on medical staff membership and clinical privileges to the applicant's respective CHRI department chairperson and/or division director~~section chief~~. Licensed allied health professional applicants will have their clinical department chief's report submitted to the subcommittee of the credentials committee charged with review of applications for associates to the medical staff.

(5) The department chairperson and/or division director ~~section chiefs~~ shall receive all initial signed and verified applications from the appropriate clinical department chief and shall make a recommendation to the medical director of credentialing on each application. The medical director of credentialing shall make an initial determination as to whether the application is complete. The credentials committee, the medical staff administrative committee, the quality and professional affairs committee, and the Wexner medical center board have the right to render an application incomplete, and therefore not able to be processed, if the need arises for additional or clarifying information. The medical director of credentialing shall forward all completed applications to the credentials committee.

(6) - (11) No Changes.

(12) The recommendation of the medical staff administrative committee regarding an appointment decision shall be made within thirty days of receipt of the credentials committee recommendation and shall be communicated by the medical director of credentialing, along with the recommendation of the director of medical affairs, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Wexner medical center board has acted, the chair of the Wexner medical center board shall instruct the director of medical affairs to transmit the final decision to the clinical department chief, the applicant, and the respective department chairperson and/or division director~~section chief~~.

(13) No Changes.

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
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(14) The director of medical affairs, who may make a separate recommendation to the Wexner medical center board, shall directly communicate the final recommendation of the medical staff administrative committee to the Wexner medical center board. When the Wexner medical center board has acted, the director of medical affairs will transmit the final decision to the clinical department chief, the applicant, the respective department chairperson and/or division director~~section chief~~, and the Ohio state university board of trustees.

(F) Procedure for reappointment.

(1) No Changes.

(2) The reappointment application shall include all information necessary to update and evaluate the qualification of the applicant. The clinical department chief shall review the information available on each applicant for reappointment and shall make recommendations regarding reappointment to the medical staff and for granting of privileges for the ensuing appointment period. The clinical department chief's recommendation shall be transmitted in writing along with the signed and completed reappointment forms to the appropriate department chairperson and/or division director ~~section chief~~ at least forty-five days prior to the end of the individual's appointment. The terms of paragraphs (A), (B), (C), (D), (E)(1), and (E)(2) of this rule shall apply to all applicants for reappointment. Only completed applications for reappointment shall be considered by the credentials committee.

(3) - (4) No Changes.

(5) The clinical department chief shall submit a report of those findings along with a recommendation on reappointment to the applicant's respective CHRI department chairperson and/or division director~~section chief~~. Licensed allied health professional applicants will have their clinical department chief's report submitted to the subcommittee of the credentials committee charged with review of application for associates to the medical staff. The department chairperson and/or division director ~~section chief~~ shall review the reappointment application and forward to the medical director of credentialing with a recommendation for reappointment. The medical director of credentialing shall forward the reappointment forms and the recommendations of the clinical department chief and department chairperson and/or division director ~~section chief~~ to the credentials committee. The credentials committee shall review the request for reappointment in the same manner, and with the same authority, as an original application for medical staff membership. The credentials committee shall review all aspects of the reappointment application including source verification of the member's quality assurance record for continuing membership qualifications and for continuing clinical privileges. The credentials committee shall review each member's performance-based profile to ensure that all medical staff members deliver the same level of quality of care with similar delineated clinical privileges across all clinical departments and across all categories of medical staff membership.

(6) - (8) No Changes.

(9) The medical staff administrative committee shall review each request for reappointment in the same manner and with the same authority as an original application for appointment to the medical staff and shall accept, reject, or modify the request for reappointment in the same manner and with the same

authority as an original application. The recommendation of the medical staff administrative committee regarding reappointment shall be communicated by the medical director of credentialing, along with the recommendation of the director of medical affairs, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Wexner medical center board has acted, the chair of the Wexner medical center board shall instruct the director of medical affairs to transmit the final decision to the clinical department chief, the applicant, and the department chairperson and/or division director~~section chief~~.

(10) - (11) No Changes.

(G) Resumption of clinical activities following a leave of absence:

(1) A member of the medical staff or credentialed provider shall request a leave of absence in writing for good cause shown such as medical reasons, educational and research reasons or military service to the chief of clinical service and the director of medical affairs. Such leave of absence shall be granted at the discretion of the chief of the clinical service and the director of medical affairs provided, however, such leave shall not extend beyond the term of the member's or credentialed provider's current appointment. A member of the medical staff or credentialed provider who is experiencing health problems that may impair his or her ability to care for patients has the duty to disclose such impairment to his or her chief of clinical department and the director of medical affairs and the member or credentialed provider shall be placed on immediate medical leave of absence until such time the member or credentialed provider can demonstrate to the satisfaction of the director of medical affairs that the impairment has been sufficiently resolved and can request for reinstatement of clinical activities. During any leave of absence, the member or credentialed provider shall not exercise his or her clinical privileges, and medical staff responsibilities and prerogatives shall be inactive.

(2) The member or credentialed provider must submit a written request for the reinstatement of clinical privileges to the chief of the clinical service. The chief of the clinical service shall forward his recommendation to the credentialing committee which, after review and consideration of all relevant information, shall forward its recommendation to the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board. The credentials committee, the director of medical affairs, the medical director of credentialing, the chief of the clinical service or the medical staff administrative committee shall have the authority to require any documentation, including advice and consultation from the member's or credentialed provider's treating physician or the committee for practitioner health that might have a bearing on the medical staff member's or credentialed provider's ability to carry out the clinical and educational responsibilities for which the medical staff is seeking privileges. Upon return from a leave of absence for medical reasons the medical staff member or credentialed provider must demonstrate his or her ability to exercise his or her clinical privileges upon return to clinical activity.

(3) All members or credentialed providers of the medical staff who take a leave of absence for medical or non-medical reasons must be in good standing on the medical staff upon resumption of clinical activities. No member shall be granted leave of absence in excess of his or her current appointment and the usual procedure for appointment and reappointment, including deadlines for submission of application as set forth in this rule will apply irrespective of the nature of the leave. Absence extending beyond his or her current term of failure to request reinstatement of clinical privileges shall be deemed a voluntary

resignation from the medical staff and of clinical privileges, and in such event, the member or credentialed provider shall not be entitled to a hearing or appeal.

(Board approval dates: 9/1/1993, 3/3/1995, 4/3/1996, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 4/5/2002, 2/6/2004, 11/4/2005, 8/6/2007, 2/6/2009, 9/18/2009, 5/14/2010, 10/29/2011, 4/8/2011, 8/31/2012, 2/1/2013, 6/6/2014, 11/7/2014, 11/6/2015, 9/2/2016)

3335-111-05 Peer review and corrective action.

(A) Informal peer review.

(1) All medical staff members agree to cooperate in informal peer review activities that are solely intended to improve the quality of medical care provided to patients at the CHRI.

(2) Information indicating a need for informal review, including patient complaints, disagreements, questions of clinical competence, inappropriate conduct and variations in clinical practice identified by the clinical ~~sections~~ departments or divisions and medical staff committees shall be referred to the chair of the practitioner evaluation committee.

(3) The practitioner evaluation committee chair or his or her designee may obtain information or opinions from medical staff members or credentialed providers as well as external peer review consultants pursuant to criteria outlined in these bylaws. The information or opinions from the informal peer review may be presented to the practitioner evaluation committee or another designated peer review committee.

~~The practitioner evaluation committee chair, or his or her designee, will consult with the affected medical staff member and obtain information or opinions from knowledgeable persons within the medical center as well as external peer review consultants, pursuant to criteria outlined in these bylaws.~~

(4) Following the assessment by the practitioner evaluation committee chair or his or her designee, the practitioner evaluation committee may make recommendations for educational actions of additional training, sharing of comparative data or monitoring or provide other forms of guidance to the medical staff member to assist him or her in improving the quality of patient care. Such actions are not regarded as adverse, do not require reporting to any governmental or other agency, and do not invoke a right to any hearing.

(5) At the conclusion of the evaluation, the practitioner evaluation committee chair or his or her designee submits a report to the applicable clinical department chief and the director of medical affairs. The clinical department chief and the director of medical affairs shall evaluate the matter to determine the appropriate course of action. They shall make an initial written determination on whether:

~~(1)~~ (a) The matter warrants no further action;

~~(2)~~ (b) Informal resolution under this paragraph is appropriate. The clinical department chief and the director of medical affairs shall determine whether to include documentation of the informal resolution in the medical staff member's file. If documentation is included in the member's file, the affected member shall have an opportunity to review it and may make a written response which shall also be placed in the

file. Informal review under this paragraph is not a procedural prerequisite to the initiation of formal peer review under paragraph (B) of this rule; or

~~(3)~~ (c) ~~-~~Formal peer review under paragraph (B) of this rule is warranted. In cases where the clinical department chief and director of medical affairs cannot agree, the matter shall be submitted and determined as set forth in paragraph (B) of this rule.

(B) Formal peer review.

(1) No Changes.

(2) Formal peer review may be initiated by the clinical department chief, the department chairperson and/or division director~~section chief~~, the director of medical affairs, any member of the medical staff, the chief executive officer of the CHRI, the dean of the college of medicine, any member of the Wexber medical center board, or the vice president for health services. All requests for formal peer review shall be in writing, shall be submitted to the director of medical affairs, and shall be supported by reference to the specific activities or conduct which constitute grounds for the requested action.

(3) - (4) No Changes.

(5) The formal peer review committee shall investigate every request and shall report in writing ~~within thirty days~~ its findings and recommendations for action to the appropriate clinical department chief and notice given to the ~~section chief~~division director. In making its recommendation the formal peer review committee may consider as appropriate, relevant literature and clinical practice guidelines, all the opinions and views expressed throughout the review process, and any information or explanations provided by the member under review. Prior to making its report, the medical staff member against whom the action has been requested shall be afforded an opportunity for an interview with the formal peer review committee. At such interview, the medical staff member shall be informed of the specific activities alleged to constitute grounds for formal peer review, and shall be afforded the opportunity to discuss, explain or refute the allegations against the medical staff member. The medical staff member may furnish written or oral information to the formal peer review committee at this time. However, such interview shall not constitute a hearing, but shall be investigative in nature. The medical staff member shall not be represented by an attorney at this interview. The written findings and recommendations for action is expected to be submitted within 90 days, unless an extension is deemed necessary by the committee.

(6) Upon receipt of the written report from the formal peer review committee, the appropriate clinical department chief shall~~, within seven days,~~ make his or her own written determination and forward that determination along with the findings and recommendations of the formal peer review committee to the director of medical affairs, or if required by paragraph (B)(3) of this rule, to the executive vice president for health sciences or designee.

(7) Following receipt of the recommendation from the clinical department chief and the report from the formal peer review committee, the director of medical affairs, or the executive vice president for health sciences or designee, shall ~~have ten days to~~ approve or to modify the determination of the clinical department chief. Following receipt of the report of the clinical department chief, the director of medical

affairs or executive vice president for health sciences or designee shall decide whether the grounds for the requested corrective action are such as should result in a reduction, suspension or revocation of clinical privileges. If the director of medical affairs, or executive vice president for health sciences or designee, decides the grounds are not substantiated, the director of medical affairs will notify the formal peer review committee; clinical department chief and if applicable, the academic department chairperson; division director~~section chief~~; person(s) who filed the complaint and the affected medical staff member, in writing, that no further action will be taken.

In the event the director of medical affairs or executive vice president for health sciences or designee finds the grounds for the requested corrective action are substantiated, the director of medical affairs shall promptly notify the affected medical staff member of that decision and of the affected medical staff member's right to request a hearing before the medical staff administrative committee pursuant to rule 3335-111-06 of the Administrative Code. The written notice shall also include a statement that the medical staff member's failure to request a hearing in the timeframe prescribed in rule 3335-111-06 of the Administrative Code shall constitute a waiver of rights to a hearing and to an appeal on the matter; a statement that the affected medical staff member shall have the procedural rights found in rule 3335-111-06 of the Administrative Code; and a copy of the rule 3335-111-06 of the Administrative Code. This notification and an opportunity to exhaust the administrative hearing and appeal process shall occur prior to the imposition of the proposed corrective action unless the emergency provisions outlined in paragraph (D) of this rule apply. This written notice by the director of medical affairs shall be sent certified return receipt mail to the affected medical staff member's last known address as determined by university records.

(8) - (9) No Changes.

(C) Composition of the formal peer review committee.

No Changes.

(D) Summary suspension.

(1) Notwithstanding the provisions of this rule, a member of the medical staff shall have all or any portion of clinical privileges immediately suspended or appointment terminated by the chief executive officer or ~~section chief~~ department chairperson and/or division director, whenever such action must be taken when there is imminent danger to patients or to the patient care operations. Such summary suspension shall become effective immediately upon imposition and the chief executive officer will subsequently notify the medical staff member in writing of the suspension. Such notice shall be by certified return receipt mail to the affected medical staff member's last known address as determined by university records.

(2) No Changes.

(3) Immediately upon the imposition of a summary suspension, the chief executive officer in consultation with the appropriate ~~section chief~~ department chairperson and/or division director, shall have the authority to provide for alternative medical coverage for the patients of the suspended medical staff member who remain in the hospital at the time of suspension. The wishes of the patient shall be considered in the selection of such alternative medical coverage. While a summary suspension is in effect,

the member of the medical staff is ineligible for reappointment to the medical staff. Medical staff and hospital administrative duties and prerogatives are suspended during the summary suspension.

(E) Automatic suspension and termination~~.~~

(1) - (2) No Changes.

(3) Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurer, shall result in immediate and automatic suspension of a medical staff member's appointment and privileges until such time as proof of appropriate insurance coverage is furnished. In the event such proof is not provided within ten days of notice of such suspension, the medical staff member or credentialed provider shall be deemed to no longer comply with medical staff requirements under 3335-111-04 and automatically relinquish ~~have voluntarily terminated~~ his or her appointment and privileges.

(4) Upon exclusion, debarment, or other prohibition from participation in any state or federal health care reimbursement program, or a federal procurement or non-procurement program, the medical staff member's appointment and privileges shall ~~be~~ immediately and automatically terminate, unless resignation in lieu of automatic terminations is permitted pursuant to rule 3335-43-04(A)(4). ~~suspended until such time as the exclusion, debarment, or prohibition is lifted.~~

(5) - (8) No Changes.

(Board approval dates: 9/1/1993, 5/2/1997, 9/1/1999, 10/1/1999, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 10/29/2011, 4/8/2011, 11/7/2014, 11/6/2015)

3335-111-06 Hearing and appellate review procedure

(A) Right to hearing before the medical staff administrative committee and to appellate review.

(1) When a member of the medical staff has exhausted remedies under paragraph (F) of rule 3335-111-04 of the Administrative Code on reappointments; or under rule 3335-111-05 of the Administrative Code for corrective action; or who has been summarily suspended under paragraph (D) of rule 3335-111-05 of the Administrative Code ~~receives notice of a proposed action by the chief executive officer or the director of medical affairs that will adversely affect reappointment as a member of the medical staff or the exercise of clinical privileges,~~ the staff member shall be entitled to an adjudicatory hearing.

(2) A medical staff member shall not be entitled to a hearing under the following circumstances:

(a) Denial of the Wexner medical center board to grant a waiver of board certification for a medical staff member.

(b) Termination of a medical staff member because of exclusion from participation in any government reimbursement program.

(c) Voluntary withdrawal of a medical staff application.

(d) Failure to submit a reappointment application.

(e) A leave of absences extending beyond current appointment or failure to request reinstatement of clinical privileges following a leave of absence.

(f) Actions or recommendations resulting from an informal peer review.

(g) Termination of courtesy B medical staff appointments upon approval by the Wexner medical center board.

(32) All hearings and appellate reviews shall be in accordance with the procedural safeguards set forth in this rule to assure that the affected medical staff member is accorded all rights to which the member is entitled.

(B) Request for hearing.

No Changes.

(D) Conduct of hearing.

No Changes.

(E) Appeal process.

(1) - (6) No Changes.

(7) Any final decision by the Wexner medical center board shall be communicated by the chief executive officer by certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records. The chief executive officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief medical officer of OSU medical center, the vice president for health services, the director of medical affairs, chief of staff, the ~~section chief~~department chairperson and/or division director, clinical department chief and the academic department chairperson and the person(s) who initiated the request for formal peer review. The chief executive officer shall take immediate steps to implement the final decision.

(Board approval dates: 9/1/1993, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 10/29/2010, 4/8/2011, 11/7/2014, 11/6/2015)

3335-111-07 Categories of the medical staff.

The medical staff of the CHRI shall be divided into honorary, physician scholar, attending, associate attending, clinical attending, ~~community associate attending,~~ consulting medical staff and limited designations. All medical staff members with admitting privileges may admit patients in accordance with state law and criteria for standards

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
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UBOT: 04.06.18

of care established by the medical staff. Medical staff members who do not wish to obtain any clinical privileges shall be exempt from the requirements of medical malpractice liability insurance, DEA registration, demonstration of recent active clinical practice during the last two years and specific annual education requirements as outlined in the list maintained in the chief medical officer's office, but are otherwise subject to the provisions of these bylaws.

(A) Honorary staff.

The honorary staff will be composed of those individuals who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature in an oncology field of interest. The honorary staff designation is awarded by the Wexner medical center board on the recommendation of the chief executive officer of the CHRI, executive vice president for health sciences, ~~section chief~~department chairperson and/or division director, or the credentials committee after approval by the medical staff administrative committee. This is a lifetime appointment. Honorary staff are not entitled to patient care privileges.

(B) Physician scholar medical staff.

(1) Qualifications: The physician scholar medical staff shall be composed of those faculty members of the colleges of medicine and dentistry who are recognized for outstanding reputation, notable scientific and professional contributions, and high professional stature. This medical staff category includes but is not limited to emeritus faculty members. Nominations may be made to the chair of the credentialing committee who shall present the candidate to the medical staff administrative committee for approval.

(2) Prerogatives: Members of the physician scholar medical staff shall have access to the CHRI and shall be given notice of all medical staff activities and meetings. Members of the physician scholar medical staff shall enjoy all rights of an attending medical staff member except physician scholar members shall not possess clinical privileges.

(3) Physician scholar medical staff must have either a full license or an emeritus registration by the State Medical Board of Ohio.

(C) Attending medical staff.

(1) Qualifications:

The attending staff shall consist of those regular faculty members of the colleges of medicine and dentistry who are licensed or certified in the state of Ohio, whose practice is at least seventy-five percent oncology and with a proven career commitment to oncology as demonstrated by the majority of the following:

Training, current board certification (as specified in paragraph (A)(5) of rule 3335-111-04 of the Administrative Code), publications, grant funding, other funding and experience (as deemed appropriate by the chief executive officer and the ~~section chief~~department chairperson and/or division director); and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.

(2) Prerogatives:

No Changes.

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
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(3) Responsibilities:

No Changes.

(D) Associate attending staff.

No Changes.

(E) Clinical attending staff.

(1) Qualifications:

The clinical attending staff shall consist of those clinical faculty members of the colleges of medicine and dentistry who have training, expertise, and experience in oncology, as determined by the chief executive officer in consultation with the ~~section chief~~ department chairperson or division director and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code.

(2) Prerogatives:

No Changes.

(3) Responsibilities:

No Changes.

~~(F) Community associate attending staff.~~

~~(1) Qualifications:~~

~~The community associate attending staff shall consist of those applicants who do not have faculty appointments in any of the academic units of the Ohio state university and who are licensed in the state of Ohio and who satisfy the requirements and qualifications for membership set forth in rule 3335-111-04 of the Administrative Code. All applications for appointment and reappointment to the community associate attending staff shall be made to the chief executive officer for initial evaluation. The chief executive officer shall consult with the clinical department chief and the chairperson of the appropriate academic department and when appropriate may refer each application for completion of the appointment procedure in accordance with pertinent requirements of paragraph (E) or (F) of rule 3335-111-04 of the Administrative Code. The approval of the clinical department chief and the academic department chairperson or section chief shall not be required.~~

~~(2) Prerogatives:~~

~~The community associate attending staff members may:~~

~~(a) Provide consulting services to James patients.~~

~~(b) Admit patients when the primary diagnosis is cancer or cancer-related.~~

~~(c) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.~~

~~(d) Attend all meetings of the medical staff as non-voting members and attend any and all medical staff or hospital education programs. The community associate attending staff member may not hold elected office in the medical~~

~~staff organization except to serve as a non-voting, ex-officio member of medical staff committees if appointed pursuant to these rules.~~

~~(3) Responsibilities:~~

~~The community associate attending staff members shall:~~

~~(a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.~~

~~(b) Retain responsibility within their care area of professional competence for the continuous care and supervision of each patient for whom the member is providing care, or arrange a suitable alternative for such care and supervision.~~

~~(c) Actively participate in such quality evaluation and monitoring activities as required by the staff and discharge such staff functions as may be required from time to time.~~

~~(d) Satisfy the requirements set forth in rule 3335-111-13 of the Administrative Code for attendance at staff meetings and meetings of those committees of which they are a member.~~

~~(e) Supervise members of the limited staff in the provision of patient care in accordance with accreditation standards and policies and procedures of approved clinical training programs.~~

(~~G~~F) Consulting medical staff.

No Other Changes.

(~~G~~H) Limited staff.

Limited staff are not considered members of the medical staff, do not have delineated clinical privileges, and do not have the right to vote in general medical staff elections. Except where expressly stated, limited staff are bound by the terms of these bylaws, rules and regulations of the medical staff and the limited staff agreement.

(1) Qualifications:

No Changes.

(2) Responsibilities:

The limited staff shall:

(a) No Changes.

(b) No Changes.

(c) Participate in the care of all patients assigned to the limited staff member under the appropriate supervision of a designated member of the attending medical staff in accordance with accreditation standards and policies and procedures of the clinical training programs. The clinical activities of the limited staff shall be determined by the program director appropriate for the level of education and training. Limited staff shall be permitted to perform only those services that they are authorized to perform by the member of the attending medical staff based

on the competence of the limited staff to perform such services. The limited staff may admit or discharge patients only when acting on behalf of the attending, associate attending or~~,~~ clinical attending ~~or community associate attending~~ medical staff. The limited staff member shall follow all rules and regulations of the service to which he or she is assigned, as well as the general rules of the CHRI pertaining to limited staff.

(d) No Changes.

(e) No Changes.

(f) Appeal by a member of the limited staff of probation, lack of ~~reappointment~~promotion, suspension or termination for failure to meet expectations for professional growth or failure to display appropriate humanistic qualities or failure to successfully complete any other competency as required by the accreditation standards of an approved training program will be conducted and limited in accordance with written guidelines established by the respective academic department or training program and approved by the program director ~~of medical affairs~~ and the Ohio state university's graduate medical education committee as delineated in the limited staff agreement and by the graduate medical education policies..

Alleged misconduct by a member of the limited staff, for reasons other than failure to meet expectations of professional growth as outlined above, shall be handled in accordance with rules 3335-111-05 and 3335-111-06 of the Administrative Code.

(3) Failure to meet reasonable expectations:

~~Failure to meet reasonable expectations may result in sanctions including but not limited to probation, lack of reappointment, suspension or termination.~~ Termination of employment from the limited staff member's residency or fellowship training program ~~limited staff member status~~ shall result in automatic termination of the limited staff member's ~~residency or fellowship~~ appointment pursuant to these bylaws.

(4) Temporary appointments:

(a) No Changes.

(b) No Changes.

(5) Supervision:

Limited staff members shall be under the supervision of an attending, associate attending~~,~~ or clinical attending ~~or community associate attending~~ medical staff member. Limited staff members shall have no privileges as such but shall be able to care for patients under the supervision and responsibility of their attending, associate attending or~~,~~ clinical attending ~~or community associate attending~~ medical staff member. The care they extend will be governed by these bylaws and the general rules and regulations of each clinical department. The practice of care shall be limited by the scope of privileges of their attending, associate attending~~,~~ or clinical attending ~~or community associate attending~~ medical staff member. Any

concerns or problems that arise in the limited staff member's performance should be directed to the attending, associate attending~~,~~ or ~~-~~clinical attending ~~or community associate attending~~ medical staff member or the director of the training program.

(a) Limited staff members may write admission, discharge and other orders for the care of patients under the supervision of the attending, associate attending or~~,~~ clinical attending ~~or community associate attending~~ medical staff member.

(b) All records of limited staff member cases must document involvement of the attending, associate attending~~,~~ or clinical attending ~~or community associate attending~~ medical staff member in the supervision of the patient's care to include co-signature of the admission order history and physical, operative report, and discharge summary.

(H~~I~~) Associates to the medical staff.

No Other Changes.

(I~~J~~) Temporary medical staff appointment.

No Other Changes.

(J~~K~~) Clinical privileges.

(1) Delineation of clinical privileges:

(a) No Changes.

(b) Each clinical department and CHRI ~~section~~ department and/or division shall develop specific clinical criteria and standards for the evaluation of privileges with emphasis on invasive or therapeutic procedures or treatment which represent significant risk to the patient or for which specific professional training or experience is required. Such criteria and standards are subject to the approval of the medical staff administrative committee and the Wexner medical center board.

(c) - (i) No Changes.

(2) Temporary and special privileges:

(a) Temporary privileges may be extended to a doctor of medicine, osteopathic medicine, dental surgery, psychologist, podiatry or to a licensed allied health professional upon completion of an application prescribed by the medical staff administrative committee, upon recommendation of

the chief of the clinical department, and approval by the director of medical affairs. The director of medical affairs~~, acting as a member and on behalf of the Wexner medical center board,~~ has been delegated responsibility by the Wexner medical center board to grant approval of temporary privileges. The temporary privileges granted shall be consistent with the applicant's training and experience and with clinical department guidelines. Prior to granting temporary privileges, primary source verification of licensure and current competence shall be required. Temporary privileges shall be limited to situations which fulfill an important patient care need and shall not be granted for a period not to exceed one hundred twenty days.

(b) - (g) No Changes.

(3) Expedited privileges:

No Changes.

(4) Podiatric privileges:

No Changes.

(5) Psychology privileges:

No Changes.

(6) Dental privileges:

No Changes.

(7) Oral and maxillofacial surgical privileges:

No Changes.

(8) Licensed allied health professionals:

No Changes.

(9) Emergency privileges:

No Changes.

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
MSAC: 12.08.17
Medical Staff Vote: 12.22.17
Quality and Professional Affairs: 03.27.18
MC Board: 04.04.18
UBOT: 04.06.18

(10) Disaster privileges:

No Changes.

(11) Telemedicine:

No Changes.

(Board approval dates: 9/1/1993, 3/3/1995, 4/3/1996, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 8/6/2006, 2/6/2009, 9/18/2009, 5/14/2010, 10/29/2011, 4/8/2011, 8/31/2012, 2/1/2013, 11/7/2014, 11/6/2015)

3335-111-08 Organization of the CHRI medical staff.

(A) The chief executive officer.

No Changes.

(B) The director of medical affairs (physician-in-chief/chief medical officer of the James cancer hospital).

(1) Method of appointment:

The director of medical affairs shall be appointed by the executive vice president for health sciences upon recommendation by the chief executive officer of the James Cancer Hospital. The director of medical affairs is the physician-in-chief and shall be the chief medical officer of the CHRI and must be a member of the attending medical staff of the CHRI.

(2) Responsibilities:

The director of medical affairs shall report to the chief executive officer~~, the executive vice president for health sciences, the CHRI hospital board,~~ and the Wexner medical center board for the quality of patient care provided in the CHRI. The director of medical affairs shall assist the chief executive officer in the administration of medical affairs including quality assurance and credentialing. In addition, the director of medical affairs ~~will decide~~ determines~~the~~ initial ~~attending status~~ medical staff category appointments, ~~and~~ reappointments and any changes in categories of the medical staff. ~~ongoing categorization of CHRI faculty~~.

(C) The chief medical officer of the Ohio state university medical center.

The chief medical officer of the Ohio state university medical center is the senior medical officer for the medical center with the responsibility and authority for all health and medical care delivered at the medical center. The chief medical officer is responsible for overall quality improvement and clinical leadership throughout the medical center, physician alignment, patient safety and medical staff development. The appointment, scope of authority,

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and responsibilities of the chief medical officer shall be as outlined in the Ohio state medical center board bylaws. The director of medical affairs will work collaboratively with the chief medical officer and medical directors of each hospital of the medical center for the: coordination and supervision of patient care and clinical activities, responsibility for the clinical organization of his or her respective hospital, and to establish priorities, jointly with the chief executive officer or executive director of his or her respective hospital, for capital medical equipment, clinical space, and the establishment of new clinical programs, or the revision of existing clinical programs.

(D) The chief quality officer of the Ohio state university medical center.

The chief quality and patient safety officer of the Ohio state university medical center is referred to herein these bylaws as the chief quality officer. The chief quality officer reports to the chief medical officer ~~for administrative and operational issues and has an independent reporting relationship to the executive vice president for health sciences regarding quality data and patient safety events~~. The chief quality officer works collaboratively with clinical leadership of the medical center, including medical director of quality for the CHRI, director of medical affairs for the CHRI, nursing leadership and hospital administration. The chief quality officer provides leadership in the development and measurement of the medical center's approach to quality, patient safety and reduction of adverse events. The chief quality officer communicates and implements strategic, operational and programmatic plans and policies to promote a culture where patient safety is an important priority for medical and hospital staff.

(E) Medical director of credentialing.

No Changes.

~~(F) Associate physician-in-chief.~~

~~The associate to the physician-in-chief oversees the alignment of clinical service lines within the cancer program. The associate serves at the direction of the physician-in-chief to further the global cancer mission at OSU. The role functions as a key strategic liaison between the physician-in-chief, chief of staff and the medical staff to strategically grow the footprint of the cancer program. The associate physician-in-chief reports to the physician-in-chief of the James.~~

(~~G~~F) Medical director ~~of surgical services~~, James surgical services.

The ~~chief of surgical services~~medical director, James surgical services has oversight of all James designated perioperative services and procedural suites. Working collaboratively with the administrator of perioperative services, the ~~chief of surgical services~~medical director, James surgical services facilitates the timely sharing of OR resources (including personnel and equipment) across the medical center in order to maximize the efficiency of OR services. The ~~chief of surgical services~~medical director, James surgical services works with clinical service lines and clinical leadership to coordinate OR services in a manner that enhances the quality of care and safety of services for patients. The ~~chief of surgical services~~medical director, James surgical services reports to the ~~physician-in-chief~~Director of medical affairs of the James.

UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
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~~-~~(H) ~~The sections.~~Professional assignments

Each member of the attending, associate attending, clinical, limited, physician scholar and honorary staff shall be assigned to a ~~CHRI section~~ division and/or department by the chief executive officer upon the recommendation of the appropriate academic department chairperson and the credentials committee.

~~There are four clinical sections: medical oncology, surgical oncology, radiation oncology and pathology.~~ Appointment to a specific ~~section~~ department and/or division ~~-~~is based on the clinical specialty of the applicant for medical staff membership. Each ~~section~~ department and/or division ~~-~~is headed by a ~~section chief~~ department chairperson or division director who has the responsibility to oversee all research and clinical activities conducted by members of the ~~section~~ department and/or division. Specifically, the ~~section chief~~ department chairperson or division director shall be responsible for the following: the development and implementation of policies and procedures that guide and support the provision of service; recommendations re: staffing needs and clinical privileges for all members appointed to the ~~section~~ department and/or division; the orientation and continuing surveillance of the professional performance of all ~~section~~ department and/or division members; recommendation for space and other resources needed. ~~The section chiefis appointed by the chief executive officer.~~

(I) Clinical department chief.

No Changes.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 12/3/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 7/7/2006, 2/6/2009, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 8/31/2012, 2/01/2013, 6/6/2014, 11/6/2015)

3335-111-09 Elected officers of the medical staff of the CHRI.

(A) Chief of staff.

The chief of staff shall:

(1) - (3) No Changes.

(4) Make medical staff committee appointments jointly with the ~~physician-in-chief~~director of medical affairs and chief of staff-elect for approval by the CHRI medical staff administrative committee.

(5) - (6) No Changes.

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(B) Chief of staff-elect.

No Changes.

(C) Delegates at-large.

Up to two additional at-large member(s) may be appointed to the ~~-~~medical staff administrative committee at the recommendation of the chief executive officer of the CHRI, subject to the approval of the medical staff administrative committee and subject to review and renewal ~~on a yearly basis~~ every two years. ~~There shall be two delegates at-large that are members of the medical staff. Each delegate at large shall be a member of the medical staff administrative committee and shall serve on those committees of the medical center board as appointed by the chairperson of the medical center board.~~

(D) Qualifications of officers.

(1) Officers must be members of the attending or associate attending staff at the time of their nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

(2) The chief executive officer and director of medical affairs, chiefs of the clinical departments, ~~department chairperson~~ or division director~~section chiefs~~, medical directors, associate and/or assistant medical directors are not eligible to serve as chief of staff or chief of staff-elect unless they are replaced in their CHRI administrative role during the period of their term of office.

(E) Election of officers.

(1) - (3) No Changes.

(4) The committee's nominees will be submitted by electronic or written ballot to all voting members of the medical staff no later than ~~April~~May.

(5) Candidates for the office of chief of staff-elect will be listed and each attending ~~or associate attending~~ staff member may vote for one. ~~Candidates for the at-large positions will be voted upon as a group. Each voting member of the medical staff may vote for two at-large candidates. The two candidates with the highest number of votes will be elected. A majority of the votes is not necessary.~~

(6) No Changes.

(F) Term of office.

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UH and James Bylaws Committee: 10.09.17
James Bylaws Committee: 12.01.17
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No Changes.

(G) Vacancies in office.

(1) - (2) No Changes.

(3) Vacancies in the at-large representatives' positions will be filled by appointment by the ~~chief of staff~~ chief executive officer.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 9/1/1999, 4/5/2002, 9/6/2002, 2/6/2004, 11/4/2005, 2/6/2009, 9/18/2009, 2/11/2011, 4/8/2011, 6/6/2014, 9/2/2016)

3335-11-10 Administration of the medical staff of the CHRI

Medical staff committees.

(A) - (B) No Changes.

(C) Medical staff administrative committee:

(1) Composition:

(a) Voting membership includes: chief of staff, chief of staff-elect, immediate past chief of staff, ~~section chiefs~~ clinical department chief ~~chairperson~~ or division director of medical oncology, radiation oncology, ~~surgical oncology, and~~ anatomic pathology and molecular pathology;~~;~~ ~~division chiefs of~~ department chairperson or division director of hematology, gynecologic oncology, otolaryngology/head and neck, hospital medicine, human genetics, infectious diseases, surgical oncology, thoracic surgery, neurological oncology, orthopaedic oncology/sarcoma, pulmonary, critical care and sleep medicine and urology; medical director of James emergency services; clinical department chiefs of anesthesia, physical medicine and rehabilitation, plastic surgery, psychiatry, and radiology; CHRI medical director of quality, CHRI medical director of credentialing, CHRI chief executive officer, CHRI director of medical affairs, director of the division of palliative medicine, chairperson of the cancer subcommittee, CCC director for clinical research, ~~and~~ CCC director for cancer control, and medical director of the James surgical services ~~and associate director of James surgical services~~. Up to two additional at-large member(s) may be appointed to the MSAC at the recommendation of the chief executive officer of the CHRI, subject to the approval of the medical staff administrative committee and subject to review and renewal on a yearly basis. If a division ~~or section head~~chairperson ~~or~~ director is a member by

leadership position, he or she will also fulfill the role of division ~~or section~~ ~~department~~ ~~chief~~ director appointment. The director of medical affairs shall be the chairperson and the chief of staff shall be the vice-chairperson.

(b) Ex-officio non-voting membership includes: the CHRI executive director, ~~the CHRI associate director for professional education,~~ the CHRI chief nursing officer, CHRI executive director of patient services, the medical director of university hospital and/or the chief medical officer of the medical center, the dean of the Ohio state university college of medicine and~~,~~ the executive vice president for health sciences. ~~and the associate director for medical staff affairs.~~

(c) - (e) No Changes.

(2) - (4) No Changes.

(D) Credentialing committee of the hospitals of the Ohio state university:

(1) Composition:

The credentialing responsibilities of the medical staff are delegated to the credentialing committee of the hospitals of the Ohio state university, the composition of which shall include representation from the medical staff of each hospital.

The chief medical officer of the medical center shall appoint the credentialing committee of the hospitals of the Ohio state university. The ~~chief of staff,~~ director of medical affairs and medical director of credentialing shall make recommendation to the chief medical officer for representation on the credentialing committee of the hospitals of the Ohio state university.

The credentialing committee of the hospitals of the Ohio state university shall meet at the call of its chair, whom shall be appointed by the chief medical officer of the medical center.

(2) Duties:

(a) - (d) No Changes.

(e) To make recommendations to the medical staff administrative committee through the medical director of credentialing regarding appointment applications and initial requests for clinical privileges. Such recommendations shall include the name, status, department (division and/or department~~division/section~~), medical school and year of graduation, residency and fellowships, medical-related employment since graduation, board certification and recertification, licensure status as well as all other relevant information concerning the applicant's current competence, experience, qualifications, and ability to perform the clinical privileges requested;

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(f) - (l) No Changes.

(3) Licensed health care professionals subcommittee:

No Changes.

(E) Medical staff bylaws committee:

(1) Composition.

(F) Committee for practitioner health.

No Changes.

(G) Cancer subcommittee:

(1) Composition:

Required to be included as members of the cancer subcommittee are physician representatives from surgery, medical oncology, ~~diagnostic~~ radiology, radiation oncology, anesthesia, plastic surgery, urology, otolaryngology/head and neck, hematology, gynecologic oncology, thoracic surgery, orthopaedic oncology, neurological oncology, emergency medicine, palliative medicine and pathology, the cancer liaison physician and nonphysician representatives from the cancer registry, administration, nursing, social services, and quality assurance. Other disciplines should be included as appropriate for the institution. The chairperson is appointed at the recommendation of the chief executive officer of the CHRI and the director of medical affairs, subject to the approval of the medical staff administrative committee and subject to review and renewal on a yearly basis.

(2) - (3) No Changes.

(H) Ethics committee.

No Changes.

(I) Practitioner evaluation committee.

No Changes.

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(J) Professionalism consultation committee.

No Changes.

3335-111-11 History and physical.

No changes.

3335-111-12 Amendments and Adoption

No changes.

3335-111-13 Meetings and dues.

(A) Meetings.

The medical staff of the CHRI shall conduct scheduled meetings semi-annually. Notice of the meetings will be sent to all medical staff at least two weeks prior to the meeting. Attendance is encouraged, but shall not be a requirement for continued medical staff membership and clinical privileges. ~~A s~~Special or electronic meetings may be called at the option of the medical staff administrative committee.

(B) No Changes.

3335-11-14 Rules of construction.

No Changes.

The James

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Quality and Professional Affairs: 3.28.18
MC Board: 4.4.18
UBOT: 4.6.18

Medical Staff Rules and Regulations – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

Updated September 2, 2016

01 Ethical pledge.

No Change

02 Admission procedures.

No Change

03 Attending assignment.

No Change

04 Consultations.

No Change

05 Order writing privileges.

No Change

06 Death procedures.

No Change

07 Emergency preparedness.

No Change

08 Surgical case review (tissue committees).

No Change

09 Tissue disposition.

No Change

The James

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Quality and Professional Affairs: 3.28.18
MC Board: 4.4.18
UBOT: 4.6.18

Medical Staff Rules and Regulations –
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

10 Medical records.

(A) (1)-(5) No Change

(6) Records storage, security, and accessibility.

All patient's records, pathological examinations, slides, radiological films, photographic records, cardiographic records, laboratory reports, statistical evaluations, etc., are the property of the CHRI and shall not be taken from the CHRI except on court order, subpoena or statute duly filed with the medical record administrator or the hospital administration. The hospital administration may, under certain conditions, arrange for copies or reproductions of the above records to be made. Such copies may be removed from the hospital after the medical record administrator or the proper administrative authority has received a written receipt thereof. In the case of readmission of the patient, all previous records or copies thereof shall be available for the use of the attending medical staff member.

In general, medical records shall be maintained by the hospital. Records on microfilms, paper, electronic tape recordings, magnetic media, optical disks, and such other acceptable storage techniques shall be used to maintain patient records for twenty-one years for minors and ten years for adults. In the case of readmission of the patient, all records or copies thereof from the past ten/twenty-one years shall be available for the use of the attending medical staff member or other health care providers.

(7) – (11) No Change

11 Committees.

No Change

12 Standards of practice.

No Change

13 Mechanism for changing rules and regulations.

No Change

Quality and Professional Affairs: 3.28.18
MC Board: 4.4.18
UBOT: 4.6.18

Medical Staff Rules and Regulations –
Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

14 Adoption of the rules and regulations.

No Change

15 Sanctions.

No Change