

**TUESDAY, AUGUST 20, 2024**  
**WEXNER MEDICAL CENTER BOARD MEETING**

Leslie H. Wexner, chair  
Alan A. Stockmeister  
Gary R. Heminger  
Tomislav B. Mitevski  
Juan Jose Perez  
George A. Skestos  
Joshua H.B. Kerner  
Robert H. Schottenstein  
Stephen D. Steinour  
Cindy Hilsheimer  
Amy Chronis  
Hiroyuki Fujita  
John W. Zeiger (ex officio, voting)  
Walter E. Carter Jr. (ex officio, voting)  
Karla Zadnik (ex officio, voting)  
Michael Papadakis (ex officio, voting)  
John J. Warner (ex officio, voting)

**Location:** Sanders Grand Lounge, Longaberger Alumni House  
2200 Olentangy River Road, Columbus, Ohio 43210

**Time:** 1:00-5:00pm

**Public Session**

1. Approval of May 2024 Wexner Medical Center Board Meeting Minutes
2. *CEO Report – Dr. John Warner* 1:00-1:10pm
3. *James Cancer Hospital Report – Dr. David Cohn* 1:10-1:15pm
4. *Wexner Medical Center Financial Report – Mr. Vincent Tammaro* 1:15-1:20pm
5. Recommend Approval to Increase Professional Services and Enter Into Construction Contracts – Mr. Frank Aucremanne 1:20-1:25pm
  - a. Rhodes 3rd Floor Lab Expansion
6. Quality and Professional Affairs Committee: Items for Approval – Mr. Alan Stockmeister, Dr. Andrew Thomas, Dr. David Cohn 1:25-1:30pm
  - a. Ratification of Committee Appointments FY24-25
  - b. Approval of the UH Trauma Verification
  - c. Approval of the OSU Wexner Medical Center FY25 Clinical Quality Management, Patient Safety and Patient Experience Plan
  - d. Approval of the James Cancer Hospital FY25 Clinical Quality, Patient Safety, and Experience Council Plan
  - e. Approval of the Plan for Patient Care Services
    - i. OSU Wexner Medical Center
    - ii. James Cancer Hospital
  - f. Approval of Scope of Care
    - i. New Albany Ambulatory Surgery Center
    - ii. Dublin Ambulatory Surgery Center
  - g. Approval of the Direct Patient Care Services Contracts and Patient Impact Service Contracts Evaluation
    - i. OSU Wexner Medical Center
    - ii. James Cancer Hospital
    - iii. New Albany Ambulatory Surgery Center
    - iv. Dublin Ambulatory Surgery Center

**TUESDAY, AUGUST 20, 2024**  
**WEXNER MEDICAL CENTER BOARD MEETING (CONT)**

- h. Approval of Amendments to the Bylaws of the Medical Staff of The Ohio State University Hospitals
  - i. The Ohio State University Hospitals
  - ii. Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

**Executive Session**



## **SUMMARY OF ACTIONS TAKEN**

*May 14, 2024 - Wexner Medical Center Board Meeting*

### **Members Present:**

Leslie H. Wexner	Juan Jose Perez	Hiroyuki Fujita (ex officio)
Alan A. Stockmeister	Taylor A. Schwein	Walter E. Carter, Jr. (ex officio)
John W. Zeiger	Stephen D. Steinour (arr. 1:49 p.m.)	Karla Zadnik (ex officio)
Gary R. Heminger	Robert H. Schottenstein (arr. 2:05 p.m.)	Michael Papadakis (ex officio)
Tomislav B. Mitevski	Cindy Hilsheimer	John J. Warner (ex officio)

### **Members Present via Zoom:**

Amy Chronis (joined at 1:06 pm)

**Members Absent:** N/A

## **PUBLIC SESSION**

The Wexner Medical Center Board convened for its 50th meeting on Tuesday, May 14, 2024, in person at Longaberger Alumni House on Ohio State's Columbus campus and virtually over Zoom. Board Secretary Jessica A. Eveland called the meeting to order at 12:59 p.m.

### ***Item for Action***

1. Approval of Minutes: No changes were requested to the February 20, 2024, meeting minutes; therefore, a formal vote was not required, and the minutes were considered approved.

### ***Items for Discussion***

2. Chief Executive Officer's Report: Dr. John J. Warner, CEO of the Wexner Medical Center and EVP at Ohio State and, started the meeting with recognizing and celebrating the accomplishments of many students and trainees. At spring commencement, 881 College of Medicine students received degrees and certificates. And at this year's Doctoral Convocation, 185 medical students earned their medical degrees.

In March, graduating medical students participated in the largest Match Day in the history of the National Resident Matching Program. Nationwide, there were 44,000 applicants for 41,000 positions. At Ohio State we had a 97% match rate — 35% matched in Ohio, including 35 who matched right here at the Wexner Medical Center and another three at Nationwide Children's Hospital. Also, our Ohio State residency programs had a 100% match rate.

Dr. Warner also shared detail regarding the College of Medicine's "My Dream, My Decision" campaign, where students share their dreams and reasons for choosing Ohio State to inspire prospective students to want to become Buckeyes themselves. As a result of the campaign and other efforts by the college, the Ohio State College of Medicine saw a 6% increase in applications for the 2024 year, and for context, nationally, there's been about a 6% decline in MD applications since 2021.

Dr. Warner then noted that the University is in the final stages of construction on the new Interdisciplinary Health Sciences Center (IHSC), a project that began in 2017 with the vision of this



Board as part of the University's Time & Change capital campaign. The IHSC will serve as the new home to the College of Medicine, and as a hub for interprofessional health sciences education for all seven of Ohio State's health sciences colleges.

Dr. Warner also celebrated the opening of the Wexner Medical Center's new Healthy Community Center. The center is located in the former Martin Luther King, Jr. branch of the Columbus Metropolitan Library, which was the first library in the U.S. to be named in honor of Dr. King. The center is dedicated to education and programming that supports healthy lifestyles with a focus on nutrition education and wellness to improve and prevent chronic illness. The center was co-designed by Ohio State and the Near East Side community through a series of community engagement sessions and a group of dedicated volunteers, along with support from PACT — Partners Achieving Community Transformation — and other area organizations and businesses.

In April, the Wexner Medical Center broke ground on Outpatient Care Powell — a 207,000-square-foot facility set to open in summer 2026. It includes a two-story health center and an attached five-story medical office building. Like its other newest outpatient care facilities in New Albany and Dublin, Outpatient Care Powell will include medical services like advanced urgent care, imaging, endoscopy, physical therapy and more.

The cities of Hilliard and Upper Arlington selected the Wexner Medical Center as their health and wellness partner for their integrative community health and wellness center. At both community centers that will open in 2025, the Wexner Medical Center will offer a wide array of comprehensive programming including outpatient physical therapy, integrative health services, group wellness classes, disease-specific programming like “exercise is medicine” and “mindfulness in motion,” as well as performance training, including tactical training for first responders, endurance training and bike fitting.

(See Attachment X for background information, page XX)

3. James Cancer Hospital Report: Dr. David Cohn, interim chief executive officer, James Cancer Hospital and Solove Research Institute, provided the James Cancer Hospital report focused on innovation of The James and how we work to improve cancer care and quality of life of patients. The Bone Marrow Transplant program celebrated its 40<sup>th</sup> anniversary this year. The program has completed more than 6,500 transplants. In July our outpatient transplant strategy will expand, and The James will be the first in central Ohio to offer an ambulatory transplantation option to our patients.

In April The James engaged with Veris Health to pilot a new at-home cancer remote patient monitoring (RPM) system. RPM enhances personalized cancer care through early detection of signals of side effects, reduced unplanned hospital admissions, and increased provider and patient satisfaction. This is the first step in expanding the “cancer at home” portfolio.

Last month The James became only one of 10 institutions in the U.S. and the only one in the Midwest to gain access to the most modern surgical robot. Dr. Robert Merritt, led the study that culminated in FDA clearance for the daVinci 5 robotic system for clinical use. Robotic surgery allows patients a shorter hospital stay and a quicker recovery time.

(See Attachment X for background information, page XX)

4. Wexner Medical Center Financial Report: Mr. Vincent Tammaro provided a high-level report out of the medical center's financial performance through the first nine months of FY2024.

(See Attachment X for background information, page XX)



Items for Actions

- 5. Recommend for Approval Wexner Medical Center FY25 Budget: Mr. Tammaro will seek the Board’s endorsement of the Wexner Medical Center FY25 Operating and Capital Budgets before it is reviewed with other Board of Trustees committees this week. He shared the proposed FY25 budget for the combined Wexner Medical Center, which reflects an 7.9% increase in total operating revenue and an 8.8% increase in total expenses compared to the FY24 budget.

(See Attachment X for background information, page XX)

- 6. Resolution No. 2024-104, Recommend Approval to Increase Professional Services and Construction Contracts:

APPROVAL TO ENTER INTO PROFESSIONAL SERVICES CONTRACTS  
JOC - NUCLEAR MEDICINE EXPANSION

Synopsis: Authorization to enter into professional services contracts, as detailed in the attached materials, is proposed.

WHEREAS in accordance with the attached materials, the University desires to enter into professional services contracts for the following project; and

	<b>Prof. Serv. Approval Requested</b>	<b>Total Requested</b>	
JOC- Nuclear Medicine Expansion	\$0.3M	\$0.3M	Auxiliary funds

NOW THEREFORE BE IT RESOLVED that the Wexner Medical Center Board hereby approves and proposes that the professional services contracts for the project listed above be recommended to the University Board of Trustees for approval.

BE IT FURTHER RESOLVED, that the President and/or Senior Vice President for Business and Finance be authorized to increase professional services contracts for the project listed above in accordance with established University and State of Ohio procedures, with all actions to be reported to the Board at the appropriate time.

(See Attachment X for background information, page XX)

- 7. Resolution No. 2024-105, Ratification of Committee Appointment FY2024-25:

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointment to the Finance Committee for FY2024-25 is as follows:

**Finance Committee**

- Stephen D. Steinour, Chair
- John W. Zeiger
- Tomislav B. Mitevski
- Juan Jose Perez
- Amy Chronis



John J. Warner  
Michael Papadakis

**Action:** Upon motion of Mr. Zeiger, seconded by Mr. Wexner, the Wexner Medical Center Board recommend the foregoing resolutions for final approval by majority roll-call vote with the following members present and voting: Mr. Wexner, Mr. Stockmeister, Mr. Zeiger, Mr. Heminger, Mr. Mitevski, Mr. Perez, Dr. Schwein, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, President Carter, Dr. Zadnik, Mr. Papadakis and Dr. Warner. Mr. Steinour and Mr. Schottenstein were not in attendance during the vote.

#### **EXECUTIVE SESSION**

It was moved by Mr. Stockmeister and seconded by Mr. Wexner that the Wexner Medical Center Board recess into executive session to discuss the sale or disposition of property; to consider business-sensitive trade secrets and quality matters required to be kept confidential by federal and state statutes; to consult with legal counsel regarding pending or imminent litigation, and to discuss personnel matters involving the appointment, employment and compensation of public officials, which are required to be kept confidential under Ohio law.

A roll-call vote was taken, and the Board voted to go into executive session with the following members present and voting: Mr. Wexner, Mr. Stockmeister, Mr. Zeiger, Mr. Heminger, Mr. Mitevski, Mr. Perez, Dr. Schwein, Ms. Hilsheimer, Ms. Chronis, Dr. Fujita, President Carter, Dr. Zadnik, Mr. Papadakis and Dr. Warner. Mr. Steinour and Mr. Schottenstein were not in attendance during the vote.

The Wexner Medical Center Board entered into executive session at 1:27 p.m. The meeting adjourned at 4:31 p.m.

# OSUCCC – James Wexner Medical Center Board Presentation

*August 20, 2024*

*David Cohn, MD, MBA*

*Interim Chief Executive Officer*

*James Cancer Hospital and Solove Research Institute*



The James



THE OHIO STATE UNIVERSITY  
COMPREHENSIVE CANCER CENTER

# New Cancer Leadership Positions



Christian Rolfo, MD PhD  
Director, Division of  
Medical Oncology



Glen Barber, PhD  
Director, Center for  
Innate Immunity and  
Inflammation  
PIIO



Anil Parwani, MD, PhD, MBA  
Chair, Department of  
Pathology



# Cancer Awards



Emily Rush, RN, MHA, OCN  
Director, Magnet Program  
Oncology Nursing Society  
Emerging Leader Award 2024

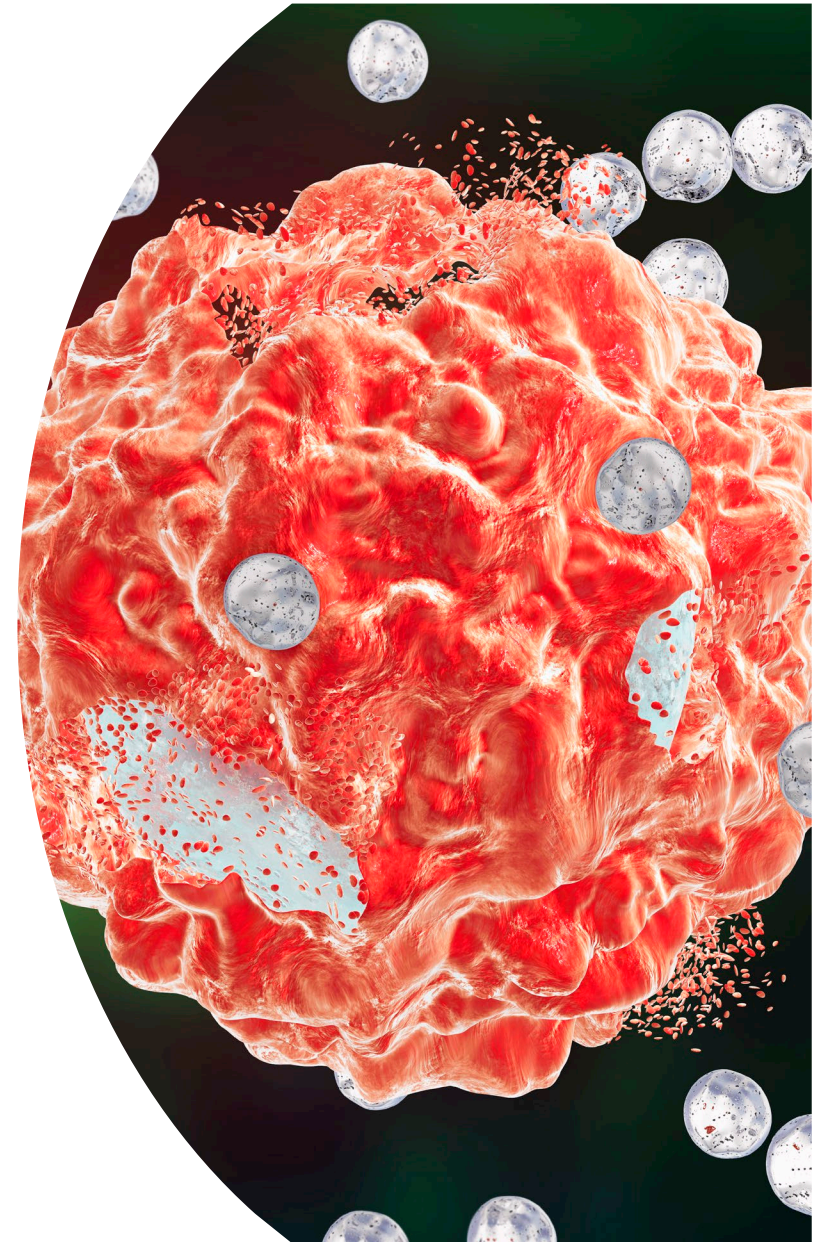


Ashley Cetnar, PhD  
Clinical Assistant Professor  
Radiation Oncology

# Ohio State Comprehensive Cancer Center - Cancer Center Support Grant (CCSG)

- Hosted a successful external advisory board in May to review the first draft of the CCSG
- The board is made up of cancer center administrators and directors of other NCI-CCC's
- The team will host additional reviews in the fall
- The full grant will be submitted in January 2025
- Site visit expected April or May 2025

The James



# ASCO 2024 - Getting Ahead of Cancer



- AI Tool helps predict colon cancer aggressiveness to guide clinical care decisions
- Vidya Arole, MBBS Pathology & Eric D Miller, MD, PhD Radiation Oncology



- Understanding how microbiome impacts early-stage cancer risk
- Ning Jin, MD Medical Oncology

# ASCO 2024 - Getting Ahead of Cancer



- Predicting risk of melanoma spread to the brain in early-stage disease.
- Merve Hassanov, MD Medical Oncology



- Health equity challenges to using multicancer detection tests.
- Norah Crossnohere, PhD Internal Medicine & Chyke Doubeni, MBBS, MPH Family Medicine



# PELOTONIA<sup>®</sup>

**OPENING  
CEREMONY**  
**AUGUST 2**

**RIDE  
WEEKEND**  
**AUGUST 3-4**

**GRAVEL  
DAY**  
**SEPTEMBER 21**



# Thank You

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Connect with us on social media:



The James



**Wexner Medical Center Board  
Financial Report  
Public Session**

August 20, 2024



# **FY2024 Year in Review**



# The Ohio State University Health System

Consolidated Statement of Operations

For the YTD ended: June 30, 2024

(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
<b>OPERATING STATEMENT</b>						
Total Operating Revenue	4,433,175	4,331,151	102,024	2.4%	3,973,861	11.6%
Operating Expenses						
Salaries and Benefits	1,849,290	1,842,709	(6,581)	-0.4%	1,704,031	-8.5%
Resident/Purchased Physician Services	224,229	218,474	(5,755)	-2.6%	196,010	-14.4%
Supplies/Pharmaceuticals/Other	1,712,527	1,651,096	(61,431)	-3.7%	1,504,124	-13.9%
Depreciation	231,473	242,307	10,834	4.5%	208,930	-10.8%
Interest	41,362	41,879	517	1.2%	44,443	6.9%
Total Expense	4,058,881	3,996,465	(62,416)	-1.6%	3,657,538	-11.0%
Gain (Loss) from Operations (pre MCI)	374,294	334,686	39,608	11.8%	316,323	18.3%
Medical Center Investments	(235,433)	(240,361)	4,928	2.1%	(229,502)	-2.6%
Income from Investments	92,051	26,943	65,108	241.7%	42,241	117.9%
Other Gains (Losses)	28,294	30,223	(1,929)	-6.4%	24,161	17.1%
Excess of Revenue over Expense	\$ 259,206	\$ 151,491	\$ 107,715	71.1%	\$ 153,223	69.2%
Non-Budgeted One-Time Recognitions	\$ 26,089	\$ -	\$ 26,089	0.0%	\$ 148,573	-82.4%
Margin with Non-Budgeted One-Time Recognitions	\$ 285,295	\$ 151,491	\$ 133,804	88.3%	\$ 301,796	-5.5%
Margin Percentage	6.4%	3.5%	2.9%	84.0%	7.6%	-1.2%
EBIDA	\$ 558,130	\$ 435,677	\$ 122,453	28.1%	\$ 555,169	0.5%
EBIDA Margin Percentage	12.6%	10.1%	2.5%	25.2%	14.0%	-1.4%

# The Ohio State University Wexner Medical Center

Combined Statement of Operations  
For the YTD ended: June 30, 2024  
(in thousands)

	Actual	Budget	Act-Bud Variance	Budget % Var	Prior Year	PY % Var
<b>OPERATING STATEMENT</b>						
Total Operating Revenue	5,991,961	5,838,254	153,707	2.6%	5,382,302	11.3%
Operating Expenses						
Salaries and Benefits	3,262,574	3,246,301	(16,273)	-0.5%	2,990,232	-9.1%
Resident/Purchased Physician Services	224,229	218,474	(5,755)	-2.6%	196,010	-14.4%
Supplies/Pharmaceuticals/Other	2,087,623	1,989,953	(97,670)	-4.9%	1,852,086	-12.7%
Depreciation	245,750	263,573	17,824	6.8%	227,549	-8.0%
Interest	41,585	42,064	479	1.1%	44,692	7.0%
Total Expense	5,861,761	5,760,366	(101,396)	-1.8%	5,310,570	-10.4%
Gain (Loss) from Operations	130,200	77,889	52,311	67.2%	71,732	81.5%
Income from Investments	101,997	36,581	65,416	178.8%	50,785	100.8%
Other Gains (Losses)	20,351	28,148	(7,797)	-27.7%	17,546	16.0%
Excess of Revenue over Expense	\$ 252,548	\$ 142,618	\$ 109,931	77.1%	\$ 140,063	80.3%
Non-Budgeted One-Time Recognitions	\$ 26,089	\$ -	\$ 26,089	0.0%	\$ 148,573	-82.4%
Margin with Non-Budgeted One-Time Recognitions	\$ 278,637	\$ 142,618	\$ 136,020	95.4%	\$ 288,636	-3.5%
Margin Percentage	4.7%	2.4%	2.2%	90.4%	5.4%	-0.7%
EBIDA	\$ 565,972	\$ 448,255	\$ 117,716	26.3%	\$ 560,877	0.9%
EBIDA Margin Percentage	9.4%	7.7%	1.7%	23.0%	10.4%	-1.0%

\* This statement does not conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.

# The Ohio State University Wexner Medical Center

## Combined Balance Sheet

As of: June 30, 2024

(in thousands)

	June 2024	June 2023	FY24-FY23 Change
<b>Cash</b>	\$ 1,476,652	\$ 1,392,047	\$ 84,605
<b>Net Patient Receivables</b>	693,628	624,951	68,677
<b>Other Current Assets</b>	221,896	206,304	15,591
<b>Assets Limited as to Use</b>	958,622	988,171	(29,549)
<b>Property, Plant &amp; Equipment - Net</b>	3,753,216	3,306,934	446,282
<b>Other Assets</b>	608,517	611,151	(2,634)
<b>Total Assets</b>	<b>\$ 7,712,532</b>	<b>\$ 7,129,558</b>	<b>\$ 582,973</b>
<b>Current Liabilities</b>	\$ 529,262	\$ 449,016	\$ 80,246
<b>Other Liabilities</b>	370,577	364,681	5,896
<b>Total Debt</b>	1,438,011	1,219,817	218,194
<b>Net Assets</b>	5,374,681	5,096,045	278,637
<b>Liabilities and Net Assets</b>	<b>\$ 7,712,532</b>	<b>\$ 7,129,558</b>	<b>\$ 582,973</b>
<b>Days Cash on Hand</b>	151.7	163.2	(11.5)
<b>Net Days in Accounts Receivable</b>	52.3	51.9	(0.3)
<b>Debt to Capital</b>	21.1%	19.3%	-1.8%

This Balance sheet is not intended to conform to Generally Accepted Accounting Principles. Different accounting methods are used in each of these entities and no eliminating entries are included.



**Thank You**

[Wexnermedical.osu.edu](http://Wexnermedical.osu.edu)

**RECOMMEND APPROVAL TO INCREASE PROFESSIONAL SERVICES  
AND ENTER INTO CONSTRUCTION CONTRACTS**

**APPROVAL TO INCREASE PROFESSIONAL SERVICES AND ENTER INTO CONSTRUCTION CONTRACTS  
RHODES 3<sup>RD</sup> FLOOR LAB EXPANSION**

Synopsis: Authorization to increase professional services and enter into construction contracts, as detailed in the attached materials, is proposed.

WHEREAS in accordance with the attached materials, the University desires to increase professional services contracts and enter into construction contracts for the following project; and

	Prof. Serv. Approval Requested	Construction Approval Requested	Total Requested	
Rhodes 3rd Floor Lab Expansion	\$0.6M	\$4.1M	\$4.7M	Auxiliary funds

NOW THEREFORE BE IT RESOLVED that the Wexner Medical Center Board hereby approves and proposes that the professional services and construction contracts for the project listed above be recommended to the University Board of Trustees for approval.

BE IT FURTHER RESOLVED, that the President and/or Senior Vice President for Business and Finance be authorized to increase professional services and enter into construction contracts for the project listed above in accordance with established University and State of Ohio procedures, with all actions to be reported to the Board at the appropriate time.

# Project Data Sheet for Board of Trustees Approval

## Rhodes - 3rd FI Lab Expansion

OSU-221149 (REQ ID# LAB220004)

Project Location: Rhodes Hall (0354)

- **Approval Requested and Amount**

Professional services	\$0.6M
Construction w/contingency	\$4.1M
<b>Total requested</b>	<b>\$4.7M</b>

- **Project Budget**

Professional services	\$0.6M
Construction w/contingency	\$4.1M
<b>Total project budget</b>	<b>\$4.7M</b>

- **Project Funding**

Auxiliary funds

- **Project Schedule**

Design	12/22 – 03/24
BoT professional services approval	08/24
BoT construction approval	08/24
Construction	08/24 – 02/26
Facility opening	07/26

- **Project Delivery Method**

Construction Manager at Risk

- **Planning Framework**

- This project is included in the FY23 and FY24 Capital Investment Plans.
- The project supports the expansion of the current Rhodes 3rd floor lab to support all patient lab testing including the spaces in the new inpatient tower.

- **Project Scope**

- The project consists of multiple phases to allow the lab to remain operational and includes several enabling projects, such as relocating a pyxis room, crash cart storage room, EVS room, and renovations of two ADA restrooms.
- Early phases will be completed prior to the opening of the new inpatient tower to allow for full lab functionality.

- **Approval Requested**

- Approval is requested to increase professional services contracts and enter into construction contracts.



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- **project team**

University project manager: Radabaugh, Alexandra  
AE/design architect: IKM Architects  
CM at Risk or Design Builder: Marker Construction

**RATIFICATION OF COMMITTEE APPOINTMENTS FY2024-25**

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves that the ratification of appointments to the Quality and Professional Affairs Committee for FY2024-25 are as follows:

**Quality and Professional Affairs Committee**

Alan A. Stockmeister, Chair

Juan Jose Perez

**George A. Skestos**

**Joshua H.B. Kerner**

Michael Papadakis

John J. Warner

Karla Zadnik

Eric Adkins

Doreen Agnese

Jay M. Anderson

Carol Bradford

Stacy Brethauer

David E. Cohn

Scott A. Holliday

Elizabeth Seely

Deana Sievert

Corrin Steinhauer

Andrew M. Thomas

**TRAUMA PROGRAM**

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the annual review of the Trauma Program for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through innovation in research, education and patient care; and

WHEREAS, the Ohio State University Hospitals continue to provide emergency, specialty and subspecialty clinical trauma services, as well as professional and public education, injury prevention, research, and performance improvement programs (collectively, the "Trauma Program"); and

WHEREAS the Ohio State University Hospitals intend to continue to meet all requirements and criteria to maintain Level I trauma center verification and support its trauma program:

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board commit to maintain the high standards needed to provide optimal care of all trauma patients and supports the application for a Level 1 trauma verification by the American College of Surgeons, Committee on Trauma.

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby commits to maintain the high standards needed to provide optimal care of all trauma patients and supports the application for a Level 1 trauma verification by the American College of Surgeons, Committee on Trauma.



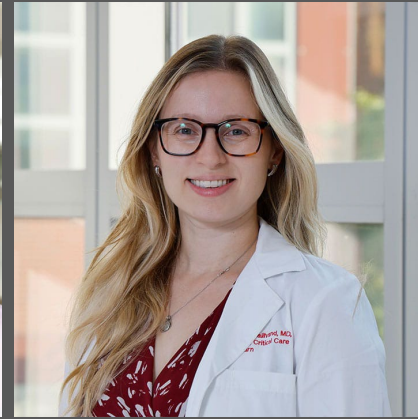
# OSUWMC Level 1 Adult Trauma Center



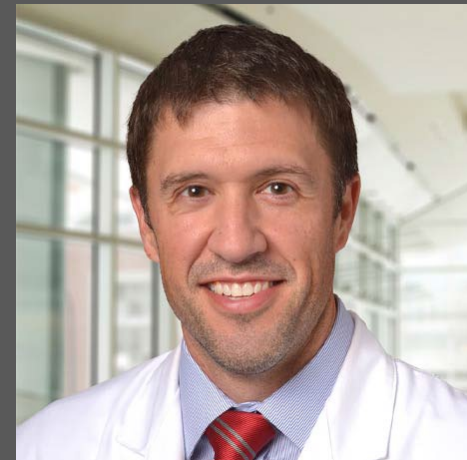
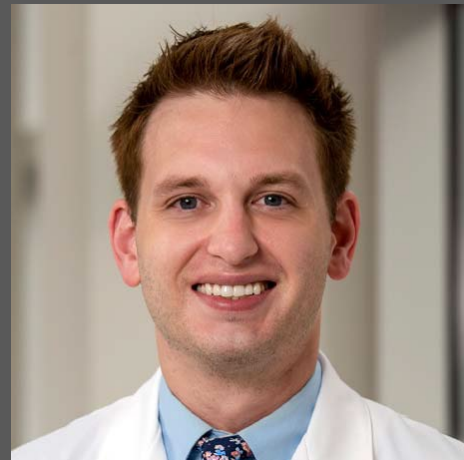
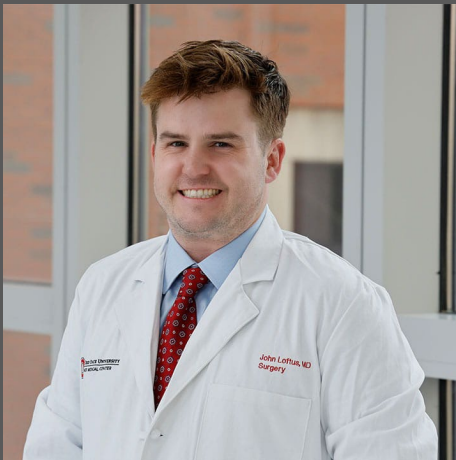
**THE OHIO STATE  
UNIVERSITY**

WEXNER MEDICAL CENTER

# OSUWMC Trauma Team: Faculty



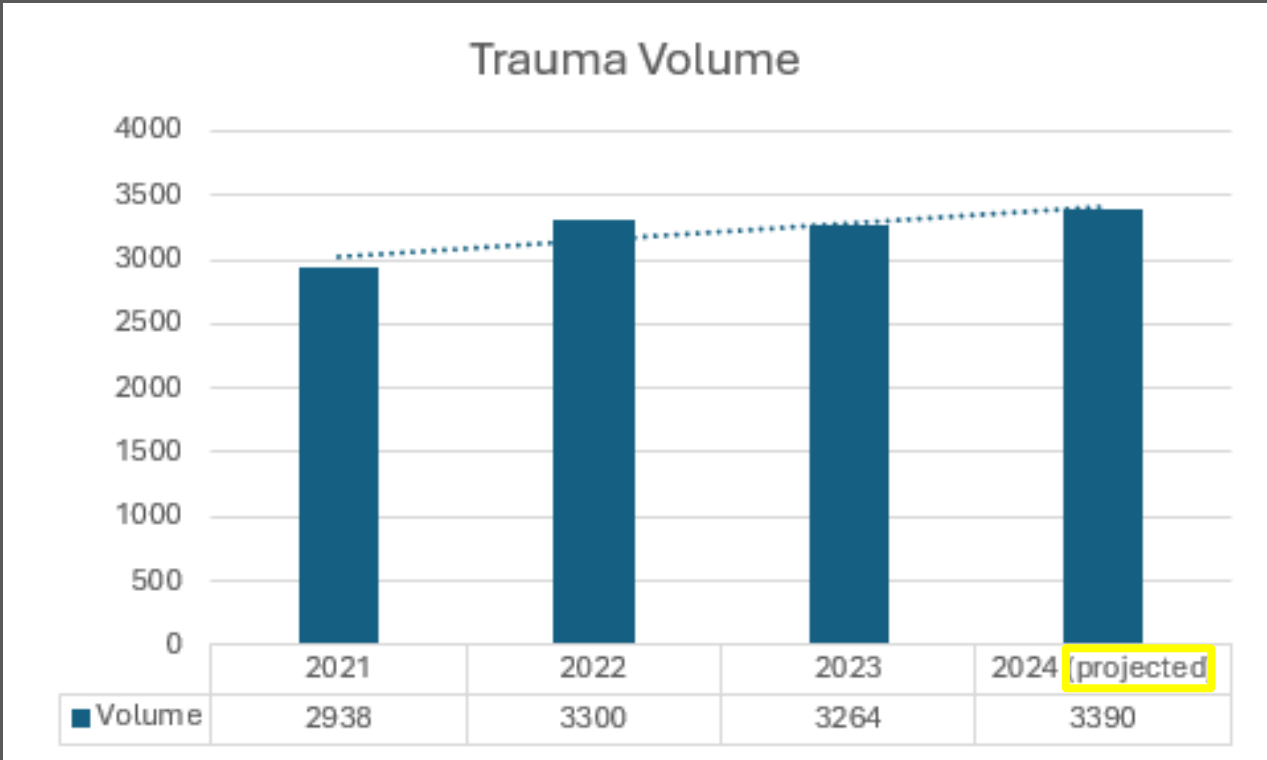
Trauma Medical Director



Faculty not pictured: Dr. Tracie Terrana & Dr. Larry Martin

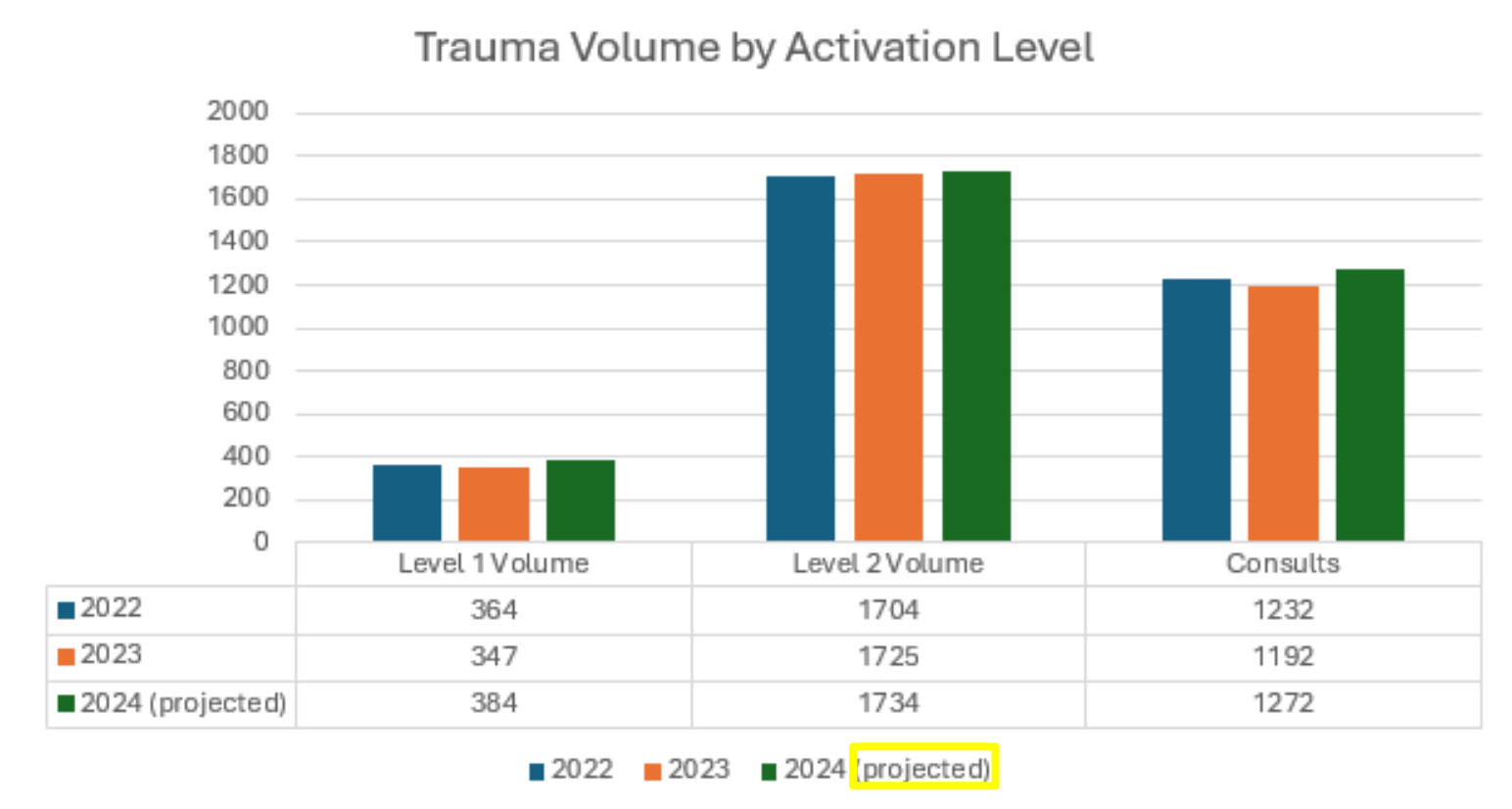
ACS Fellows not pictured: Dr. Jacob Holzemer & Dr. Jinwei Hu

# OSUWMC Annual Trauma Volume



Source: Trauma Registry

# OSUWMC Annual Trauma Volume



Source: Trauma Registry

# Standard 1.1 Administrative Commitment

- **Definition:** “...must demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of verification throughout the verification cycle.”

## 1.1 Administrative Commitment—TYPE I

### Applicable Levels

LI, LII, LIII, PTCL, PTCII

### Definition and Requirements

In all trauma centers, the institutional governing body, hospital leadership, and medical staff must demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of verification throughout the verification cycle.

### Additional Information

Human resources include physicians, registered nurses, advanced practice providers (APPs), physician assistants, coordinators, and so forth.

This standard fully encompasses all staffing needs, physical structures, space allotments, and equipment needed for a trauma center to function optimally.

### Measures of Compliance

Documentation that demonstrates compliance, including:

- Hospital Board of Directors (or other administrative governing authority) approval of the establishment of the trauma center at the level specified and of the application for verification
- Commitment to adherence to the standards required for the level of verification
- Commitment to ensuring that the necessary personnel, facilities, and equipment are made available to support adherence to the standards

# Standard 1.1 Administrative Commitment, continued

- **Documented compliance:**
  1. “Hospital Board of Directors approval of the establishment of the trauma center at the level specified and of the application for verification”
  2. “Commitment to adherence to the standards required for level of verification”
  3. “Commitment to ensuring that the necessary personnel, facilities, and equipment are made available to support adherence to the standards”

## 1.1 Administrative Commitment—TYPE I

### Applicable Levels

LI, LII, LIII, PTCL, PTCII

### Definition and Requirements

In all trauma centers, the institutional governing body, hospital leadership, and medical staff must demonstrate continuous commitment and provide the necessary human and physical resources to properly administer trauma care consistent with the level of verification throughout the verification cycle.

### Additional Information

Human resources include physicians, registered nurses, advanced practice providers (APPs), physician assistants, coordinators, and so forth.

This standard fully encompasses all staffing needs, physical structures, space allotments, and equipment needed for a trauma center to function optimally.

### Measures of Compliance

Documentation that demonstrates compliance, including:

- Hospital Board of Directors (or other administrative governing authority) approval of the establishment of the trauma center at the level specified and of the application for verification
- Commitment to adherence to the standards required for the level of verification
- Commitment to ensuring that the necessary personnel, facilities, and equipment are made available to support adherence to the standards

**THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER CLINICAL QUALITY MANAGEMENT, PATIENT SAFETY, AND PATIENT EXPERIENCE PLAN**

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the annual review of The Ohio State University Wexner Medical Center Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY25 for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS The Ohio State University Wexner Medical Center Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY25 outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an environment of minimal risk for inpatients and outpatients of the University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

WHEREAS the annual review of The Ohio State University Wexner Medical Center Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY25 was approved by the University Hospitals Medical Staff Administrative Committee on July 10, 2024:

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY25:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the Clinical Quality Management, Patient Safety, and Patient Experience Plan for FY25 for the Ohio State University Hospitals, including Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

# QUALITY LEADERSHIP COUNCIL

The Ohio State University Wexner Medical Center  
Clinical Quality Management, Patient Safety, &  
Patient Experience Plan

FY 2025

July 1, 2024 - June 30, 2025



# Clinical Quality Management, Patient Safety, & Patient Experience Plan

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# The Ohio State University Wexner Medical Center

## Clinical Quality Management, Patient Safety, and Patient Experience Plan

### **Ambition, Mission, Vision and Values**

**Ambition:** To be a top 20 (Honor Roll) academic health center driving breakthrough healthcare solutions to improve people's lives and the communities in which we live.

**Mission:** To improve health in Ohio and across the world through innovations in research and transformation in research, education, patient care and community engagement.

**Vision:** By pushing the boundaries of discovery and knowledge, we will solve significant health problems and deliver unparalleled care

**Values:** Inclusiveness, Determination, Empathy, Sincerity, Ownership and Innovation

### **Definition**

The Clinical Quality Management, Patient Safety and Patient Experience Plan is the health system approach to the systematic assessment and improvement of process design and performance aimed at improving quality of care, patient safety, and patient experience.

The approach to clinical quality management, patient safety, and patient experience is leadership-driven and involves significant staff and provider engagement. The activities within the health system are multi-disciplinary and rooted in the system's ambition, mission, vision, and values. The plan embodies a culture of continuously measuring, assessing, and initiating changes to improve outcomes. The health system employs the following principles which support the Institute of Medicine's six aims of care (Safe, Timely, Effective, Efficient, Equitable and Patient Centered). These principles are:

- **Customer Focus:** Knowledge and understanding of internal and external customer needs and expectations.
- **Leadership & Governance:** Dedication to continuous improvement instilled by leadership and the Board.
- **Education:** Ongoing development and implementation of a curriculum for quality, safety & service for of all staff, employees, clinicians, patients, and learners.
- **Everyone is involved:** All members have mutual respect for the dignity, knowledge, and potential contributions of others. Everyone is engaged in improving the processes in which they work.
- **Data Driven:** Decisions are based on knowledge derived from data.

- **Process Improvement**: Analysis of processes for redesign and variance reduction using a scientific approach.
- **Continuous**: Measurement and improvement are ongoing.
- **Safety Culture**: A culture that is open, honest, transparent, collegial, team-oriented, accountable and non-punitive when system failures occur.
- **Personalized Health Care**: Incorporate evidence-based medicine in patient centric care that considers the patient's health status, genetics, cultural traditions, personal preferences, values family situations and lifestyles.

The Plan was developed in accordance with The Joint Commission (TJC) accreditation standards and the Center for Medicare & Medicaid Services (CMS) Conditions of Participation outlining a Quality Assurance and Performance Improvement (QAPI) program. In addition to the principles outlined above, the following will also serve as fundamental components of the plan.

### **Consistent Level of Care**

Certain elements of the OSUWMC Clinical Quality Management, Patient Safety, & Patient Experience Plan assure that patient care standards for the same or similar services are comparable in all areas throughout the health system. For example,

- **Policies, procedures and services provided are not payer driven**
- **Application of a single standard for physician credentialing**
- **Health system monitoring tools to measure like processes**
- **Standardize and unify health system policies and procedures that promote patient centered, high quality, and safe care**

### **Performance Transparency**

The OSUWMC Medical and Administrative leadership, in conjunction with the Board of Trustees, has a strong commitment to transparency of performance as it relates to clinical quality, patient safety, and patient experience performance. As supported by the long-range quality plan, the organization is committed to providing transparency to our patients and communities regarding our performance.

Performance data are shared internally with faculty and staff through a variety of methods. The purpose of providing data internally is to assist faculty and staff in having real-time performance results and to use those results to drive change and improve performance when applicable.

On-line performance scorecards have been developed to cover a variety of clinical quality, safety and patient experience metrics. When applicable, on-line scorecards provide the ability to “drilldown” on the data by discharge service, department and nursing unit. In some cases, password authentication also allows for practitioner-specific data to be viewed by Department Chairs and various Quality and Administrative staff. Transparency of information will be provided within the limits of the Ohio law that protects attorney client privilege, quality inquiries and reviews, as well as peer review.

## **Confidentiality**

Confidentiality is essential to the quality management and patient safety process. All records and proceedings are confidential and are to be marked as such. Written reports, data, and meeting minutes are to be maintained in secure files. Access to these records is limited to appropriate administrative personnel and others as deemed appropriate by legal counsel. As a condition of staff privilege and peer review, it is agreed that no record, document, or proceeding of this program is to be presented in any hearing, claim for damages, or any legal cause of action. This information is to be treated for all legal purposes as privileged information. This is in keeping with the Ohio Revised Code 121.22 (G)-(5) and Ohio Revised Code 2305.251.

## **Scope/Purpose**

The Clinical Quality Management, Patient Safety & Patient Experience Plan includes all inpatient and outpatient facilities in The OSU Wexner Medical Center (OSUWMC) and appropriate entities across the continuum of care and in any clinical setting. The execution of the Clinical Quality Management, Patient Safety & Patient Experience Plan will demonstrate measurable improvements in health outcomes and the value of patient care provided within the OSUWMC.

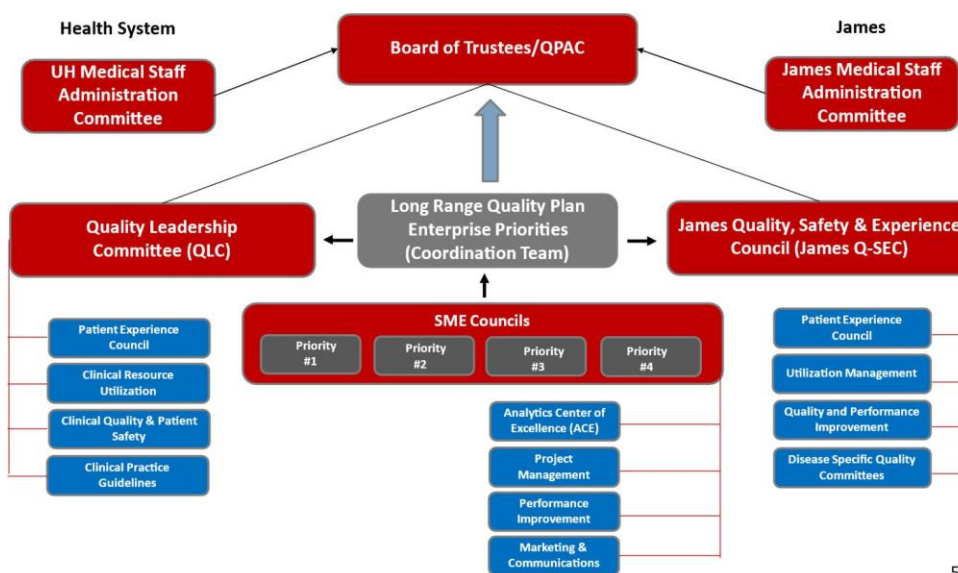
As part of the Quality Assurance and Performance Improvement (QAPI program), the organization provides oversight for contracted services. The contracts are reviewed annually by the Medical Staff Administrative Committee (MSAC) and then forwarded to the Quality and Professional Affairs Committee of the governing body for review and approval.

## **Objectives**

- Continuously monitor, evaluate, and improve outcomes and sustain improved performance.
- Implement reliable system changes that will improve patient care and safety by assessing, identifying, and reducing risks within the organization and responding accordingly when undesirable patterns or trends in performance are identified, or when events requiring intensive analysis occur.

- Assure optimal compliance with accreditation standards, state, federal and licensure regulations.
- Develop, implement, and monitor adherence to evidenced-based practice guidelines and companion documents in accordance with best practice to standardize clinical care and reduce practice variation.
- Improve patient experience and perception of treatment, care and services by identifying, evaluating, and improving performance based on patient needs, expectations, and satisfaction.
- Improve value by providing the best quality of care at the minimum cost possible. Incorporate value metrics, specifically the cost of care, into quality data and discussions where appropriate.
- Provide a mechanism by which the governance, medical staff and health system staff members are educated in quality management principles and processes.
- Provide appropriate levels of data transparency to both internal and external customers.
- Create a level of accountability for all system-wide quality improvement initiatives at the dyad/triad leadership level and assure processes involve an interdisciplinary teamwork approach.
- Improve processes to prevent patient harm.
- Improve clinical documentation to accurately reflect the severity of illness for the patients in which we provide care.

## Structure for Quality Oversight



The Quality Leadership Council serves as the single, multidisciplinary quality and safety oversight committee for the OSUWMC. In accordance with the Long-Range Quality Plan (**Appendix A**), The Quality Leadership Council utilizes criteria (**Appendix B**) to determine priorities for the health system that are reported in the Quality & Safety Priorities (**Appendix C**). Given the James Cancer Hospital has a separate provider number with a requirement for a distinct QAPI program, they have a specific substructure that ultimately reports to QPAC (**Appendix D**).

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## **Committees**

### **Medical Center Board**

The Medical Center Board is accountable to The Ohio State University Board of Trustees through the President and Executive Vice President (EVP) for Health Sciences and is responsible for overseeing the quality and safety of patient care throughout the Medical Center including the delivery of patient services, quality assessment, improvement mechanisms, and monitoring achievement of quality standards and goals.

The Medical Center Board receives clinical quality management, patient safety and patient experience reports, and provides resources and support systems for clinical quality management, patient safety and patient experience functions, including medical/health care error occurrences and actions taken to improve patient safety and service. Board members receive information regarding the responsibility for quality care delivery or provision, and the Hospital's Clinical Quality Management, Patient Safety and Patient Experience Plan. The Medical Center Board ensures all caregivers are competent to provide services.

### **Quality Professional Affairs Committee (QPAC)**

**Composition:** The committee shall consist of no fewer than four voting members of the university Wexner medical center board, appointed annually by the chair of the university Wexner medical center board, one of whom shall be appointed as chair of the committee. The chief executive officer of the Ohio state university health system; chief medical officer of the medical center; the director of medical affairs of the James; the medical director of credentialing for the James; the chief of the medical staff of the university hospitals; the chief of the medical staff of the James; the associate dean of graduate medical education; the chief quality and patient safety officer; the chief nurse executive for the OSU health system; and the chief nursing officer for the James shall serve as ex-officio, voting members. Other members as appointed by the chair of the university Wexner medical center board, in consultation with the chair of the quality and professional affairs committee.

#### **Function:**

The QPAC shall be responsible for the following specific duties:

- Reviewing and evaluating the patient safety and quality improvement programs of the university Wexner medical center;
- Overseeing all patient care activity in all facilities that are a part of the university Wexner medical center, including, but not limited to, the hospitals, clinics, ambulatory care facilities, and physicians' office facilities;
- Monitoring quality assurance performance in accordance with the standards set by the university Wexner medical center;
- Monitoring the achievement of accreditation and licensure requirements;
- Reviewing and recommending to the university Wexner medical center board changes to the medical staff bylaws and medical staff rules and regulations;
- Reviewing and approving clinical privilege forms;
- Reviewing and approving membership and granting appropriate clinical privileges for the credentialing of practitioners recommended for membership and clinical privileges by the university hospitals medical staff administrative committee and the James medical staff administrative committee;
- Reviewing and approving membership and granting appropriate clinical privileges for the expedited credentialing of such practitioners that are eligible by satisfying minimum approved criteria as determined by the university Wexner medical center board and are recommended for membership and clinical privileges by the university hospitals medical staff administrative committee and the James medical staff administrative committee;
- Reviewing and approving reinstatement of clinical privileges for a practitioner after a leave of absence from clinical practice;
- Conducting peer review activities and recommending professional review actions to the university Wexner medical center board;
- Reviewing and resolving any petitions by the medical staffs for amendments to any rule, regulation or policy presented by the chief of staff on behalf of the medical staff pursuant to the medical staff bylaws and communicating such resolutions to the university hospitals medical staff administrative committee and the James medical staff administrative committee for further dissemination to the medical staffs; and
- Such other responsibilities as assigned by the chair of the university Wexner medical center board.

### **Medical Staff Administrative Committees (MSACs)**

**Composition:** Refer to Medical Staff Bylaws and Rules and Regulations

**Function:** Refer to Medical Staff Bylaws and Rules and Regulations

The organized medical staff, under the direction of the Medical Director and the MSAC(s) for each institution, implements the Clinical Quality Management, Patient Safety and Patient Experience Plan throughout the clinical departments.

The MSAC(s) reviews reports and recommendations related to clinical quality management, efficiency, patient safety and service quality activities. This committee has responsibility for evaluating the quality and appropriateness of clinical performance and service quality of all individuals with clinical privileges. The MSAC(s) reviews corrective actions and provides authority within their realm of responsibility related to clinical quality management, patient safety, efficiency, and service quality activities.

### **Quality Leadership Council (QLC)**

**Composition:** Refer to Medical Staff Bylaws and Rules and Regulations

**Function:** Refer to Medical Staff Bylaws and Rules and Regulations

The QLC is responsible for designing and implementing systems and initiatives to enhance clinical care, outcomes and the patient experience throughout the integrated health care delivery system. The QLC serves as the oversight council for the Clinical Quality Management, Patient Safety and Patient Experience plan. Quality improvement activities within the Quality Accountability Team will be reported up to the QLC to ensure alignment of priorities for system-wide quality improvement projects and to provide consistent interventions (toolkits) to all stakeholders in the system.

### **Subject Matter Expert Councils (SME)**

The SME councils serve as the functional arm of Quality and Patient Safety to implement specific quality improvement initiatives within the Health System. The councils leverage the triad/dyad teams and selected leaders across the system to establish a clear level of accountability for quality improvement activities. The councils use data provided by ACE to identify and prioritize processes and tactics to improve a specific outcome or priority. The council may develop implementation toolkits consistent with best practice. These toolkits decrease variation in how quality improvement efforts are undertaken across the system for common issues such as falls, hospital acquired infections, and patient safety indicators. SME Council members are responsible for the successful implementation and maintenance of these QI efforts within their areas of responsibility.

**Composition:** An SME council is co-chaired by the Chief Quality and Patient Safety Officer and the Senior Director of Quality and Patient Safety. The council consists of existing and future triad and dyad leaders across the system and selected business unit, nursing, pavilion, as well educational and administrative leaders.



**Function:**

- System-wide implementation of quality improvement efforts for specific quality opportunities impacting a broad patient population.
- SME councils are not intended to replace any service line or business unit level quality committee or activity but are intended to align QI efforts across the system for specific opportunities.
- Priorities are established based on current performance and identified gaps in performance when compared to industry leaders; data is provided from the ACE and quality teams.
- SME councils are tasked with creating a system-wide QI plan to improve performance to include a standardized toolkit for implementation.
- The council coordinates with ACE to develop process measures, adherence reports, and outcome reporting for the project.
- After implementation, council leaders are responsible for ongoing surveillance of process adherence and outcomes for their respective units.
- SME councils report priorities, progress, and results to the QLC as appropriate.

**Clinical Practice Guideline Committee (CPGC)**

**Composition:** The CPGC consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Information Technology, Pharmacy, Nursing, and other allied health professionals. An active member of the medical staff chairs the committee. The CPGC reports to QLC and shares pertinent information with the Medical Staff Administrative Committees.

**Function:**

- Develop and update evidence-based clinical practice guidelines and best practices to support the delivery of patient care that promotes high quality, safe, efficient, effective, and patient centered care.
- Develop and implement Health System-specific resources and tools to support evidence-based guideline recommendations and best practices to improve patient care processes, reduce variation in practice, and support health care education.
- Develop measures to evaluate guideline use, processes, and outcomes of care.

**Clinical Quality and Patient Safety Committee (CQPSC)**

**Composition:** The CQPSC consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Information Technology, Nursing, Pharmacy, Laboratory,

Respiratory Therapy, Diagnostic Testing and Risk Management. An active member of the Medical Staff chairs the Committee. The committee reports to QLC and additional committees as deemed applicable. The primary role of the CQPSC is to ensure that OSUWMC is compliant with the Joint Commission and CMS Requirements for Participation.

**Function:**

- Creates, a culture of safety which promotes organizational learning and minimizes individual blame or retribution for reporting or involvement in a medical/health care error
- Assure optimal compliance with patient safety-related accreditation standards
- Proactively identifies risks to patient safety and initiates actions to reduce risk with a focus on process and system improvement
- Oversees completion of proactive risk assessment as required by TJC
- Oversees education & risk reduction strategies as they relate to Sentinel Event Alerts from TJC
- Provides oversight for clinical quality management committees
- Evaluates and, when indicated, provides recommendations to improve clinical care and outcomes
- Ensures actions are taken to improve performance whenever an undesirable pattern or trend is identified
- Receive reports from committees that have a potential impact on the quality & safety in delivering patient care

**Patient Experience Council(s)**

**Composition:** The Patient Experience Councils consists of executive, physician, and nursing leadership spanning the inpatient and outpatient care settings. The University Hospitals Council is co-chaired by the Chief Nurse Executive for the Health System, The Chief Administrative Officer for the Hospitals Division, and Chief Quality and Patient Safety Officer. The committee reports to the QLC and reports out to additional committees as applicable. The James Patient Experience Council reports to the James Quality, Patient Safety and Experience Council which then reports to QPAC. The Council's key strategic initiatives center on empathy, trust, and personal connections as well as leveraging technology to enhance communication with patients and families.

**Function:**

- Create a culture and environment that delivers an unparalleled patient experience consistent with the OSU Medical Center's mission, vision and values focusing largely on service quality.
- Set strategic goals and priorities for improving the patient experience to be implemented by area specific patient experience councils and teams.

- Serve as a communication hub reporting out objectives and performance to the system.
- Serve as a coordinating body for subcommittees working on specific aspects of the patient experience.
- Measure and review voice of the customer information in the form of Patient and Family Experience Advisor Program and related councils, patient satisfaction data, comments, letters, and related measures.
- Monitor publicly reported and other metrics used by various payers to ensure optimal reimbursement.
- Collaborate with other departments to reward and recognize faculty and staff for service excellence performance.

### **Practitioner Evaluation Committee (PEC)**

**Composition:** The Practitioner Evaluation Committee (PEC) (**Appendix E**) is the Peer Review committee that provides medical leadership in overseeing the Peer Review process. The PEC is co-chaired by the CQPSO and a CMO appointee. The committee is composed of the Chair of the Clinical Quality and Patient Safety Committee, physicians, and advanced practice licensed health care providers from various business units & clinical areas as appointed by the CMO & Physician in Chief at the James. The Medical Center CMO & Physician-in-Chief at the James serves Ex- Officio. In FY24, a subcommittee of PEC will be established to review OPPE outliers and to report these concerns to PEC.

#### **Function:**

- Provide leadership for OSUWMC clinical quality improvement processes.
- Provide clinical expertise to the practitioner peer review process thorough and timely review of clinical care and/or patient safety issues referred to the PEC.
- Advises the CMO & Director of Medical Affairs at the James regarding action plans to improve the quality and safety of clinical care at the OSUWMC.
- Develop follow up plans to ensure action is successful in improving quality and safety.
- Monitor OPPE reports (via subcommittee) to identify outliers in the faculty prior to their recertification review every three years.
- Establish Peer Review Process Policy to clearly define the scope, methods, and timing of peer review events.

### **Sentinel Event Team**

**Composition:** The OSUWMC Sentinel Event Team (SET) includes an Administrator, the Chief Quality and Patient Safety Officer, the Administrative Director for Quality & Patient Safety, a member of the Physician Executive Council, a member of the Nurse Executive Council,

representatives from Quality and Operations Improvement and Risk Management and other areas as necessary.

**Function:**

- Approves & makes recommendations on sentinel event determinations and teams, and action plans as received from the Sentinel Event Determination Group,
- Evaluates findings, recommendations, and approves action plans of all root cause analyses.

**The Sentinel Event Determination Group (SEDG)**

The SEDG is a sub-group of the Sentinel Event Team and determines whether an event will be considered a sentinel event, a significant event or a non-event. SEDG has the authority to assign the Root Cause Analysis (RCA) Executive Sponsor, RCA Workgroup Leader, RCA Workgroup Facilitator, and recommends the Workgroup membership to the Executive Sponsor. When the RCA is presented to the Sentinel Event Team, the RCA Workgroup Facilitator will attend to support the members.

**Composition:** The SEDG voting membership includes the CQPSO or designee, Director of Risk Management, and Quality Director of respective business unit for where the event occurred (or their designee). Additional guests attend as necessary.

**Clinical Quality & Patient Safety Sub-Committees**

**Composition:** For the purposes of this plan, Quality & Patient Safety Sub-Committees will refer to any standing committee or sub-committee functioning under the Quality Oversight Structure. Membership on these committees will represent the major clinical and support services throughout the hospitals and/or clinical departments. These committees report, as needed, to the appropriate oversight committee(s) defined in this Plan.

**Function:** Serve as the central resource and interdisciplinary work group(s) for the continuous process of monitoring and evaluating the quality and services provided throughout a hospital, clinical department, and/or a group of similar clinical departments.

## Process Improvement Teams

**Composition:** For the purposes of this plan, Process Improvement Teams are any ad-hoc committee, workgroup, team, taskforce etc. that function under the Quality Oversight Structure and are generally time-limited in nature. Process Improvement Teams are comprised of owners or participants in the process under study. The process may be clinical (e.g. prophylactic antibiotic administration or not clinical (e.g., appointment availability). Generally, the members fill the following roles: team leader, facilitator, physician advisor, administrative sponsor, and technical expert.

**Function:** Improve current processes using traditional QI tools and by focusing on customer needs.

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## Roles and Responsibilities

### Executive Vice President/CEO

The EVP leads all seven health science colleges and the Wexner Medical Center

Enterprise which includes seven hospitals, a nationally ranked college of medicine, 20-plus research institutes, multiple ambulatory sites, an accountable care organization and a health plan. Additionally, the EVP serves as the Chief Executive Officer for Wexner Medical Center and serves in an ex-officio role for the Wexner Board of Trustees, as well as being the Chairman for the Quality and Professional Affairs committee which is a Board committee.

### Chief Operating Officer (COO)

The COO for the Medical Center is responsible for providing leadership and oversight for the overall Clinical Quality Management, Patient Safety and Patient Experience Plan across the OSUWMC.

### Chief Clinical Officer (CCO)

The CCO for the Medical Center is responsible for facilitating the implementation of the overall Clinical Quality Management, Patient Safety & Patient Experience Plan at OSUWMC. The CCO is responsible for facilitating the implementation of the recommendations approved by the various committees under the Quality Leadership Committee (QLC).

## **Chief Quality and Patient Safety Officer (CQPSO)**

The CQPSO reports to the Chief Operating Officer and provides oversight and leadership for the OSUWMC in the conceptualization, development, implementation and measurement of the OSUWMC approach to quality, patient safety and patient experience.

## **Senior Director, Quality and Safety**

The Senior Director of Quality and Safety works in dyad partnership with the CQPSO to provide oversight and leadership for the OSUWMC in the conceptualization, development, implementation, and measurement of the OSUWMC approach to quality, patient safety, and patient experience.

## **Associate Chief Quality and Patient Safety Officers**

The Associate Chief Quality and Patient Safety Officers supports the CQPSO in the development, implementation, and measurement of OSUWMC's approach to quality, safety, and patient experience.

## **Medical Director/Director of Medical Affairs**

Each business unit Medical Director is responsible for the review, implementation and oversight of the Clinical Quality Management, Patient Safety & Patient Experience Plan.

## **Associate Medical Directors**

The Associate Medical Directors assist the CQPSO in the oversight, development, and implementation of the Clinical Quality Management, Patient Safety & Patient Experience Plan as it relates to the areas of quality, safety, evidence-based medicine, clinical resource utilization and service.

## **Chief Administrative Officers – Acute Care Division/Post-Acute and Home-Based Care Division/Outpatient and Ambulatory Division/Clinical and Physician Network**

The OSUWMC Chief Administrative Officers are responsible to the Board for implementation of the Clinical Quality Management, Patient Safety & Patient Experience Plan for their respective divisions.

## **Business Unit Executive Directors**

The OSUWMC staff, under the direction of the Health System Chief Administrative Officer and Hospital Administration, implements the program throughout the organization. Hospital Administration provides authority and supports corrective actions within its realm for clinical quality management, patient safety, and patient experience activities.

## **Clinical Department Chief and Division Directors:**

Each department chairperson and division director are responsible for ensuring the standards of care and service are maintained within their department/division. In addition, department chairpersons/division director may be asked to implement recommendations from the Clinical Quality Management, Patient Safety and Patient Experience Plan, or participate in corrective action plans for individual physicians, or the division/department as a whole.

## **Medical Staff**

Medical staff members are responsible for achieving the highest standard of care and services within their scope of practice. As a requirement for membership on the medical staff, members are expected and must participate in the functions and expectations set forth in the Clinical Quality Management, Patient Safety, & Patient Experience Plan. In addition, members may be asked to serve on quality management committees and/or quality improvement teams.

## **House Staff Quality Forum (HQF)**

The House Staff Quality Forum (HQF) is comprised of representatives from each Accreditation Council for Graduate Medical Education (ACGME) program. HQF has Executive Sponsorship from the CQPSO and the Associate CQPSO.

The purpose of the HQF is to provide post-graduate trainees an opportunity to participate in clinical quality, patient safety and patient experience-related initiatives while incorporating the perspective of the frontline provider. HQF will work on quality, safety and patient experience related projects and initiatives that are aligned with the health system goals and will report to the Clinical Quality and Patient Safety committee. The Chair HQF will serve as a member of the Leadership Council.

## **Nursing Quality**

The primary responsibility of the Nursing Quality and Evidence-Based Practice (EBP) Department is to monitor and evaluate performance of the nursing staff in support of organizational quality, safety and patient experience goals, submit required data to the National Database for Nursing Quality Indicators (NDNQI), review benchmark data and identify opportunities for improvement, use the literature to guide recommended changes to nursing practice and policy, coordinate and facilitate nursing quality improvement initiatives, facilitate participation/collaboration with system-wide patient safety activities, and use EBP and research to improve both the delivery and outcomes of personalized nursing care.

Nursing Quality team members serve as internal consultants for the development and evaluation of quality improvement, patient safety, and EBP activities. The department maintains

human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

## **Hospital Department Directors**

Each department director is responsible for ensuring the standards of care and service are maintained or exceeded within their department. Department directors are responsible for implementing, monitoring, and evaluating activities in their respective areas and assisting medical staff members in developing appropriate mechanisms for data collection and evaluation. In addition, department directors may be asked to implement recommendations from the Clinical Quality Management, Patient Safety and Patient Experience Plan or participate in corrective action plans for individual employees or the department as a whole. Department directors provide input regarding committee memberships and serve as participants on quality management committees and/or quality improvement teams.

## **Health System Staff**

Health System staff members are responsible for ensuring the standards of care and services are maintained or exceeded within their scope of responsibility. The staff is involved through formal and informal processes related to clinical quality improvement, patient safety and patient experience efforts, including but not limited to:

- Reporting events, including near misses or “good catches” via the internal Patient Safety Reporting System (PSRS)
- Suggesting processes to improve quality, safety and service
- Monitoring activities and processes, such as patient complaints and patient satisfaction
- Participating in focus groups
- Attending staff meetings
- Participating in efforts to improve quality and safety including Root Cause Analysis and Proactive Risk Assessments

## **Quality and Operations Improvement**

The primary responsibility of the Quality and Operations Improvement team is to coordinate and facilitate clinical quality management and patient safety activities throughout the Health System. The primary responsibility for the implementation and evaluation of clinical quality management and patient safety activities resides in each department/program; however, the quality and operations improvement staff also serve as an internal consultant for the development and evaluation of quality management and patient safety activities. The team maintains human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

The department is comprised of five main functions – , Patient Safety, Quality Outcomes Management, Provider Engagement and Peer Review. **Appendix F** shows the current organizational structure.

## **Patient Experience**

The primary responsibility of the Patient Experience team is to coordinate and facilitate a service-oriented approach to providing healthcare throughout the Health System. This is



accomplished through both strategic and program development as well as through managing operational functions within the Health System. The implementation and evaluation of service-related activities resides in each department/program; however, the Patient Experience staff also serves as an internal consultant for the development and evaluation of service quality activities as well as a representative of the “voice of the patient” throughout the organization by reflecting or providing patient feedback to shape decision making. The Patient Experience Department maintains human and technical resources for interpreter services, information desks, patient relations, pastoral care, team facilitation, survey management, and performance improvement. The department also oversees the Patient and Family Experience Advisor Program which is a group of current/former patients, or their primary caregivers, who have had experiences at any OSU facility. These individuals are volunteers who serve as advisory members on committees and workgroups, complete public speaking engagements and review materials.

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## Approach to Clinical Quality, Patient Safety & Patient Experience Management

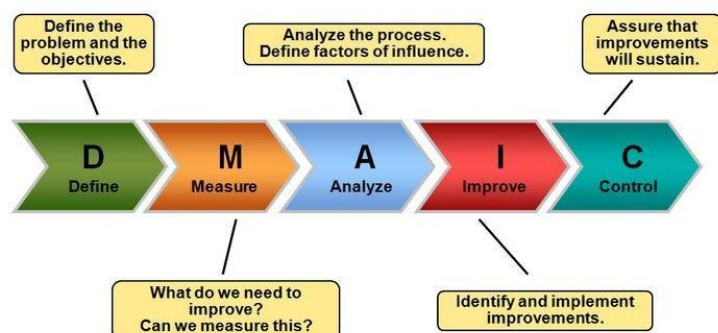
### Systematic Approach/Model to Process Improvement

The OSUWMC embraces change and innovation as one of its core values. Organizational focus on process improvement and innovation is embedded within the culture using a general Process Improvement Model that includes:

- 1) an organizational expectation that the entire workforce is responsible for enhancing organizational performance and;
- 2) active involvement of multidisciplinary teams and committees focused on improving processes.

With the increased organizational emphasis on utilizing metric-driven approaches to reducing unintended medical errors, eliminating rework, and enhancing the efficiency/effectiveness of our work processes, the DMAIC methodology will be instrumental as a tool to help focus our process improvement efforts.

#### DMAIC Roadmap



## Determining Priorities

The OSUWMC has a process in place to identify and direct resources toward quality management, patient safety, and patient experience activities. The OSUWMC criteria are approved and reviewed by QLC and the Medical Center Board. The prioritization criteria are reevaluated annually according to the mission and strategic plan of the OSUWMC. The leaders may also set performance improvement priorities and reevaluate on an ad hoc basis in response to unusual or urgent events.

## Data Measurement and Assessment

### Determination of Data Needs

The OSUWMC data needs are determined according to improvement priorities and surveillance needs. The OSUWMC collects data for monitoring important processes and outcomes related to patient care and the OSUWMC functions. In addition, each department is responsible to identify quality indicators specific to their area of service. The quality management committee of each area is responsible for monitoring and assessment of the data collected.

### Collection/Measurement

Data, including patient demographic and clinical information, are systematically collected throughout the OSUWMC through various mechanisms including:

- Administrative and clinical registries and databases
- Retrospective and concurrent medical record review (e.g., infection surveillance)
- Reporting systems (e.g., patient safety reporting system)
- Surveys (i.e. patients, families, and staff)

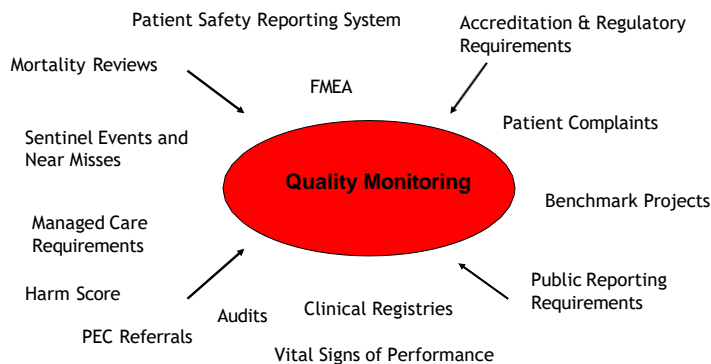
### Assessment

Statistical methods such as control charts, g-charts, confidence intervals, and trend analysis are used to identify undesirable variance, trends, and opportunities for improvement. The data is compared to previous performance, and external benchmarks. Accepted standards of care and aspirational performance targets are used to establish metrics and goals. Annual goals are established to evaluate performance. Where appropriate, OSUWMC has adopted the philosophy of setting multi-year aspirational targets. Annual targets are set as steps to achieve the aspirational goal.

### Surveillance

The OSUWMC systematically collects and assesses data in different areas to monitor and evaluate the quality and safety of services, including measures related to accreditation and other requirements. Data collection also functions as a surveillance system for timely identification of undesired variations or trends in quality indicators. Other mechanisms by which data may be obtained are outlined in the graphic below.

# Methods for Monitoring



## Benchmark data

Both internal and external benchmarking provides value to evaluating performance.

- **Internal Benchmarking**  
Internal benchmarking uses processes and data to compare OSUMCs performance to itself overtime. Internal benchmarking provides a gauge of improvement strategies within the organization.
- **External Benchmarking**  
OSUWMC participates in various database systems, clinical registries and focused benchmarking projects to compare performance with that of peer institutions. Vizient, The US News & World Report, National Database of Nursing Quality Indicators, and The Society of Thoracic Surgery are examples of several external organizations that provide benchmarking opportunities.

## External reporting requirements

There are several external reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations. An annual report is given to the Compliance Committee to ensure all regulatory requirements are met.

## Communication of Data/Performance

### Metric Headquarters (Metric HQ)

Metric HQ is a newly launched set of dashboards designed to consolidate quality and safety data across the OSUWMC. The intent of Metric HQ is to become the single source of truth for quality and safety performance across the organization. Specific data within Metric HQ is available at the system, business unit, and unit level. Additional plans are underway to provide process measure data as leading indicators for established outcomes or priorities. Examples of data available within Metric HQ is the following:

## **Vital Signs of Performance**

The Vital Signs of Performance is an online dashboard available to everyone in the Medical Center with a valid user account that shows Mortality, Length of Stay, Patient Safety Indicators, and Readmission data over time. The data can be displayed at the health system, business unit, clinical service, and nurse station level.

## **Patient Satisfaction Dashboard**

The Patient Satisfaction dashboard consists of patient experience indicators and comments gathered from surveys after discharge or visit to a hospital or outpatient area. The dashboard covers performance in areas such as overall experience, physician communication, nurse communication, responsiveness, and environment. It also measures process indicators, such as joint physician-nurse rounding and nurse leader rounding, as well as serves as a resource for best practices. The information contained on the dashboard is shared in various forums with staff, clinicians, administration, including the Boards.

## **Performance Based Physician Quality & Credentialing**

Performance-based credentialing ensures processes that assist to promote the delivery of quality and safe care by physicians and advanced practice licensed health care providers. Both Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) occur. Focused Professional Practice Evaluation (FPPE) is utilized on 3 occasions: initial appointment, when a Privileged Practitioner requests a new privilege, and for cause when questions arise regarding the practitioner's ability to provide safe, high quality patient care. Ongoing Professional Practice Evaluation (OPPE) is performed on an ongoing basis (every 6 months).

### **Profiling Process:**

- Data gathering from multiple sources
- Report generation and indicator analysis
- Department chairs (division directors as well) have online access 24/7 to physician profiles for their ongoing review
  - Individual physician access to their profiles 24/7
- Discussion at Credentialing Committee
- Final Recommendation & Approval:
  - Medical Staff Administrative Committees
  - Medical Director
  - Hospital Board

## **Service-Specific Indicators**

Several of the indicators are used to profile each physician's performance. The results are included in a physician profile which is reviewed with the department chair as part of credentialing process.

The definition of service/department specific indicators is the responsibility of the director/chair of each unit. The performance in these indicators is used as evidence of competence to grant privileges in the re-appointment process. The clinical departments/divisions are required to collect the performance information as necessary related to these indicators and report that information to the Department of Quality & Operations Improvement.

## **Purpose of Medical Staff Evaluation**

- To monitor and evaluate medical staff performance ensuring a competent medical staff
- To integrate medical staff performance data into the reappointment process and create the foundation for high quality care, safe, and efficacious care
- To provide periodic feedback and inform clinical department chairs of the comparative performance of individual medical staff
- To identify opportunities for improving the quality of care

## **Conflict of Interest**

Any person, who is professionally involved in the care of a patient being reviewed, should not participate in peer review deliberations and voting. A person is professionally involved if they are responsible for patient care decision making either as a primary or consulting professional and/or have a financial interest (as determined by legal counsel) in the case under review. Persons who are professionally involved in the care under review are to refrain from participation except as requested by the appropriate administrative or medical leader. During peer review evaluations, deliberations, or voting, the chairperson will take steps to avoid the presence of any person, including committee members, professionally involved in the care under review. The chairperson of a committee should resolve all questions concerning whether a person is professionally involved. In cases where a committee member is professionally involved, the respective chairperson may appoint a replacement member to the committee. Participants and committee members are encouraged to recognize and disclose, as appropriate, a personal interest or relationship they may have concerning any action under peer review.

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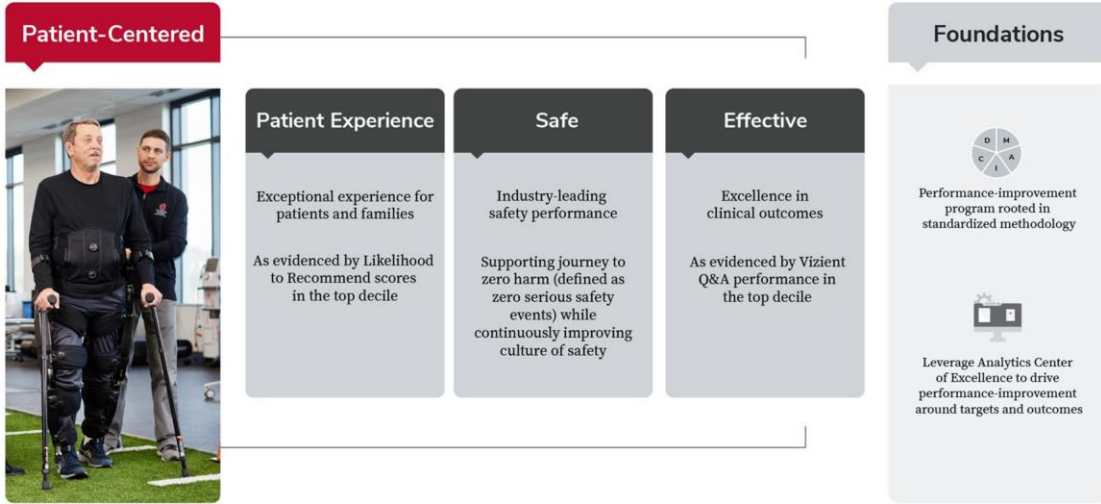
## **Annual Approval and Continuous Evaluation**

The Clinical Quality Management, Patient Safety & Patient Experience Plan is approved by the QLC, the Medical Staff Administrative Committees, and the Medical Center Board on an annual basis. The annual evaluation includes a review of the program activities and an evaluation of the effectiveness of the structure.

# Appendix A: Long Range Quality Plan

## Long-Range Quality Plan

*World Class Care: Every Person, Every Time*



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## Appendix B: Prioritization Criteria

The following criteria are used to prioritize clinical value enhancement initiatives to ensure the appropriate allocation of resources.

1. Ties to strategic initiatives and is consistent with hospital's mission, vision, and values
2. Reflects areas for improvement in patient safety, appropriateness, quality, and/or medical necessity of patient care (e.g., high risk, serious events, problem-prone)
3. Has considerable impact on our community's health status (e.g., morbidity/mortality rate)
4. Addresses patient experience issues (e.g., access, communication, discharge)
5. Reflects divergence from benchmarks
6. Addresses variation in practice
7. Is a requirement of an external organization
8. Represents significant cost/economic implications (e.g., high volume)

## Appendix C: FY25 Priorities/Metrics

### — FY25 Quality & Safety Priorities

*Board endorsed quality priorities*

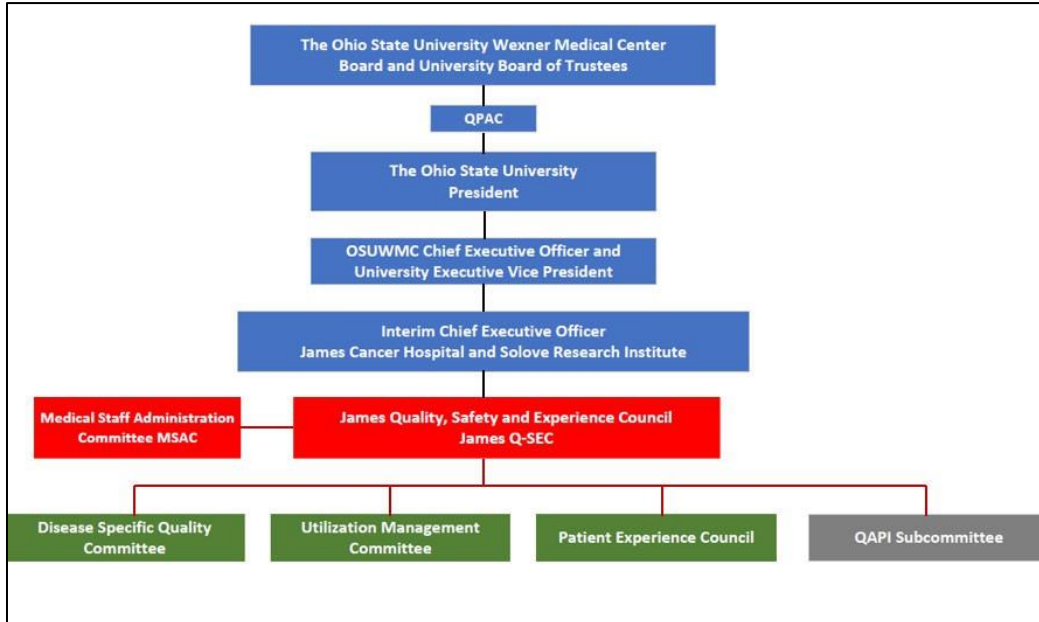
- Mortality
- Patient Experience (Likelihood to Recommend)
- Central Line Associated Blood Stream Infections (CLABSI)
- Falls with Injury
- Retained Foreign Bodies

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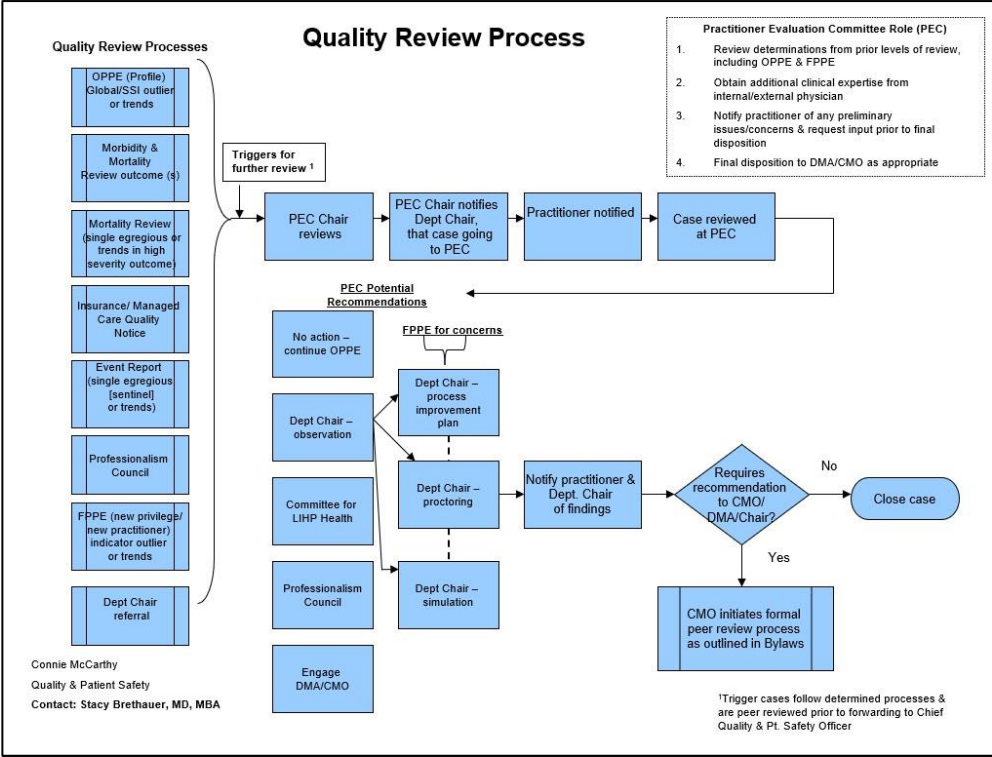
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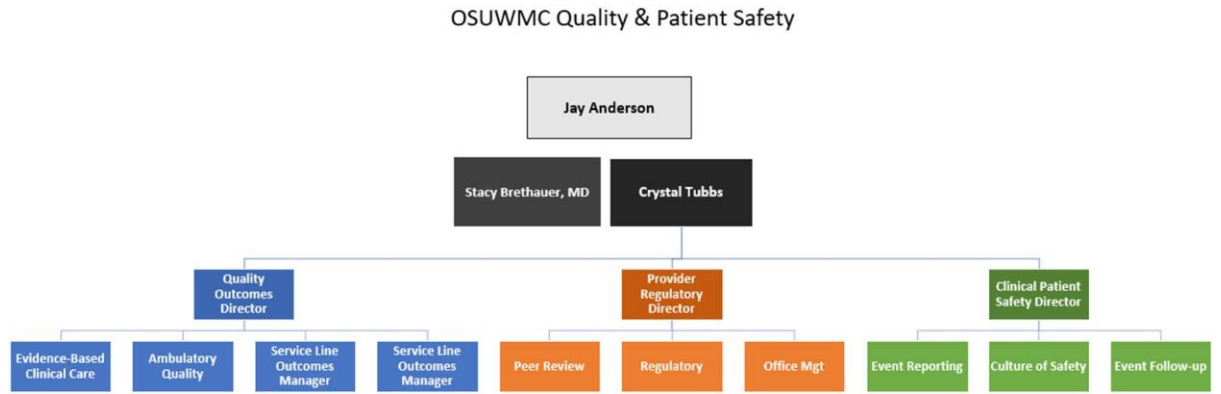
# Appendix D: Quality Structure for The James Cancer Hospital & Solove Research Institute



# Appendix E: Quality Review Process & Physician Performance Based Profile



# Appendix F: Quality Organizational Structure



**THE JAMES QUALITY, SAFETY, AND EXPERIENCE COUNCIL PLAN**

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER  
ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the annual review of The James Quality, Safety, and Experience Council Plan for FY25 for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS The James Quality, Safety, and Experience Council Plan for FY25 outlines assessment and improvement of processes in order to deliver safe, effective, optimal patient care and services in an environment of minimal risk for inpatients and outpatients of The James; and

WHEREAS the annual review of The James Quality, Safety, and Experience Council Plan for FY25 was approved by James Quality, Safety and Experience Council on April 24, 2024; and

WHEREAS the annual review of The James Quality, Safety, and Experience Council Plan for FY25 was approved by The James Medical Staff Administration Committee on May 17, 2024:

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve The James Quality, Safety, and Experience Council Plan for FY25:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves The James Quality, Safety, and Experience Council Plan for FY25 for The James.

Approvals:  
MSAC: May 17, 2024  
QPAC: July 23, 2024  
Wexner Medical Center Board:

# **The James Cancer Hospital Quality, Safety and Experience Council Plan**

The Ohio State University  
James Cancer Hospital and  
Solove Research Institute  
The Comprehensive Cancer Center  
(The James and CCC)

Fiscal Year 2025  
July 1, 2024, through June 30, 2025

## The James



**THE OHIO STATE UNIVERSITY**  
COMPREHENSIVE CANCER CENTER

**The James Cancer Hospital Quality, Safety and Experience Council Plan**  
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# The James Cancer Hospital & Solove Research Institute

## The James Quality, Safety and Experience Council Plan

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### Mission, Vision, and Values:

**Mission:** To eradicate cancer from individuals' lives by creating knowledge and integrating groundbreaking research with excellence in education and patient-centered care.

**Vision:** Creating a cancer-free world. One person, one discovery at a time.

**Values:** Excellence, Collaborating as One University, Integrity and Personal Accountability, Openness and Trust, Diversity in People, and Ideas, Change and Innovation, Simplicity in Our Work, Empathy, Compassion, and Leadership.

The James' model of patient-centered care is enhanced by the teaching and research programs. Patient service, both directly and indirectly, provides the foundation for teaching and research programs. This three-part mission and a staff dedicated to its fulfillment, distinguish The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute as a Comprehensive Cancer Center and as one of the nation's premier cancer treatment centers.

### Definition:

The James Quality, Safety, and Experience Council Plan (hereinafter The Plan) of The James Cancer Hospital and Solove Research Institute is our organization-wide approach to systematic assessment of process design and performance improvement targeting quality of care, patient safety, and patient experience. The Plan serves to provide direction for how clinical care and activities are to be designed to enrich patient outcomes, reduce harm, and improve value-added care and service to the cancer patient population.

### Scope:

As a Prospective-Payment-System-exempt (PPS-exempt) hospital, which serves as the clinical care delivery-arm of an NCI-designated Comprehensive Cancer Center, The James has a unique opportunity to ensure value-added services and research expertise are provided to our patients, families, and the community – both nationally and internationally. The Plan encompasses all clinical services. Through close partnership with the Comprehensive Cancer Center, The Plan includes quality and patient safety goals for process improvements related to functions and processes involving both the Cancer Center and the hospital and ambulatory clinics/treatment areas.

With a close partnership within OSUWMC, The Plan provides oversight of the clinical contracted services and serves as a component of The Quality Assessment and Performance Improvement (QAPI) requirements from the Center for Medicaid and Medicare Services. These services are evaluated on an annual basis by The James Quality, Safety and Experience Council (Q-SEC), The James Quality Assessment and Performance Improvement (QAPI) Subcommittee, The James Medical Staff Administrative Committee (MSAC), and then forwarded each year to the Quality and Professional Affairs Committee

(QPAC) as a part of the governing body, to ensure quality and safety of care is provided to all James' patients.

### **Purpose:**

The purpose of the Plan is to provide guidance for the resources and processes available to ensure measurable improvements to patient care are occurring. The James recognizes the vital importance of creating and maintaining a safe environment for all patients, visitors, employees, and others within the organization to bring about personalized care through evidence-based medicine.

### **Objectives:**

The central objectives of The James Quality, Safety and Experience Council Plan are to:

1. Provide guidance for monitoring and evaluation of effort(s) in clinical care to sustain high performance and improved outcomes for all patients.
2. Evaluate and recommend system changes to improve patient care and safety by assessing, identifying, and reducing risk within the organization when undesirable patterns or trends in performance are identified, or when events requiring intensive analysis occur.
3. Assure overall program meets or exceeds accreditation standards, state, federal and licensure regulations.
4. Provide information for adherence to evidence-based practice guidelines to standardize clinical care and reduce practice variation.
5. Improve patient satisfaction and perception of treatment, care, and services by continuously identifying, evaluating, and improving performance based on needs, expectations, and satisfaction results.
6. Enhance the patient experience by providing safe and high-quality care at the best value.
7. Provide education to the governance, faculty and staff regarding quality management principles and processes for improving systems.
8. Provide appropriate levels of data transparency.
9. Assure quality and patient safety processes developed involve trans-disciplinary teamwork.
10. Provide process improvement initiatives to clinical systems to prevent or eliminate patient harm.

### **Structure for Quality Oversight:**

The James Quality, Safety and Experience Council (Q-SEC) serves as the primary entity within The James to develop annual goals which are consistent with goals from the Health System. However, these goals for The James are designed to specifically target and focus on the cancer patient population and cancer research agendas.

### **Governance and Committees:**

#### **Governing Body**

The Wexner Medical Center Board is the governing body, responsible to The Ohio State University Board of Trustees, for operation, oversight and coordination of the Wexner Medical Center and The James Cancer Hospital. The Wexner Medical Center Board is composed of sixteen voting members, plus an additional group of university and medical center senior leaders who serve in ex-officio roles. The Quality & Professional Affairs Committee (QPAC) reports to the Wexner Medical Center Board and is responsible



for, among other things, annually reviewing and evaluating The James Quality Safety, and Experience Council Plan, along with goals and process improvements made for improved patient safety and quality programs, QPAC is also responsible for granting clinical privileges for the credentialing of practitioners. The Board of Trustees and its committees meet throughout the year with focused agendas and presentations.

#### The Quality and Professional Affairs Committee (QPAC):

##### **Composition:**

This committee consists of no fewer than four voting members of the University Wexner Medical Center Board of Trustees. Members are appointed each year by the Chair of the OSUWMC Board, and one of these shall be assigned as the Chair of the committee. The CEO of the OSU Health System; CMO of the University Medical Center; CMO of The James; the Medical Director of Credentialing for The James; the Chief of Medical Staff of the University hospitals; the Chief of Medical Staff for The James; the Associate Dean of Graduate Medical Education; the Chief Quality and Patient Safety Officer; The Chief Nurse Executive for the OSU Health System; and the Chief Nursing Officer for The James serve in ex-officio, voting positions. Other members as may be appointed by The Chair of the OSUWMC board, in consultation with the Chair of Quality and Professional Affairs committee.

##### **Function:**

The Quality and Professional Affairs Committee (QPAC) shall be responsible for the following specific duties:

1. Reviewing and evaluating the Quality and Patient Safety programs of OSUWMC.
2. Overseeing all patient care activity in all facilities as a part of OSUWMC, including but not limited to, hospitals, clinics, ambulatory care, and physician office facilities.
3. Monitoring quality assurance performance in accordance with the standards set by OSUWMC.
4. Monitoring the achievement of accreditation and licensure requirements.
5. Reviewing and then recommending to the OSUWMC board changes to the medical staff bylaws and medical staff rules and regulations.
6. Reviewing and approving clinical privilege forms.
7. Reviewing and approving membership, as well as granting appropriate clinical privileges for the credentialing of practitioners, recommended for membership and clinical privileges by the hospital's Medical Staff Administrative Committees (MSAC).
8. Reviewing and approving membership and granting appropriate clinical privileges for the expedited credentialing of such practitioners that are eligible by satisfying the minimum approved criteria which is determined by the OSUWMC board and recommended for membership and clinical privileges to the MSACs of OSUWMC and The James.
9. Reviewing and approving reinstatement of clinical privileges for a practitioner after a leave of absence from clinical practice.
10. Conducting Peer Review activities and recommending professional review actions to the OSUWMC board.
11. Reviewing and resolving any petitions by the medical staff for amendments to any rule, regulation or policy presented by the Chief of Staff on behalf of the medical staff pursuant to the medical staff bylaws and communicating such resolutions to the hospital's MSACs.
12. Such other responsibilities as assigned by the Chair of the OSUWMC Board.

## The James Medical Staff Administrative Committee (MSAC)

### **Composition:**

*Refer to Medical Staff Bylaws and Rules and Regulations*

### **Function:**

*Refer to Medical Staff Bylaws and Rules and Regulations*

The organized medical staff, under the direction of the Director of Medical Affairs/Chief Medical Officer, implements The Plan throughout the clinical departments. The James MSAC reviews reports, and recommendations related to clinical quality management, patient safety, and service quality activities. This Committee has responsibility for evaluating the quality and appropriateness of clinical performance and service quality of all individuals with clinical privileges. The James MSAC reviews corrective actions and provides authority within their realm of responsibility related to clinical quality management, patient safety, and service quality activities.

## The James Quality, Safety and Experience Council (Q-SEC)

### **Composition:**

The James Quality, Safety and Experience Council (Q-SEC) consists of representatives from Medical Staff, Administration, Advanced Practice Providers, and staff from Cancer Program Analytics, Epidemiology, Environmental Services, Clinical Informatics, Laboratory, Nursing, Pharmacy/Medication Safety, Patient Experience, Social Work, and Risk Management. This Council reports to Executive Leadership and The James Medical Staff Administrative Committee (MSAC).

### **Function:**

- Create a culture which promotes organizational learning and recognition of clinical quality (improving outcomes) and patient safety (reducing harm).
- Develop and sustain a culture of safety which strives to embed Just Culture principles in the follow up of healthcare errors.
- Assure compliance with patient safety-related accreditation standards.
- Proactively identify risks to patient safety and creates a call-to-action to reduce risk with a focus on process and system improvement.
- Oversee education and risk reduction strategies as they relate to Sentinel Event Alerts from The Joint Commission.
- Evaluate standards of care and evidence-based practices and provide recommendations to improve clinical care and outcomes.
- Ensures actions are taken to improve performance whenever an undesirable pattern or trend is identified.
- Receive reports from disease specific committees that have a potential impact on the quality & safety in delivering patient care such as, but not limited to, Apheresis, BMT and Acute Leukemia, Cell Therapy, Lymphoma, Sickle Cell, Radiation Oncology, Translational Research, Patient Experience, Grievance Committee, Utilization Management Committee, and Infection Prevention Committees.
- Receive reports from Shared Services as they represent the metrics for quality and safety of care for the cancer patient population.
- Maintain follow-up on Shared Services action plans as necessary for improving metrics for quality and safety of care for the cancer patient population.

## The James Quality, Safety and Experience Council QAPI Sub-Committee

### **Composition:**

The James Quality, Safety and Experience QAPI Sub-Committee refers to the sub-committee functioning under the quality oversight structure of The James Quality, Safety and Experience Council (Q-SEC). Membership on this sub-committee represents the major clinical and support services throughout the hospitals and/or clinical departments, as well as members from The James Quality, Safety and Experience Council. The QAPI Sub-committee will identify department barriers requiring escalation to the James Quality, Safety and Experience Council (Q-SEC), or as defined by The Plan.

### **Function:**

- Serve as the central resource and interdisciplinary work groups for the continuous process of monitoring and evaluating the quality and services provided throughout a hospital, clinical department, and/or a group of similar clinical departments.
- Conducts department reviews for services provided by the The James and services received from Wexner Medical Center, including process/patient safety metrics and PSRS events reviews.
- Receive reports from Shared Services as they represent the metrics for quality and safety of care for the cancer patient population.
- Maintain follow-up on Shared Services action plans as necessary for improving metrics for quality and safety of care for the cancer patient population.

## The James Patient Experience Council

### **Composition:**

The Patient Experience Council consists of multidisciplinary representatives from Hospital Administration, Medical Staff, Nursing, Nutrition Services, Environmental Services, Communications, and the Patient Experience Department. The Patient Experience Council has a liaison member connected to The James Quality, Safety and Experience Council (Q-SEC).

### **Function:**

- Create a culture and environment to deliver exceptional patient experience consistent with the mission, vision and values focused on service quality.
- Measure and review voice of the customer information in the form of patient satisfaction, comments, letters, and related measures. Recommend system goals and expectations for a consistent patient experience.
- Provides guidance and oversight on patient experience improvement efforts ensuring effective deployment and accountability throughout the system.
- Oversees the service excellence reward and recognition program.
- Communicates the work of the Council throughout the organization.

## The James Utilization Management Committee (JUMC)

### **Composition:**

The James Utilization Management Committee (JUMC) is co-chaired by the Associate Chief Medical Officer of the Care Continuum and the Director of Patient Care Resource Management. Committee membership will include James Physician Advisors and Emergency Department Physician Advisors, physician members of the medical staff, representatives from the Patient Care Resource Management (PCRM) Department, Administration, Finance, Advance Practice Professionals, Providers, Quality and Safety, Revenue Cycle and Compliance, Nursing and Service Line Administration. Other departments in

The James will be invited to join meetings as necessary when opportunities have been identified for improvement and input. JUMC members will not include any individual who has a financial interest in any hospital in the health system. No JUMC member will be included in the review process for a case when that member has direct responsibility for patient care in the case being reviewed.

**Function:**

The JUMC has responsibility to establish and implement The James Utilization Management Plan. The JUMC implements procedures for reviewing the efficient utilization of care and services, including, but not limited to admissions, continued stays, readmissions, over and under-utilization of services, the efficient scheduling of services, appropriate stewardship of hospital resources, access and throughput and timeliness of discharge planning. Any quality or utilization opportunities identified by the JUMC through utilization review activities are acted upon by the committee or referred to the appropriate entity for resolution. The JUMC provides education on care and utilization issues to all health care professionals and medical staff at The James.

### Practitioner Evaluation Committee (PEC)

**Composition:**

The Practitioner Evaluation Committee (PEC) is the medical staff peer review committee that provides leadership in overseeing the peer review process. The PEC is composed of the Chair of the Clinical Quality and Patient Safety Committee, medical staff, and advanced practice providers from various business units and clinical areas as appointed by the Chief Medical Officer (CMO) of the Health System and the Director of Medical Affairs/Chief Medical Officer.

**Function:**

- Provide leadership for the provider clinical quality improvement processes.
- Provide clinical expertise to the practitioner peer review process by thorough and timely review of clinical care and/or patient safety issues referred to the PEC.
- Give advice to the Director of Medical Affairs/CMO at The James regarding action plans to improve the quality and safety of clinical care.
- Provide input to the Director for Advanced Practice Providers when there is an APP Peer Review completed.
- Develop follow up plans to ensure action is successful in improving quality and patient safety.

### Health System Information Systems Steering Team (HSISST)

**Composition:**

The HSISST is a multidisciplinary team chaired by the Chief Medical Information Officer of OSUWMC.

**Function:**

The HSISST oversees information technology for both The James and OSUWMC. The team is responsible for oversight of information technology and processes currently in place, as well as reviewing replacement and/or introduction of new systems, and related policies/procedures. Individual team members are charged with responsibility to communicate and receive input from their various communities of interest on relevant topics discussed at committee meetings and other forums.

### Sentinel Event Committee and Sentinel Event Determination Group (SEDG):

**Composition:**

The Sentinel Event Team includes membership from both The James and the OSUWMC. Membership from The James includes: the Executive Director Medical Affairs/Chief Medical Officer, the Quality

Medical Director for The James, the Quality Medical Director for Perioperative services, and the Director of Quality & Patient Safety and Nursing Quality Director. Members from the Medical Center include: an Administrator, Chief Medical Officer, Chief Quality Officer, Associate Chief Quality and Patient Safety Officer, Associate Executive Director of Quality & Safety, a member of the Physician Executive Council, Quality and Operations Improvement, and Medication Safety Officer. Members from Risk Management are also included.

The Sentinel Event Determination Group (SEDG) is a sub-group of the Sentinel Event Team which is comprised of quality leaders from The James and OSUWMC and are chaired by the Health System Chief Quality Officer. The SEDG membership includes the CQO, Associate CQO, Director of Risk Management, James Quality Medical Director, Directors of Quality & Patient Safety and Nursing Quality Directors of respective business units. The SEDG meets weekly to review sentinel event and significant events. Once an event is determined to be a significant or sentinel event, SEDG members assign a Root Cause Analysis (RCA) Team who includes Executive Sponsor, RCA Workgroup Leader, and RCA Workgroup Facilitator. The James Director of Quality and Patient Safety serves as the executive sponsor for the RCA, and receives the input from SEDG, collaborates with facilitators and physician leaders to finalize the team membership, initiate team charters, and ensure that team meetings and action plans are completed in accordance with requirements to satisfy regulatory compliance.

**Function:**

Approve and make recommendations on sentinel event determinations and teams, and action plans as received from the Sentinel Event Determination Group. Results of a sentinel event, significant event or near-miss information are considered confidential according to Ohio Revised Code Section 2305.25 and are not externally reported or released.

### The James Continuous Quality Improvement Teams

**Composition:**

For the purposes of this plan, Quality Improvement Teams are considered as ad-hoc committees, disease specific workgroups, performance improvement teams, taskforces, etc., that function under the quality oversight structure and are time-limited in nature, as well as the new Health System groups that will report up to Q-SEC (an example is the Hospital Acquired Infection group). Continuous Quality Improvement teams are comprised of owners or participants in the process under study. The process may be clinical or non-clinical. The members fill the following roles: team leader, Process Engineer or facilitator, physician advisor, administrative sponsor, and technical experts.

**Function:**

Improve current practice or processes using traditional continuous process improvement tools such as rapid cycle improvements, LEAN principles and DMAIC/DMADV/PDCA.

### Roles and Responsibilities

The management of clinical quality, patient safety and excellence are responsibilities of all faculty, staff, and volunteers.

### Chief Executive Officer (CEO)

The CEO for The James reports to the OSUWMC Chief Executive Officer and is responsible for providing leadership and oversight for the overall functions within The James. The CEO has authority for the James

Quality, Safety and Experience Council Plan and collaborates with all employees and medical staff to ensure safe care is delivered to our patients to achieve quality outcomes for each encounter.

### **Director of Medical Affairs/Chief Medical Officer (CMO)**

The Director of Medical Affairs is the Chief Medical Officer for The James Cancer Hospital who provides leadership and strategic direction for the faculty, medical staff, and other providers to ensure the delivery of high quality, cost-effective health care consistent with The James mission. The CMO has oversight of the medical staff responsibilities for progress towards goals and process improvements. The CMO is a member of The James Medical Staff Administrative Committee (MSAC) and is the medical director for provider credentialing within The James.

### **Quality Medical Director**

The James Quality Medical Director reports to the Chief Medical Officer and is responsible for assisting the Quality Department with medical review for all patient safety and quality outcomes. This physician also works collaboratively with the health system quality medical directors and the Chief Quality and Patient Safety Officer in determining sentinel and significant events, as well as reporting events, when necessary, through the peer review process. The Quality Medical Director is a member of both the James Quality, Safety and Experience Council and a member of The James Medical Staff Administrative Committee (MSAC).

### **Medical Director**

Each business unit Medical Director is responsible to review the recommendations from The Plan and implement quality goals and plans, along with maintaining oversight in their clinical areas.

### **Medical Staff**

Medical staff members are responsible to achieve the highest standard of care and services within their scope of practice. As a requirement for membership on the medical staff, members are expected to and must participate in the functions and expectations set forth in The Plan. In addition, members serve on quality management/patient safety committees and/or continuous quality improvement teams throughout the year.

### **Executive Director, Clinical Services**

The James Executive Director for Clinical Services provides leadership and oversight of The Plan and works collaboratively with the OSUWMC Quality Leadership Council (QLC) initiatives. The Executive Director is integral to the establishment and implementation of The Plan, organization-wide quality goals, and performance improvement achievements.

### **Chief Nursing Officer**

The James CNO reports to the Executive Director of Clinical Services to work and provide senior leadership within the nursing structure to influence the nursing process and practices. The CNO ensures the overall James Quality, Safety and Experience Council Plan is utilized to assist with the development, implementation, and initiating of The James Nursing Strategic Plan. The CNO has oversight of the nursing shared governance model and the nursing leadership which establishes and implements annual nursing-sensitive goals.

### **Nursing Leadership**

The Chief Nursing Officer, as well as the Associate Chief Nursing Officer(s), and Directors of Nursing are responsible to implement, maintain oversight, and incorporate opportunities and goals identified in collaboration with the OSUWMC- QLC Committee.

Nursing directors and managers are to implement recommendations or participate in action plans for individual employees or the department. They provide input regarding committee memberships, and serve as participants in the departmental, hospital and Health System quality/patient safety committees. Clinical Nurse Specialists (CNS) support quality improvement initiatives by providing leadership in the application and use of evidence-based practice. The James nursing staff is responsible to provide the highest standard of care and services within their scope of practice.

### **Quality and Patient Safety Leadership**

The Sr. Director of Integrated Care Management and Quality, Director for Quality and Patient Safety, and the Director of Clinical Outcomes collaborates directly with the executive leaders as well as the directors and managers of all areas to evaluate, plan and improve on patient safety and quality outcomes. In addition, the Directors have leadership oversight of the quality improvement goals, patient safety improvements, and facilitates team(s) charged for implementation of annual hospital level goals.

### **The James Quality Improvement and Patient Safety Department**

The primary responsibilities of The James Quality Improvement and Patient Safety Department is:

- Track and trend quality events as well as Sentinel Events.
- Coordinate and facilitate clinical quality management for improved outcomes.
- Monitor patient safety incidents and work with the management teams for elimination or reduction of risk/harm to patients.
- Improve patient care services by assuring the voice of the patient is heard throughout The James.
- Assist managers with evaluations of situations by use of the Just Culture algorithm and training.

While primary responsibility for the implementation and evaluation of clinical quality, patient safety, and service activities resides within each department/program, The James Quality and Patient Safety staff also serve as internal consultants for the development, evaluation, and on-going monitoring of those activities. The James Quality Improvement and Patient Safety Departments including The James Operations Improvement staff, and the Cancer Program Analytics staff, maintain human and technical resources for team facilitation, use of performance improvement tools, data collection, statistical analysis, and reporting.

### **Hospital Management Team**

Each associate executive director, all service line administrators, department directors and managers are responsible to ensure the standards of care and service are maintained or exceeded within their department(s), and are responsible to implement, monitor, and evaluate activities in their areas and assist clinical staff members in developing appropriate mechanisms for data collection and evaluation. Department directors, managers and/or assistant managers participate in action plans for individual employees or the department. All department directors/managers provide input regarding committee memberships and serve as participants on quality management/patient safety committees and/or

quality improvement teams. Managers and staff are engaged through formal and informal processes related to quality improvement and clinical patient safety efforts, including but not limited to:

- Suggesting process improvements and reporting medical/health care events and near misses.
- Implementing evidence-based practices.
- Monitoring and responding to activities and processes, such as patient complaints and patient satisfaction.
- Participating in audits, observations and peer-to-peer review and feedback; and,
- Participating in efforts to improve patient outcomes and enhance patient safety.

### **The James Patient Experience/Guest Services Department**

The primary responsibility of The James Patient Experience and Guest Services Department is to coordinate and facilitate a service-oriented approach to providing healthcare. This is accomplished through both strategic program developments and managing operational functions. The Patient Experience staff serves as an internal consultant for the development and evaluation of service-quality activities. The Department maintains human and technical resources for interpreter services, information desks, patient relations, team facilitation, and use of performance improvement tools, data collection, statistical analysis, and reporting. The Department also oversees the Patient/Family Advisor Program consisting of current and former patients, or their primary caregivers, who have had experiences at any James facility. These individuals are volunteers who serve on committees and workgroups, as Advisory Council members, complete public speaking engagements, and review materials.

### **Philosophy of Patient Care Services**

The James provides innovative and patient-focused comprehensive cancer care and services which includes the following:

- A mission statement that outlines the relationship between patient care, research, and teaching.
- Long-range, strategic planning conducted by leadership to determine the services to be provided.
- Establishing annual goals and objectives consistent with the hospital mission, and which are based on a collaborative assessment of patient/family and the community's needs.
- Provision of services appropriate to meet the needs of patients.
- Ongoing evaluation of services provided such as: performance assessment and improvement activities, budgeting, and staffing plans.
- Integration of services through the following: continuous quality improvement teams; clinical interdisciplinary quality programs; performance assessment and improvement activities; communications through management operations meetings, nursing shared governance structure, Medical Staff Administrative Committee, administrative staff meetings; participation in OSUWMC and OSU governance structures, special forums; and leadership and employee education/development.
- Maintaining competent patient care leadership and staff by providing education and ongoing competency reviews which are focused towards identified patient care needs.
- Respect for each patient's rights and decisions as an essential component in the planning and provision of care.



- Utilizing the Relationship Based Care principles which encompass Care of Patient, Care of Colleague, Care of Self and Care of the Community.
- Embracing the principles of a Just Culture and honoring a Culture of Safety for all team members, faculty, and staff.

## Principles

The principles of providing high quality, safe care support the Institute of Medicine's Six Aims of Care which are:

- **Safe:** Care should be as safe for patients in health care facilities as in their homes.
- **Effective:** The science and evidence behind health care should be applied and serve as the standard in the delivery of care.
- **Efficient:** Care and service should be cost effective, and waste should be removed from the system.
- **Timely:** Patients should experience no waits or delays in receiving care and service.
- **Patient centered:** The system of care should revolve around the patient, respect patient preferences, and put the patient in control; and
- **Equitable:** Unequal treatment should be a fact of the past; disparities in care should be eradicated.

The IOM *10 Rules for Redesign* are guiding principles for the provision of safe and quality care. These are:

1. **Care is based on continuous healing relationships.** Patients should receive care whenever they need it and, in many forms, not just face-to-face visits. This implies that the health care system must be always responsive, and access to care should be provided over the Internet, by telephone, and by other means in addition to in-person visits.
2. **Care is customized according to patient needs and values.** The system should be designed to meet the most common types of needs but should have the capability to respond to individual patient choices and preferences.
3. **The patient is the source of control.** Patients should be given the necessary information and opportunity to exercise the degree of control they choose over health care decisions that affect them. The system should be able to accommodate differences in patient preferences and encourage shared decision making.
4. **Knowledge is shared and information flows freely.** Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. **Decision making is evidence-based.** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. **Safety is a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
7. **Transparency is necessary.** The system should make available to patients and their family's information that enables them to make informed decisions when selecting a health plan, hospital, or clinical practice, or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

8. **Needs are anticipated.** The system should anticipate patient needs, rather than simply react to events.
9. **Waste is continuously decreased.** The system should not waste resources or patient time.
10. **Cooperation among clinicians is a priority.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Following these principles, The James has instituted the following guidelines as the approach to quality, safety, and experience services:

- **Customer Focus:** Knowledge and understanding of internal and external customer needs and expectations.
- **Leadership & Governance:** Dedication to continuous improvement instilled by leadership and the Board.
- **Education:** Ongoing development and implementation of curricula for quality, safety, and reliability for all faculty, staff, volunteers, and students.
- **Involvement:** All team members must have mutual respect for the dignity, knowledge, and contributions of others. Everyone is engaged in improvement of processes where they work.
- **Data-driven decision making:** Decisions for quality, safety, and reliability are based on the knowledge derived from data.
- **Continuous Process Improvement:** Analysis of processes for design, redesign and to reduce variations are accomplished by use of an approach using science and LEAN/DMAIC/PDCA. Measures and improvements are ongoing.
- **Just Culture:** Our framework of quality, safety, and reliability services are based on a culture that is open, honest, transparent, collegial, team-oriented, accountable, and non-punitive when system failures have occurred.
- **Personalized Health Care:** The incorporation of evidence-based medicine in patient-centered care which considers the patient's health status, genetics, cultural tradition, personal preferences, and values family and lifestyle situations.
- **Reducing Health Disparities:** Ongoing commitment to make health care disparities an organizational quality and safety priority by assessing, identifying trends in data, developing, and implementing action plans, and communicating progress to key stakeholders.

### Consistent Level of Care

Certain elements of The Plan help to ensure that patient care standards for the same or similar services are comparable in all areas. These elements include, but are not limited to:

- Policies and procedures and services provided are not payer driven and is standardized to promote high quality and safe care.
- Application of a single standard for physician credentialing.
- Cancer care delivery is based upon nationally recognized standards of care from the National Comprehensive Cancer Network (NCCN).
- Use of monitoring tools to measure like processes in areas of the Health System and The James.

### Performance Transparency

The James Medical and Administrative leadership have a long-standing and strong commitment to transparency of performance as it relates to clinical quality, safety, and service performance.

Performance data is shared internally with faculty and staff through a variety of methods. The purpose of providing data internally is to assist faculty and staff in obtaining real-time performance results, and to use those results to drive change and improve performance, when applicable. Transparency of the information provided is within the limits of the Ohio law that protects attorney–client privilege, quality inquiries and reviews, as well as peer review. Current quality data is shared on The James internal intranet site. The Cancer Program Analytics team works with many departments and partners with other reporting groups to build and enhance quality and safety dashboards, as well as display of other important metrics to build on the equation of value for our patients.

### **Confidentiality**

Confidentiality is essential to the quality management and patient safety process. All records and proceedings are confidential and are to be marked as such. Written reports, data, and meeting minutes are to be maintained in secure files. Access to these records is limited to appropriate administrative personnel and others as deemed appropriate by legal counsel. As a condition of staff privilege and peer review, it is agreed that no record, document, or proceeding of this program is to be presented in any hearing, claim for damages, or any legal cause of action. This information is to be treated for all legal purposes as privileged information. This is in keeping with the Ohio Revised Code 121.22 (G)-(5) and Ohio Revised Code 2305.251.

### **Conflict of Interest**

A person is professionally involved if they are responsible for patient care decision making either as a primary or consulting professional and/or have a financial interest (as determined by legal counsel) in a case under review. Persons who are professionally involved in the care under review are to refrain from participation except as requested by the appropriate administrative or medical leader. During peer review evaluations, deliberations, or voting, the chairperson will take steps to avoid the presence of any person, including committee members, professionally involved in the care under review. The chairperson of a committee should resolve all questions concerning whether a person is professionally involved. In cases where a committee member is professionally involved, the respective chairperson may appoint a replacement member to the committee. Participants and committee members are encouraged to recognize and disclose, as appropriate, a personal interest or relationship they may have concerning any action under peer review.

### **Priority Criteria**

The following criteria are used to prioritize clinical value enhancement initiatives and continuous quality improvement opportunities, to ensure the appropriate allocation of resources.

1. Ties to strategic initiatives consistent with the hospital’s mission, vision, and values.
2. Reflects areas for improvement in patient safety, appropriateness, quality, and/or medical necessity of patient care (e.g., high-risk, serious events, problem-prone).
3. Has considerable impact on our community’s health status (e.g., morbidity/mortality rate).
4. Addresses patient experience issues (e.g., access, communication, discharge).
5. Reflects divergence from benchmarks.
6. Addresses variation in practice.
7. Required by an external organization.
8. Represents significant cost/economic implications (e.g., high volume).

## Determining Priorities

The James has a process in place to identify and direct resources toward quality management, patient safety, and service excellence activities. The prioritization criteria are reevaluated annually according to the mission and strategic plan. The leaders set performance improvement priorities and reevaluate annually in response to unusual or urgent events. Whenever possible, NCI, ADCC or other appropriate cancer specific benchmarks are utilized to compare performance metrics for The James, to assist with determination of priorities each year to improve performance.

## Design and Evaluation of New Processes

New processes are designed and evaluated according to the organizational mission, vision, values, and priorities, and are consistent with sound business practices.

The design or re-design of a process may be initiated by:

- Surveillance data indicating undesirable variance.
- Patients, staff, or payers perceived need to change a process.
- Information from within the organization and from other organizations about potential risks to patient safety, including the occurrence of sentinel events.
- Review and assessment of data and/or review of available literature to confirm the need and/or by evidence-based practices.

## Data Measurement and Assessment

### Determination of Needs

Data needs are determined according to improvement priorities and surveillance needs. The James Cancer Program Analytics and the Quality and Patient Safety departments collect and report data for monitoring important processes and outcomes related to patient care. In addition, each department is responsible for identifying quality indicators specific to their area of service. The quality management committee of each area is responsible for monitoring and assessment of the data collected. Quality and Safety monitoring is on-going and reviewed by The James Quality, Safety and Experience Council each year.

### External Reporting Requirements

The reporting requirements related to quality, safety, and service. These include regulatory, governmental, payer, and specialty certification organizations.

### Collection of Data

Data, including patient demographic and diagnosis, are systematically collected by various mechanisms including but not limited to:

- Administrative and clinical databases
- Retrospective and concurrent medical record review
- Reporting systems (e.g., patient safety and patient satisfaction)
- Surveys (e.g., patients, families, and staff)
- External (e.g., Vizient, CDC-NHSN, NDNQI, CMS, or other vendors)

## Assessment of Data

Statistical methods are used to identify undesirable variance, trends, and opportunities for improvement. The data are compared to the previous performance, external benchmarks, and accepted standards of care to establish goals and targets. Annual goals are established to evaluate performance.

### **Surveillance System**

The James systematically collects and assesses data in different areas to monitor and evaluate the quality and safety of services, including measures related to accreditation and other requirements. Data collection also functions as a surveillance system for timely identification of undesired variations or trends in quality indicators.

### **The James Quality and Safety Scorecard**

Patient Safety is the highest priority for all faculty and staff at The James. As a crucial element to caring for our patients, there is an on-going process of monitoring safety events and any untoward trends from patient care. The James Quality and Patient Safety Scorecard (hereinafter The Scorecard) is a portal consisting of various dashboards with key performance indicators related to events considered potentially preventable, and which cause a level of harm to the patient. The Scorecard covers areas such as mortality, falls, hospital acquired infections, hospital-acquired pressure ulcers, medication events, as well as additional indicators such as patient satisfaction, readmissions, and length of stay.

This information is shared in various quality forums with the medical staff, clinicians, James's administration, and senior staff, and The Quality and Professional Affairs Committee (QPAC) at the Wexner Medical Board. The indicators to be included in The Scorecard are reviewed each year to represent the priorities of the Quality and Patient Safety program. The Patient Safety program evaluates opportunities each monthly at The James Quality, Safety and Experience Council, as well as monthly at the Medical Staff Administrative Committee. Safety goals are reviewed annually and adjusted as necessary by use of event trending, regulatory changes, needs identified from the culture of safety surveys and/or national cancer benchmarks.

### **The James Patient Satisfaction Dashboard**

The Patient Satisfaction dashboard is a set of patient experience indicators gathered from surveys after discharge or visit to a system-based clinic or hospital. The dashboard displays performance in areas such as physician communication, nursing responsiveness, admitting, and discharging efficiencies and quality in addition to other service categories. The information from this dashboard is shared in forums with staff, clinicians, administration, including the Board. Performances on these indicators serve as annual goals for leaders and members of clinical and patient experience teams.

### **Quality and Patient Safety Staff Education**

Education is identified as a key principle for providing safe, high-quality care, and excellent service for our patients. There is on-going development and implementation of a curriculum for quality, safety and service for all staff, employees, clinicians, patients, and students. There are a variety of forums and venues utilized to enhance the education surrounding quality and patient safety including, but not limited to:

- Online videos
- Newsletters
- Classroom forums

- Simulation training
- Computerized Based Learning Modules (e-learning/CBLs)
- Curriculum Development within College of Medicine
- Websites (internal SharePoint and external OSUMC)
- Patient Safety/Quality Lesson's Learned and Patient Safety Alerts

### **The James Benchmark Data**

Both internal and external benchmarking provides value when evaluating performance.

#### ***Internal Benchmarking***

Internal benchmarking uses processes and data to compare The James performance to itself over time and provides a gauge of improvement strategies within the organization.

#### ***External Benchmarking***

The James participates in various database systems and focused benchmarking projects to compare performance with that of cancer hospital - peer institutions. The James Cancer Hospital utilizes and joins other comprehensive cancer centers for benchmarking such as C4QI (Comprehensive Cancer Center Consortium for Quality Improvement) and ADCC (Alliance of Dedicated Cancer Centers), National Cancer Institute (NCI). Also, The James participates in national benchmarking efforts through the following, but not limited to, The Vizient's Clinical Database (CDB), The US News and World Report, Ohio Department of Health, Press Ganey, National Database of Nursing Quality Indicators (NDNQI), Centers for Disease Control – National Healthcare Safety Network (NHSN), The American College of Surgeons (ACoS) and others.

### **Performance Based Provider Quality & Credentialing**

Performance based credentialing ensures processes that assist with promoting the delivery of quality and safe care by physicians and advanced practice licensed health care providers. Both Focused Professional Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) occur. Focused Professional Practice Evaluation (FPPE) is utilized on three occasions: initial appointment, when a Privileged Practitioner requests a new privilege, and for cause when questions arise regarding the practitioner's ability to provide safe, high quality patient care. Ongoing Professional Practice Evaluation (OPPE) is performed on an ongoing basis (every 6 months).

#### **Profiling Process:**

- Data gathering from multiple sources.
- Report generation and indicator analysis.
- Profile review meetings with department chairs.
- Discussion at Credentialing Committee
- Final recommendation & approval:
- Medical Staff Administrative Committees
- Medical Director
- Hospital Board

### **Service-Specific Indicators**

Indicators are used to profile each physician's performance. The results are included in a physician profile, which is reviewed with the department chair as part of the credentialing process. The definition of service/department-specific indicators is the responsibility of the director/chair of each unit. The performance of these indicators is used as evidence of competence to grant privileges in the re-

appointment process. The clinical departments/divisions are required to collect the performance information related to these indicators and report that information to the Department of Quality and Operations Improvement.

The purpose of the medical Staff Evaluation is several-fold:

- To appoint quality medical staff.
- To monitor and evaluate medical staff performance.
- To integrate medical staff performance data into the reappointment process and create the foundation for high quality care.
- To provide periodic feedback and inform clinical department chairs of the comparative performance of individual medical staff.
- To identify opportunities for improving quality of care.

### **Annual and Ongoing Evaluations**

The James Quality Safety, and Experience Council Plan is approved annually by The James Quality, Safety and Experience Council (Q-SEC) and The Quality and Professional Affairs Committee (QPAC).

### **Enterprise-Wide Alignment and Strategic Plan**


The James Quality, Safety and Experience Plan has been developed in alignment with the OSUWMC Enterprise-Wide Long Range Quality Plan (Attachment A). The Long-Range Quality Plan focuses on the foundations and three pillars of patient centered care that have been deemed priorities by the OSUWMC Quality Leadership Council (QLC).

Attachment A: Long Range Quality Plan

## Long-Range Quality Plan

*World-Class Care: Every Person, Every Time*

**Patient-Centered**



**Patient Experience**

*Exceptional experience for patients and families*

As evidenced by Likelihood to Recommend scores in the top decile

**Safe**

*Industry-leading safety performance*

Supporting journey to zero harm (defined as zero preventable serious safety events) while continuously improving culture of safety

**Effective**

*Excellence in clinical outcomes*

As evidenced by Vizient Q&A performance in the top decile

**Foundations**



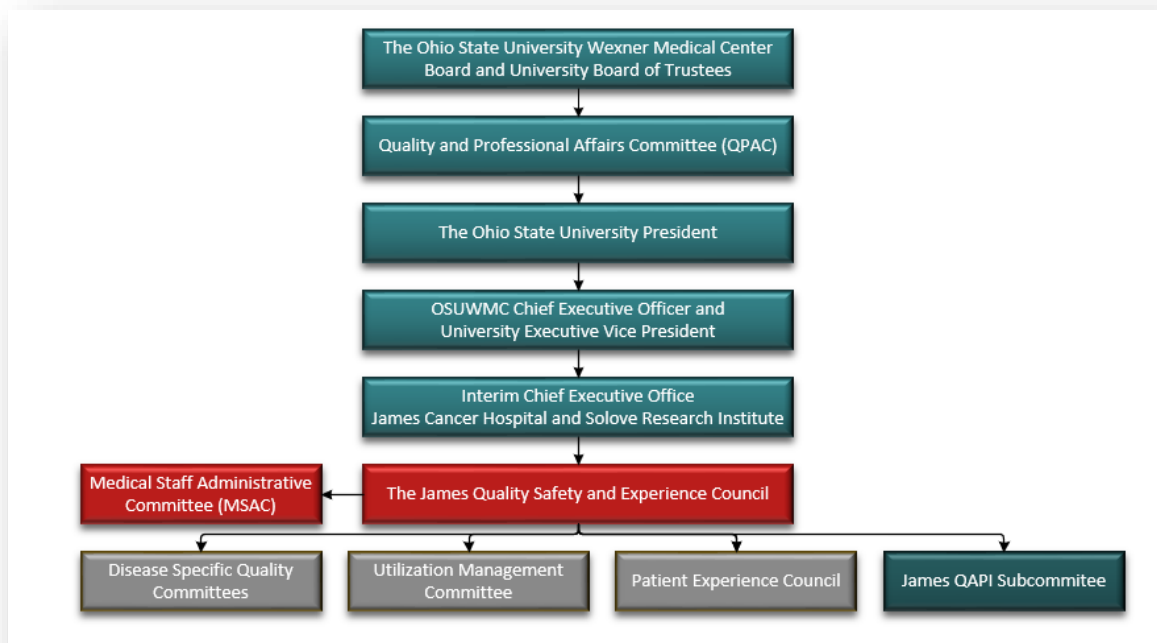
Performance-improvement program rooted in standardized methodology



Leverage Analytics Center of Excellence to drive performance improvement around targets and outcomes

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Attachment B: The James Quality, Safety and Experience Council Structure





**PLAN FOR PATIENT CARE SERVICES**

**OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER**

Synopsis: Approval of the annual review of the plan for patient care services for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and The Ohio State University Wexner Medical Center East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the plan for inpatient and outpatient care services describes the integration of clinical departments and personnel who provide care and services to patients at University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

WHEREAS the annual review of the plan for patient care services was approved by the University Hospital Medical Staff Administrative Committee on June 12, 2024; and

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the plan for patient care services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the plan for patient care services for the Ohio State University Hospitals, including University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

**TITLE: THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER (INCLUDING UNIVERSITY HOSPITAL, RICHARD M. ROSS HEART HOSPITAL, BRAIN AND SPINE HOSPITAL, DODD REHABILITATION HOSPITAL, HARDING HOSPITAL, AND EAST HOSPITAL) HOSPITAL PLAN FOR PROVIDING PATIENT CARE**

University Hospital, Richard M. Ross Heart Hospital, Brain and Spine Hospital, Dodd Rehabilitation Hospital, Harding Hospital, and East Hospital (hereafter referred to as the Hospitals) plan for patient care services describes the integration of departments and personnel who provide care and services to patients based on the Hospitals' mission, vision, shared values and goals. The plan encompasses both inpatient and outpatient services of the Hospitals.

**OHIO STATE UNIVERSTY WEXNER MEDICAL CENTER (OSUWMC) MISSION, VISION AND VALUES**

**Mission Statement:**

To improve health in Ohio and across the world through innovations and transformation in research, education, patient care, and community engagement.

**Vision Statement:**

By pushing the boundaries of discovery and knowledge, we will solve significant health problems and deliver unparalleled care.

**Values:**

Inclusiveness, Determination, Empathy, Sincerity, Ownership and Innovation

The mission, vision and values statements, developed by our staff members, physicians, governing body members and administration team members, complements and reflects the unique role the hospitals fulfill within The Ohio State University.

**PHILOSOPHY OF PATIENT CARE SERVICES**

In collaboration with the community, the Hospitals will provide innovative, personalized, and person centered care through:

- a) A mission statement that outlines the synergistic relationship between patient care, research, and education;
- b) Long-range strategic planning with medical center leadership to determine the services to be provided; including, but not limited to essential services as well as special areas of concentration;
- c) Establishing annual goals and objectives consistent with the mission, which are based on a collaborative assessment of needs;
- d) Planning and design conducted by medical center leadership, which involves the potential communities to be served;
- e) Provision of services that are appropriate to the scope and level required by the patients to be served based on assessment of need;
- f) Ongoing evaluation of services provided through formalized processes; e.g., performance assessment and improvement activities, budgeting and staffing plans;
- g) Integration of services through the following mechanisms: continuous quality improvement teams; clinical interdisciplinary quality programs; performance assessment and improvement activities; communications through management team meetings, administrative staff meetings, special forums, and leadership and employee education/development;
- h) Maintaining competent patient care leadership and staff by providing education designed to meet identified needs;

- i) Respect for each patient's rights and decisions as an essential component in the planning and provision of care; and,
- j) Staff member behaviors that reflect a philosophical foundation based on the values of The Ohio State University Wexner Medical Center.

## **THE HOSPITAL LEADERSHIP**

The Hospital leadership is defined as the governing board, CEO/Executive Vice President, administrative staff, physicians and nurses in appointed or elected leadership positions. The Hospital leadership is responsible for the framework of planning health care services provided by the organization based on the hospital's mission and for developing and implementing an effective planning process that allows for defining timely and clear goals.

The planning process includes a collaborative assessment of our customer and community needs, defining a long range strategic plan, developing operational plans, establishing annual operating budgets and monitoring compliance, establishing annual capital budgets, monitoring and establishing resource allocation and policies, and ongoing evaluation of the plans' implementation and success. The planning process addresses both patient care functions (e.g. patient rights, patient assessment, patient care, patient and family education, coordination of care, and discharge planning) and organizational support functions (e.g. information management, human resource management, infection control, quality and safety, the environment of care, and the improvement of organizational performance).

The Hospital leadership works collaboratively with all operational and clinical managers and leaders to ensure integration in the planning, evaluation, and communication processes within and between departments to enhance patient care services and support. This occurs informally on a daily basis and formally via interdisciplinary leadership meetings. The leadership involves department heads in evaluating, planning and recommending annual budget expenses and capital objectives, based on the expected resource needs of their departments. Department leaders are held accountable for managing and justifying their budgets and resource utilization. This includes, but is not limited to identifying, investigating and budgeting for new technologies and resources which are expected to improve the delivery of patient care and services.

Other leadership responsibilities include:

- a) Communication of the organization's mission, vision, goals, objectives and strategic plans across the organization;
- b) Ensuring appropriate and competent direction, management and leadership of all services and/or departments;
- c) Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served;
- d) Supporting the patient's continuum of care by integrating systems and services to improve efficiencies and care from the patient's viewpoint and diversity, equity and inclusion;
- e) Ensuring staffing resources are available to appropriately and effectively meet the needs of the patients served and to provide a comparable level of care to patients in all areas where patient care is provided;
- f) Ensuring the provision of a uniform standard of patient care throughout the organization;
- g) Providing appropriate job enrichment, employee development and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services;
- h) Establishing standards of care that all patients can expect and which can be monitored through the hospital's quality assurance and performance improvement (QAPI) process;

- i) Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to untoward and unexpected events;
- j) Implementing an effective and continuous program to improve patient safety;
- k) Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input; and,
- l) Supporting patient rights and ethical considerations.

### **ROLE OF THE CHIEF NURSING OFFICER**

The Chief Nursing Officer is responsible for the practice of nursing by ensuring consistency in the standard of nursing practice across the clinical settings. The CNO supports and facilitates an interdisciplinary team approach to the overall delivery of care to patients, families, and the community. This includes creating an environment in which collaboration is valued and excellence in clinical care, education, and research is promoted and achieved. The CNO leads quality, safety, and innovation initiatives in partnership with the Hospital Executive Directors.

The CNO is responsible for developing and driving the nursing strategic plan to deliver excellent patient care. The role will include responsibility for nursing performance improvement, program management, business operations, budgets, resource utilization, financial stewardship and maintenance of the professional contracts with the Ohio State University Nursing Organization and the International Association of Machinists and Aerospace Workers. The CNO ensures the vision, strategic direction, and the advancement of the profession of nursing at OSUWMC.

### **ROLE OF THE ASSOCIATE CHIEF NURSING OFFICER**

The Associate Chief Nursing Officer (ACNO) is a member of the Nursing Executive Leadership team. The ACNO works collaboratively with both the CNO and Executive Director of their business entities. The ACNO has the authority and responsibility for directing the activities related to the provision of nursing care in those departments defined as providing nursing care to patients.

The ACNO is responsible to plan, develop, implement, and oversee programs and projects designed to evaluate and improve clinical quality, safety, resource utilization and operations in all areas staffed by nurses. The role includes implementation of patient care services strategies to support efficiency, clinical effectiveness, clinical operations and quality improvement with interdisciplinary team members. The ACNO works with teams to develop projects, programs and implement system changes that promote care coordination across the health care continuum.

### **FUNCTIONS OF NURSING LEADERSHIP**

The Chief Nursing Officer and ACNOs ensure the following functions are addressed:

- a) Evaluating patient care programs, policies, and procedures describing how patients' nursing care needs are assessed, evaluated and met throughout the organization;
- b) Developing and implementing the plan for the provision of patient care through evidence-based practice and nursing research;
- c) Participating with leaders from the governing body, management, medical staff and clinical areas in organizational decision-making, strategic planning and in planning and conducting performance improvement activities throughout the organization;
- d) Implementing an effective, ongoing program to assess, measure and improve the quality of nursing care delivered to patients; developing, approving, and implementing standards of nursing practice,

- standards of patient care, and patient care policies and procedures that include current research/literature findings that are evidence based;
- e) Participating with organizational leaders to ensure that resources are allocated to provide a sufficient number of qualified nursing staff to provide patient care;
  - f) Ensuring that nursing services are available to patients on a continuous, timely basis.

## **DEFINITION OF PATIENT SERVICES, PATIENT CARE AND PATIENT SUPPORT**

**Patient Services** are limited to those departments that have direct contact with patients. Patient services occur through organized and systematic throughput processes designed to ensure the delivery of appropriate, safe, effective and timely care and treatment. The patient throughput process includes those activities designed to coordinate patient care before admission, during the admission process, in the hospital, before discharge and at discharge. This process includes:

- **Access in:** emergency process, admission decision, transfer or admission process, registration and information gathering, placement;
- **Treatment and evaluation:** full scope of services; and,
- **Access out:** discharge decision, patient/family teaching and counseling, arrangements for continuing care and discharge.

**Patient Care** encompasses the recognition of disease and health, patient teaching, patient advocacy, spirituality and research. The full scope of patient care is provided by professionals who are charged with the additional functions of patient assessment and planning patient care based on findings from the assessment. Providing patient services and the delivery of patient care requires specialized knowledge, judgment, and skill derived from the principles of biological, chemical, physical, behavioral, psychosocial and medical sciences. As such, patient care and services are planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize the unique physical, emotional and spiritual (body, mind and spirit) needs of each person. Under the auspices of the Hospitals, medical staff, registered nurses and allied health care professionals function collaboratively as part of an interdisciplinary, personalized patient-focused care team to achieve positive patient outcomes.

Competency for patient caregivers is determined in orientation and at least annually through performance evaluations and other department specific assessment processes. Credentialed providers direct all medical aspects of patient care as delineated through the clinical privileging process and in accordance with the Medical Staff By-Laws. Registered nurses support the medical aspect of care by directing, coordinating, and providing nursing care consistent with statutory requirements and according to American Nurses Association Nursing Scope and Standards of Practice book as well as hospital-wide policies and procedures. Allied health care professionals provide patient care and services in keeping with their licensure requirements and in collaboration with physicians and registered nurses. Unlicensed staff may provide aspects of patient care or services at the direction of and under the supervision of licensed professionals.

**Nursing Care** (nursing practice) is defined as competently providing all aspects of the nursing process in accordance with Chapter 4723 of the Ohio Revised Code (ORC), which is the law regulating the Practice of Nursing in Ohio. The law gives the Ohio Board of Nursing the authority to establish and enforce the requirements for licensure of nurses in Ohio. This law also defines the practice of both registered nurses and licensed practical nurses. All of the activities listed in the definitions, including the supervision of nursing care, constitute the practice of nursing and therefore require the nurse to have a current valid license to practice nursing in Ohio.

**Patient Support** is provided by a variety of individuals and departments which might not have direct contact with patients, but which support the integration and continuity of care provided throughout the continuum of care by the hands-on care providers.

## **SCOPE OF SERVICES / STAFFING PLANS**

Each patient care service department has a defined scope of service approved by the hospital's administration and medical staff, as appropriate. The scope of service includes:

- the types and age ranges of patients served;
- methods used to assess and meet patient care needs (includes services most frequently provided such as procedures, etc.);
- the scope and complexity of patient care needs (such as most frequent diagnosis);
- support services provided directly or through referral contact;
- the extent to which the level of care or service meets patient need (hours of operation if other than 24 hours a day/7days a week and method used for ensuring hours of operation meet the needs of the patients to be served with regard to availability and timeliness);
- the availability of necessary staff (staffing plans) and;
- recognized standards or practice guidelines, when available (the complex or high level technical skills that might be expected of the care providers).

Additional operational details and staffing plans may also be found in department policies, procedures and operational/performance improvement plans.

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed. Nursing units are staffed to accommodate a projected average daily patient census. Unit management (including nurse manager and/or charge nurse) reviews patient demands to plan for adequate staffing. Staffing can be increased or decreased to meet patient needs. When the number of patients is high or the need is great, float staff assist in providing care. When staff availability is projected to be low, the unit manager and director may request temporary agency nurses. The Ohio State University Wexner Medical Center follows the Staffing Guidelines set by the American Nurses Association. In addition, we utilize staffing recommendations from various specialty nursing organizations, including: ENA, ANCC, AACN, AORN, ASPN, NDNQI, AWHONN, and others.

The Administrative Team, in conjunction with the budget and performance measurement process, reviews all patient care areas staffing and monitors ongoing regulatory requirements. Each department staffing plan is formally reviewed during the budget cycle and takes into consideration workload measures, utilization review, employee turnover, performance assessment, improvement activities, and changes in customer needs/expectations. A variety of workload measurement tools may be utilized to help assess the effectiveness of staffing plans.

## **STANDARDS OF CARE**

Patients of the Hospitals can expect that:

- 1) Staff will do the correct procedures, treatments, interventions, and care following the policies, procedures, and protocols that have been established. Efficacy and appropriateness of procedures, treatment, interventions and care provided will be demonstrated based on patient assessments/reassessments, standard practice, and with respect for patient's rights and confidentiality.
- 2) Staff will provide a uniform standard of care and services throughout the organization.
- 3) Staff will design, implement and evaluate systems and services for care delivery (assessments, procedures, treatments, interventions) which are consistent with a personalized health care focus and which will be delivered:

- a. With compassion, courtesy, respect and dignity for each individual without bias using a patient centered approach;
- b. In a manner that best meets the individualized needs of the patient;
- c. Coordinated through interdisciplinary collaboration, to ensure continuity and seamless delivery of care to the greatest extent possible; and,
- d. In a manner that maximizes the efficient use of financial and human resources, streamlines processes, decentralizes services, enhances communication, supports technological advancements and maintains patient safety.

**Patient Assessment:**

Individual patient care requirements are determined by assessments (and reassessments) performed by qualified health professionals. Each service within the organization providing patient care has defined the scope of assessment provided. This assessment (and reassessment) of patient care needs continues throughout the patient's contact with the hospital.

**Coordination of Care:**

Patients are identified who require discharge planning to facilitate continuity of medical care, social determinant needs, and/or other care to meet identified needs. Discharge planning is timely, is addressed at a minimum during initial assessment as well as during discharge planning processes and can be initiated by any member of the interdisciplinary team. Case Managers coordinate patient care between multiple delivery sites and multiple caregivers; collaborate with physicians and other members of the care team to assure appropriate treatment plan and discharge care.

**STANDARDS OF COMPETENT PERFORMANCE/STAFF EDUCATION**

All employees receive an orientation consistent with the scope of responsibilities defined by their job description and the patient population to whom they are assigned to provide care. Ongoing education (such as in-services) is provided within each department. In addition, the Educational Development and Resource Department provides annual mandatory education and provides appropriate staff education associated with performance improvement initiatives and regulatory requirements. Performance appraisals are conducted at least annually between employees and managers to review areas of strength and to identify skills and expectations that require further development.

**CARE DELIVERY MODEL**

The care delivery model is guided by the following goals:

- The patient and family will experience the benefits of the AACN Synergy model for patient care. This model is driven by the core concept that the patient and family needs influence the competencies and characteristics of the nursing care provided. The benefits include enhanced quality of care, improved service, appropriate length of hospitalization and minimized cost.
- Hospital employees will demonstrate values and behaviors consistent with the OSUWMC Buckeye Spirit set of core values. The philosophical foundation reflects a culture of inclusiveness, sincerity, determination, ownership, empathy and innovation.
- Effective communication will impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximizing the patient's involvement in his/her own plan of care.
- Configuring departmental and physician services to accommodate the care needs of the patient in a timely manner will maximize quality of patient care and patient satisfaction.
- The Synergy professional nursing practice model is a framework which reflects our underlying philosophy and vision of providing care to patients based on their unique needs and characteristics. Aspects of the professional model support:

- (1) matching nurses with specific skills to patients with specific needs to ensure “safe passage” to achieve the optimal outcome of their hospital stay;
  - (2) the ability of the nurse to establish and maintain a therapeutic relationship with their patients;
  - (3) the presence of an interdisciplinary team approach to patient care delivery. The knowledge and expertise of all caregivers is utilized to restore a patient to the optimal level of wellness based on the patient’s definition;
  - (4) physicians, nurses, pharmacists, respiratory therapists, case managers, dietitians and many other disciplines collaborate and provide input to patient care.
- The patient and family will be involved in establishing the plan of care to ensure services that accommodate their needs, goals and requests.
  - Streamlining the documentation process will enhance patient care.

## **PATIENT RIGHTS AND ORGANIZATIONAL ETHICS**

### *Patient Rights*

In order to promote effective and compassionate care, the Hospitals’ systems, policies, and programs are designed to reflect an overall concern and commitment to each person’s dignity. All Hospital employees, physicians and staff have an ethical obligation to respect and support the rights of every patient in all interactions. It is the responsibility of all employees, physicians and staff of the Hospitals to support the efforts of the health care team, while ensuring that the patient’s rights are respected. Each patient (and/or family member as appropriate) is provided a list of patient rights and responsibilities upon admission and copies of this list are posted in conspicuous places throughout the Hospitals.

### *Organizational Ethics*

The Hospitals have an ethics policy established in recognition of the organization’s responsibility to patients, staff, physicians and the community served. General principles that guide behavior are:

- Services and capabilities offered meet identified patient and community needs and are fairly and accurately represented to the public.
- Adherence to a uniform standard of care throughout the organization, providing services only to those patients for whom we can safely care for within this organization. The Hospitals do not discriminate based age, ancestry, color, disability, gender identity or expression, genetic information, HIV/AIDS status, military status, national origin, race, religion, sex, gender, sexual orientation, pregnancy, protected veteran status or any other basis under the law.
- Patients will be billed only for care and services provided.

### *Biomedical Ethics*

A biomedical ethical issue arises when there is uncertainty or disagreement regarding medical decisions, involving moral, social, or economic situations that impact human life. A mechanism is in place to provide consultation in the area of biomedical ethics in order to:

- improve patient care and ensure patient safety;
- clarify any uncertainties regarding medical decisions;
- explore the values and principles underlying disagreements;
- facilitate communication between the attending physician, the patient, members of the treatment team and the patient’s family (as appropriate); and,
- mediate and resolve disagreements.

## **INTEGRATION OF PATIENT CARE, ANCILLARY AND SUPPORT SERVICES**

The importance of a collaborative interdisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. See Appendix A for a listing of ancillary and support services.



Open lines of communication exist between all departments providing patient care, patient services and support services within the hospitals, and as appropriate with community agencies to ensure efficient, effective and continuous patient care. Functional relationships between departments are evidenced by cross-departmental Performance Improvement initiatives as well as the development of policies, procedures, protocols, and clinical pathways and algorithms.

To facilitate effective interdepartmental relationships, problem solving is encouraged at the level closest to the problem at hand. Staff is receptive to addressing one another's issues and concerns and work to achieve mutually acceptable solutions. Supervisors and managers have the responsibility and authority to mutually solve problems and seek solutions within their spans of control; positive interdepartmental communications are strongly encouraged. Employees from departments providing patient care services maintain open communication channels and forums with one another, as well as with service support departments to ensure continuity of patient care, maintenance of a safe patient environment and positive outcomes.

### **CONSULTATIONS AND REFERRALS FOR PATIENT SERVICES**

The Hospitals provide services as identified in the Hospital Plan for Providing Patient Care to meet the needs of our community. Patients whose assessed needs require services not offered are transferred to the member hospitals of The Ohio State University Wexner Medical Center or another quality facility (e.g., Nationwide Children's Hospital) in a timely manner after stabilization. Safe transportation is provided by air or ground ambulance with staff and equipment appropriate to the required level of care. Physician consultation occurs prior to transfer to ensure continuity of care. Referrals for outpatient care occur based on patient need.

### **INFORMATION MANAGEMENT PLAN**

The overall goal for information management is to support the mission of The Ohio State University Wexner Medical Center. Specific information management goals related to patient care include:

- Develop and maintain an integrated information and communication network linking research, academic and clinical activities.
- Develop computer-based patient records with integrated clinical management and decision support.
- Support administrative and business functions with information technologies that enable improved quality of services, cost effectiveness, and flexibility.
- Build an information infrastructure that supports the continuous improvement initiatives of the organization.
- Ensure the integrity and security of the Hospital's information resources and protect patient confidentiality.

### **PATIENT CARE ORGANIZATIONAL IMPROVEMENT ACTIVITIES**

All departments are responsible for following the Hospitals' Quality Assurance and Performance Improvement (QAPI) plan. Departments utilize the QAPI plan and cascade the hospital's goals to service line quality plans to ensure proper alignment to support the overall hospital quality goals.

### **PLAN REVIEW**

The Hospital Plan for Providing Patient Care will be reviewed regularly by the Hospitals' leadership to ensure the plan is adequate, current and that the Hospitals are in compliance with the plan. Interim adjustments to the overall plan are made to accommodate changes in patient population, redesign of the care delivery systems or processes that affect the delivery, level or amount of patient care required.

**Appendix A: Scope of Services: Patient Ancillary and Support Services**

Other hospital services that support the comfort and safety of patients are coordinated and provided in a manner that ensures direct patient care and services are maintained in an uninterrupted, efficient, and continuous manner. These support and ancillary services will be fully integrated with the patient care departments of the Hospitals:

<b>DEPARTMENT</b>	<b>SERVICE</b>
BEHAVIORAL EMERGENCY RESPONSE TEAM (BERT)	Expert team that provides innovative and quality care to patients with complex behavioral symptoms while working collaboratively with staff through consultation, education, and early intervention
CARDIAC PROCEDURAL	Cardiac procedural areas include both cardiac catheterization and electrophysiology. Procedures may be diagnostic or interventional.
CARDIOVASCULAR IMAGING SERVICES	Diagnostic and therapeutic procedures in cardiac MR/CT, Nuclear Medicine, Echocardiography, Vascular Imaging Stress Test. Cardiovascular Imaging Services can be provided at inpatient, outpatient, and emergency locations.
CARE MANAGEMENT	As part of the health care team, provides personalized care coordination and resource management with patients and families.
CENTRAL STERILE SUPPLY (CSS)	Responsible for supporting all instrument cleaning and sterilization needs across the organization. In addition, CSS is responsible for providing case carts to the operating rooms which contain all of the instrumentation and disposable supply needs for each surgical case.
CHAPLAINCY AND CLINICAL PASTORAL EDUCATION	Assists patients, their families and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.
CLINICAL ENGINEERING	Routine equipment evaluation, maintenance, and repair of electronic equipment owned or used by the hospital; evaluation of patient owned equipment.
CLINICAL INFORMATICS	A subset of IT services that focuses on appropriately integrating the clinical care provided to the patient into the Electronic Health Record (EHR) through the specialized knowledge of clinical care and informatics. Additionally, direct work with the clinicians occurs through this team to ensure the EHR is adopted and aligns with the clinical work occurring in the organization and provides an accurate depiction of the patients' clinical course while being cared for in the organization.
CLINICAL LABORATORY	Responsible for pre-analytic, analytic and post-analytic functions on clinical specimens in order to obtain information about the health of a patient as pertaining to the diagnosis, treatment, and prevention of disease; assisting care providers with clinical information related to patient care, education, and research.
COMMUNICATIONS AND MARKETING	Responsible for developing strategies and programs to promote the organization's overall image and specific products and services to targeted internal and external audiences. Handles all media relations, advertising, internal communications, special events and publications.
DECEDENT AFFAIRS	Provide support to families of patients who died & assist them with completing required disposition decisions. Ensure notification of the CMS designated Organ Procurement Agency (OPO) – Lifeline of Ohio (Lifeline). Promote & facilitate organ/eye/tissue donation by serving as the OSU hospital Lifeline Liaison. Analyze data provided by Lifeline regarding organ/tissue/eye donation.
DIAGNOSTIC TRANSPORTATION	Provision of on-site transportation services for patients requiring diagnostic, operative or other ancillary services.
DIALYSIS	Dialysis is provided for inpatients of the medical center within a dedicated unit unless the patient cannot be moved. In those instances, bedside dialysis will be administered.

<b>DEPARTMENT</b>	<b>SERVICE</b>
EARLY RESPONSE TEAM (ERT)	Provides timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. Consists of a Critical Care RN and Respiratory Therapist who are trained to help patient care staff when there are signs that a patient's health is declining.
EDUCATION, DEVELOPMENT & RESOURCES	Provides and promotes ongoing development and training experiences to all member of the OSUWMC community; provides staff enrichment programs, organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations.
ENDOSCOPY	Provides services to patients requiring a nonsurgical review of their digestive tract.
ENVIRONMENTAL SERVICES	Provides routine housekeeping and quality monitoring of such. Additional services upon request: extermination, wall cleaning, etc.
EPIDEMIOLOGY	Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital setting.
FACILITIES OPERATIONS	Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provide preventative, repair and routine maintenance in all areas of all buildings serving patients, guests, and staff. This would include items such as electrical, heating and ventilation, plumbing, and other such items. Also providing maintenance and repair to basic building components such as walls, floors, roofs, and building envelope. Additional services available upon request.
FISCAL SERVICES	Works with departments/units to prepare capital and operational budgets. Monitors and reports on financial performance monthly.
HUMAN RESOURCES	Serves as a liaison for managers regarding all Human Resources information and services; assists departments with restructuring efforts; provides proactive strategies for managing planned change within the Health System; assists with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develops hiring strategies and coordinates process for placements; provides strategies to facilitate sensitivity to issues of cultural diversity; provides HR information to employees, and establishes equity for payroll.
INFORMATION SYSTEMS	Work as a team assisting departments to explore, deploy and integrate reliable, state of the art Information Systems technology solutions to assist in the provision and documentation of care and services and to manage change of such systems.
MATERIALS MANAGEMENT	Routinely stocks supplies in patient care areas, distributes linen. Sterile Central Supply, Storeroom - upon request, distributes supplies/equipment not stocked on units.
MEDICAL INFORMATION MANAGEMENT	Maintains patient records serving the needs of the patient, provider, institution, and various third parties to health care.
NUTRITION SERVICES	Provides nutrition care and food service for Medical Center patients, staff, students, and visitors. Clinical nutrition assessment, care plan development, and consultation are available in both inpatient and outpatient settings. The Department provides food service to inpatients and selected outpatient settings in addition to operating a variety of retail café locations and acts as a liaison for vending and sub-contracted food services providers. Serve as dietetic education preceptors.
PATIENT ACCESS SERVICES	Coordinates registration/admissions with nursing management.
PATIENT EXPERIENCE	Develops programs for support of patient relations and customer service, and includes front-line services such as information desks.
PATIENT FINANCIAL SERVICES	Provides financial assistance upon request from patient/family. Also responsible for posting payments from patients and insurance companies among others to a patient's bill for services.

<b>DEPARTMENT</b>	<b>SERVICE</b>
PATIENT FLOW DEPARTMENT	Monitors and supports all admissions, discharges, and transfers across OSUWMC. Ensures timely, safe, and individualized access to all patients and families through collaboration with the healthcare team.
PERIOPERATIVE SERVICES	Perioperative Services include preoperative, intraoperative and postoperative care.
PHARMACY	Provides comprehensive pharmaceutical care through operational and clinical services. Responsible for medication distribution via central and satellite pharmacies, as well as 797 compliant IV compounding room and automated dispensing cabinets. Some of the many clinical services include pharmacokinetic monitoring, renal and hepatic dose adjustments, and patient education. Specialist pharmacists also round with patient care teams to optimize medication regimens and serve as the team's primary medication information resource.
QUALITY AND OPERATIONS IMPROVEMENT	Provides an integrated quality management program and facilitates continuous quality improvement efforts throughout the medical center.
RADIOLOGIC SERVICES	Diagnostic and therapeutic procedures in MR, CT, X-ray, Fluoroscopy, Interventional Radiology, Ultrasonography. Radiologic Services can be provided at inpatient, outpatient, and emergency locations.
RESPIRATORY THERAPY	Provide all types of respiratory therapeutic interventions and diagnostic testing, by physician order, mainly to critically ill adults and neonates, requiring some type of ventilator support, bronchodilator therapy, or pulmonary hygiene, due to chronic lung disease, multiple trauma, pneumonia, surgical intervention, or prematurity. Provides pulmonary function testing and diagnostic inpatient and outpatient testing to assess the functional status of the respiratory system. Bronchoscopy and other diagnostic/interventional pulmonology procedures are performed to diagnose and/or treat abnormalities that exist in the airways, lung parenchyma or pleural space.
REHABILITATION SERVICES	Physical therapists, occupational therapists, speech and language pathologists, and recreational therapists evaluate and develop a plan of care and provide treatment based on the physician's referral. The professional works with each patient/family/caregiver, along with the interdisciplinary medical team, to identify and provide the appropriate therapy/treatment and education needed for the established discharge plan and facilitates safe and timely movement through the continuum of care.
RISK MANAGEMENT	Protect resources of the hospital by performing the duties of loss prevention and claims management. Programs include: Risk Identification, Risk Analysis, Risk Control, Risk Financing, Claims Management and Medical-Legal Consultation.
SAFETY and EMERGENCY PREPAREDNESS	Manages programs related to general safety, life safety and emergency preparedness. Maintains compliance with regulatory agencies including, The Joint Commission, Centers for Medicare and Medicaid Services, Ohio Department of Health, State Fire Marshal, Environmental Protection Agency and other authorities having jurisdiction over hospital operations.
SECURITY	Provides a safe and secure environment for patients, visitors, and staff members by responding to all emergencies such as workplace violence, fires, bomb threats, visitor/staff/patient falls, Code Blues (cardiac arrests) in public places, internal and external disasters, armed aggressors, or any other incident that needs an emergency response.
SOCIAL WORK SERVICES	Social Work services are provided to patients/families to meet their medically related social and emotional needs as they impact on their medical condition, treatment, recovery and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources

<b>DEPARTMENT</b>	<b>SERVICE</b>
	and linkage with community agencies. Consults can be requested by members of the treatment team, patients or family members.
VOLUNTEER SERVICES	Volunteer Services credential and place volunteers to fill departmental requests. Volunteers serve in wayfinding, host visitors in waiting areas, serve as patient / family advisors, and assist staff.
WOUND CARE	Wound Care includes diagnosis and management for skin impairments.

**PLAN FOR PATIENT CARE SERVICES**

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER  
ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the annual review of the plan for patient care services for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS The James plan for patient care services describes the integration of clinical departments and personnel who provide care and services to patients at The James; and

WHEREAS the annual review of the plan for patient care services was approved by The James Medical Staff Administrative Committee on May 17, 2024; and

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the plan for patient care services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the plan for patient care services for The James as outlined in the attached Plan for Patient Care Services.



## **Title: Arthur G. James Cancer Hospital and Richard J. Solove Research Institute Plan for Patient Care Services**

The Plan for Providing Patient Care Services is described herein. The Plan is based on the mission, vision, values, and goals. The plan encompasses both inpatient and outpatient services delivered by the teams who provide comprehensive care, treatment, and services to patients with cancer diagnoses and their loved ones. The plan encompasses both inpatient and outpatient services of the hospital.

### **The Mission, Vision, and Values:**

**Mission:** To eradicate cancer from individuals' lives by creating knowledge and integrating ground-breaking research with excellence in education and patient-centered care.

**Vision:** Create a cancer-free world, one person, and one discovery at a time.

**Values:** Excellence, Collaborating as One University, Integrity and Personal Accountability, Openness and Trust, Diversity in People, and Ideas, Change and Innovation, Simplicity in our Work, Empathy, Compassion, and Leadership.

At The James, no cancer is routine. Our researchers and oncologists study the unique genetic makeup of each patient's cancer, understand what drives it to develop, and then deliver the most advanced and targeted treatment for the individual patient. The James' patient centered, and relationship-based care is enhanced by our teaching and research programs. Our mission, and staff are dedicated to the fulfillment and success and distinguishes The Arthur G. James Cancer Hospital and Richard J. Solove Research Institute as one of the nation's premier comprehensive cancer centers.

### **Philosophy of Patient Care Services**

The James Cancer Hospital and Solove Research Institute, in collaboration with the community, provides innovative and patient-focused multi-disciplinary cancer care through:

- Maintaining a mission which outlines the synergistic relationship between patient care, research, and teaching.
- Developing a long-range strategic plan with input from hospital leaders to determine the services and levels of care to be provided.

- Establishing annual goals and objectives consistent with the hospital mission and strategic plan, which are based on a collaborative assessment of patient/family and community needs.
- Planning and designing from the hospital leadership, involving the communities served.
- Providing individualized care, treatment, and services appropriate to the scope and level required by each patient based on professional assessments of need.
- Evaluating ongoing services provided through formalized processes such as: performance assessment and improvement activities, budgeting, and staffing plans.
- Integrating services through the following mechanisms: continuous quality improvement teams; clinical interdisciplinary quality programs; communications through management and operations meetings, Division of Nursing shared governance structure, Medical Staff Administrative Committee, administrative staff meetings, participation in Ohio State University Wexner Medical Center (OSUWMC) governance structures, special forums, leadership and employee education and professional/development.
- Maintaining competent patient care leadership and staff by providing education designed to meet identified needs.
- Respecting each patient's rights and their decisions as an essential component in the planning and provision of care.
- Assuring every staff member demonstrates behaviors which reflect the philosophical foundation based on the values of The James Cancer Hospital and Solove Research Institute.

### **Hospital Leadership**

The hospital leadership is defined as the governing Board of Trustees, the University President, Executive Vice President/Chief Executive Officer, administrative staff, faculty, physicians, nurses, clinical, and operational leaders in both appointed and elected positions. The hospital's leadership team is responsible for producing a framework to plan health care services which are to be provided by the organization, based on the hospital's mission and strategic planning. These responsibilities include developing and implementing a planning process that allows for defining timely and clear goals.

The planning process also includes an assessment of our customer and community needs. This process begins with:

- Developing a long-range strategic plan.
- Developing annual operational plans.
- Establishing annual operating and capital budgets, and monitoring compliance.



- Establishing resource allocations and policies.
- Ongoing evaluation of every plan's implementation and ongoing success.

The planning process addresses both patient care functions (patient: rights, assessment, care, safety, patient and family education, coordination of care, and discharge planning) and organizational support functions (information management, human resource management, infection control, quality, the environment of care, and the improvement of organization performance).

The hospital leadership team works collaboratively with all operational and clinical leaders to ensure integration of planning, evaluation, and communication processes within and between departments, to enhance patient care services and support. This occurs informally, daily, and formally, via multi-disciplinary leadership meetings. The leadership team works with each department manager to evaluate, plan, and recommend annual budget expenses and capital objectives, based on the expected resource needs of the department. Department leaders are accountable for managing, justifying their budgets and resource utilization. This includes, but is not limited to identifying, investigating, budgeting for modern technologies, and resources that are expected to improve the delivery of patient care and services.

Other leadership responsibilities include but are not limited to:

- Communicating the organization's mission, vision, goals, objectives, and strategic plans across the organization.
- Ensuring appropriate, competent management and leadership of all services and/or departments.
- Collaborating with community leaders and organizations to ensure services are designed to be appropriate for the scope and level of care required by the patients and communities served.
- Supporting the continuum of care by integrating systems and services to improve efficiencies and care from a patient's viewpoint.
- Ensuring staff resources are available and competent to effectively meet the needs of the patients and to provide a high level of care to patients in all clinical areas.
- Ensuring the provision of uniform standards of patient care are delivered throughout the continuum of care in accordance with each respective disciplines' approved standards of practice and organizational policy/procedure.
- Providing appropriate job enrichment, employee development, continuing education opportunities that serve to promote retention of staff and to foster excellence in care delivery and support services.
- Establishing standards of care for all patients, and which can be monitored through the hospital's performance assessment and improvement plan.
- Approving the organizational plan to prioritize areas for improvement, developing mechanisms to provide appropriate follow up actions and/or reprioritizing in response to unexpected events.

- Implementing an effective and continuous program to monitor and improve patient safety.
- Appointing appropriate committees, task forces, and other forums to ensure interdepartmental collaboration on issues of mutual concerns and requiring interdisciplinary input.
- Supporting patient rights and ethical considerations.
- Support of evidence-based practice (EBP) to drive patient care decision-making.

### **Role of the Executive Director of Clinical Services, and the Chief Nursing Officer**

The Executive Director of Clinical Services, and the Chief Nursing Officer are members of the Executive Leadership Team who has the requisite authority and responsibility for directing activities related to the provision of care, treatment and services in those departments defined as providing care to patients.

The Executive Director of Clinical Services ensures the following functions are addressed:

- Evaluating patient care programs, policies, and procedures which describe how patients' care needs are assessed, evaluated, and met throughout the organization.
- Implementing the plan for the provision of patient care.
- Participating with leaders from the governing body, medical staff, and clinical areas in organizational decision-making. Strategic planning and conducting performance improvement activities through the organization.
- Implementing an effective, ongoing program to assess, measure and improve the quality of care and safe outcomes of care provided for patients.
- Participating with organizational leaders to ensure that resources are allocated to provide enough qualified and competent staff to provide patient care.
- Ensuring services are available to patients on a continuous, timely basis.
- Reviewing the plan for the providing patient care services on an annual basis.

The Chief Nursing Officer (CNO) ensures the following functions are addressed:

- Implementing standards of nursing practice, standards of patient care, patient care policies, and procedures that include current research and evidence-based practice.
- Supports and facilitates a multi-disciplinary team approach to the overall delivery of care to patients, families, and the community.
- Promotes relationship-based care (RBC), leads quality, safety, and innovation initiatives in partnership with the Executive Director of Clinical Services.
- Responsible for driving nursing strategic plan to deliver excellent patient care.
- Responsible for nursing performance improvement, program management,

business operations, budgets, resource, utilization, and maintenance of the professional contract with the Ohio State University Nursing Organization (OSUNO).

## **Definition of Patient Services, Patient Care, Nursing Care, and Patient Support**

### *Patient Services*

Defined as those departments and care providers with direct contact with patients. These services occur through organized and systematic through-put processes designed to ensure the delivery of appropriate, safe, effective, and timely care and treatment. The patient through-put process includes those activities designed to coordinate patient care before admission, during the admission process, in the hospital, in the ambulatory exam or treatment clinics before discharge and at discharge. This process includes:

- Access in emergency process, admission decision, transfer or admission process, registration and information gathering, placement in the appropriate care areas.
- Treatment and evaluation: full scope of service from the care service department.
- Access out: discharge decision, patient/family education, counseling, arrangements for continuing care, and discharge.

### *Patient Care:*

Encompasses the recognition of disease, health, and patient education, which allows the patient to participate in their care, advocacy, and spirituality. The full scope of patient care is provided by professionals who perform the functions of assessing, planning patient care based on information gathered from the assessment, as well as past medical history, social history, and other pertinent findings. Patient care and services are planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize the unique physical, emotional, and spiritual (body, mind, and spirit) needs of each person. Under the auspices of the hospital medical staff, registered nurses, and allied health professionals function collaboratively as part of an interdisciplinary, patient-focused care team to achieve positive patient outcomes and personalized care.

Competency for staff resources is determined during the initial orientation period and at least annually through performance evaluations and other department specific assessment processes. Physicians direct all aspects of a patient's medical care as delineated through the clinical privileging process and in accordance with the Medical Staff By-Laws. Registered Nurses support the medical aspect of care by assessing, directing, coordinating, providing nursing care consistent with statutory requirements, according to the organization's approved Nursing Standards of Practice and hospital-wide policies and procedures. Allied health professionals provide patient care and services keeping within their licensure requirements and in collaboration with physicians and

registered nurses. Unlicensed staff may provide aspects of patient care or services at the direction of and under the supervision of licensed professionals.

*Nursing Care and Practice:*

Defined as competently providing all aspects of the nursing process in accordance with Chapter 4723 of the Ohio Revised Code (ORC), which is the law regulating the Practice of Nursing in Ohio. This law gives the Ohio Board of Nursing the authority to establish and enforce the requirements for licensure of nurses in Ohio. This law defines the practice of both registered nurses and licensed practical nurses. All activities listed in the definitions, including the supervision of nursing care, constitute the practice of nursing and therefore require the nurse to have a current valid license to practice nursing in Ohio.

*Patient Support:*

Provided by the rich resource of individuals and departments which may not have direct contact with patients, but which support the integration and continuity of care provided throughout the continuum of care by the direct care providers.

## **Scope of Services and Staffing Plans**

Each patient care service department has a defined scope of service approved annually by administration and medical staff, as appropriate. The scope of service includes:

- The type and age ranges of patients served.
- Methods used to assess and meet patient care needs (including services most frequently provided such as procedures, medication administration, surgery, etc.).
- The scope and complexity of patient care needs.
- The appropriateness, clinical necessity, and timeliness of support services provided directly or through referral contact.
- The extent to which the level of care or service meets patient needs, hours of operation if other than 24 hours a day/7days a week, and a method used to ensure hours of operation meet the needs of the patients to be served regarding availability and timeliness.
- The availability of necessary staff.
- Recognized standards or practice guidelines.

Staffing plans for patient care service departments are developed based on the level and scope of care provided, the frequency of the care to be provided, determination of the level and mix of staff that can most appropriately, competently, and confidently provide the type of care needed. Patient care units are staffed to accommodate a projected average

daily patient census based on historical data.

Unit management (including nurse manager, assistant nurse manager, charge nurse or the administrative nursing supervisor (ANS)) provide 24/7 on-site oversight and review the demand for patient care to plan for adequate staffing. Staffing can be increased or decreased to meet patient needs or changes in volume. When the census is high or the need is great, float/resource staff are available to assist in providing care.

Administrative leaders, in conjunction with budget and performance measurements, review staffing within all patient care areas and monitor ongoing regulatory requirements. Each department staffing plan is formally reviewed during the budget cycle and takes into consideration workload measures, utilization review, employee turnover, performance assessment, improvement activities, and changes in patient needs or expectations. A variety of workload measurement tools are utilized to help assess the effectiveness of staffing plan.

## **Standards of Care**

Individualized health care at The James is the integrated practice of medicine and support of patients based upon the individual's unique biology, behavior, and environment. It is envisioned we will utilize gene-based information to understand each person's individual requirements for the maintenance of their health, prevention of disease, and therapy tailored to their genetic uniqueness. The direction of personalized health care is to be predictive and preventive.

Patients of The James Cancer Hospital and Solove Research Institute can expect that:

- Hospital staff provide the correct procedures, treatments, interventions, and care. The efficacy and appropriateness of care will be demonstrated based on patient assessment and reassessments, evidence-based practices, and achievement of desired outcomes.
- Hospital leadership staff design, implement and evaluate care delivery systems and services which are consistently focused on patient-centered care that is delivered with compassion, respect, and dignity for everyone, without bias, and in a manner that best meets the individual needs of the patients and their loved ones.
- Staff will provide a uniform standard of care and service throughout the organization.
- Patient care is coordinated through interdisciplinary collaboration to ensure continuity and seamless delivery of care to the greatest extent possible.
- Efficient use of finances, human resources, streamlined processes, enhanced

communication, and supportive technological advancements all while focused on quality of care and patient safety.

*Patient Assessment:*

Individual patient and loved one's care requirements are determined by on-going assessments performed by qualified health professionals. Each service providing patient care within the organization has a defined scope of assessment provided. This assessment and reassessment of patient care needs continues throughout the continuum and the patient's contact.

*Coordination of Care:*

Staff provide patient discharge planning to facilitate continuity of medical care and/or other care to meet identified needs. Discharge planning is timely, addressed during initial assessment and/or upon admission, as well as during the discharge planning process, and can be initiated by any member of the multidisciplinary team. Registered nurses, patient care resource managers, advanced practice nurses, and social workers coordinate and maintain close contact with the healthcare team members to finalize a distinct discharge plan best suited for each patient.

The medical staff is assigned by clinical department or division. Each clinical department has an appointed chair responsible for a variety of administrative duties, including development and implementation of policies that support the provision of departmental services, maintaining the proper number of qualified, and competent personnel needed to provide care within the service needs of the department.

## **Care Delivery Model**

Individualized, patient-focused care is the model in which teams deliver care for similar cancer patient populations, intricately linking the physician and other caregivers for optimal communication and service delivery. Personalized patient-focused care is guided by the following principles:

- The patient and their loved ones will experience the benefits of individualized care that integrates skills of all care team members. These benefits include enhanced quality of care, improved service, appropriate length of hospitalization, value-based cost related to quality outcomes, and patient safety.
- Hospital employees will demonstrate behaviors consistent with the philosophy of personalized health care. This philosophical foundation reflects a culture of collaboration, enthusiasm, and mutual respect.
- Effective communication will impact patient care by ensuring timeliness of services, utilizing staff resources appropriately, and maximize the patient's involvement in their own plan of care.
- Configuring departmental and physician services to accommodate the care needs of the patient in a timely manner will maximize quality of patient care

and patient satisfaction.

- Primary nursing characteristics, such as relationship-based care, conceptual framework supporting the professional practice model are used to reflect the guiding philosophy and vision of providing individualized care.
- The patient and their loved ones will be involved in establishing the plan of care to ensure services that accommodate their needs, goals, and requests.

## **Patient Rights and Organizational Ethics**

### *Patient Rights:*

To promote effective and compassionate care, systems, processes, policies, and programs are designed to reflect an overall concern and commitment to each person's dignity and privacy. All hospital employees, physicians, and staff have an ethical obligation to respect and support the rights of every patient in all interactions. It is the responsibility of all employees, physicians, and staff to support the efforts of the health care team, to ensure the patient's rights are respected. Each patient (and/or loved one as appropriate) is given a list of patient rights and responsibilities upon admission and copies of this list are posted in conspicuous places throughout the hospital.

### *Organizational Ethics:*

The James utilizes an ethics policy to articulate the organization's responsibility to patients, staff, physicians, and community served. General guiding principles include:

- Services and capabilities offered meet identified patient and community needs and are fairly and accurately represented to the public.
- The hospital adheres to a uniform standard of care throughout the organization, providing services to those patients for whom we can safely provide care. The James does not discriminate based upon age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, or source of payment.
- Patients are only billed for care and services received.

### *Biomedical Ethics:*

A biomedical ethical issue arises when there is uncertainty or disagreement regarding medical decisions involving moral, social, or economic situations that impact human life. A mechanism is in place to provide consultation in biomedical ethics to:

- Improve patient care and ensure patient safety.
- Clarify any uncertainties regarding medical decisions.
- Explore the values and principles of underlying disagreements.
- Facilitate communication between the attending physician, the patient, members of the treatment team, and the patient's family or loved ones (as appropriate).
- Mediate and resolve disagreements.

## **Integration of Patient Care and Support Services**

The importance of a collaborative, interdisciplinary team approach, that considers the unique knowledge, judgment, and skills. A variety of disciplines are involved to achieve the desired patient outcomes and serves as a foundation for integration of patient care. Continual process improvement initiatives support effective integration of hospital and health system policies, procedures, protocols, and relationships between departments. See appendix A (Page 11) for a listing of support services.

An open line of communication exists between all departments providing patient care, patient services, support services within the hospital, and as appropriate with community agencies to ensure efficient, effective, and continuous patient care. To facilitate effective interdepartmental relationships, problem solving is encouraged at the level closest to the problem. The staff is receptive to addressing one another's issues and concerns and work to achieve mutually acceptable solutions. Supervisors and managers have the responsibility and authority to mutually solve problems and seek solutions within their scope. Positive interdepartmental communications are strongly encouraged. Direct patient care services maintain open communication with each other in alignment with organizational Code of Conduct, as well as with service support departments to ensure continuity of patient care, maintenance of a safe patient environment, and positive outcomes.

## **Consultations and Referrals for Patient Services**

The James provides services as identified in this plan to meet the needs of our community. Patients with assessed needs requiring services not offered at The James are transferred in a timely manner after stabilization; and/or transfers are arranged with another quality facility.

Safe transportation is provided by air or ground ambulance with staff and equipment appropriate to the required level of care. Physician consultation occurs prior to transfer to ensure continuity of care. Referrals for outpatient care occur based on patient need.

## **Information Management Plan**

The overall goal for information management is to support the mission of The James. Specific information management goals related to patient care include:

- Ensuring the integrity and security of the hospital's information resources and protect patient confidentiality.
- Developing and maintaining an integrated information, communication network linking research, academic and clinical activities.



- Developing computer-based patient records with integrated clinical management and decision support.
- Supporting administrative and business functions with information technologies that enable improved quality of services, cost effectiveness, and flexibility.
- Building an information infrastructure that supports continuous improvement of the organization.

### **Patient Organization Improvement Activities**

All departments participate in the hospital's plan for improving organizational performance.

### **Plan Review**

The hospital's plan for providing patient care is reviewed regularly by leadership to ensure the plan is adequate, current and compliance is maintained with the plan. Interim adjustments to the plan are made as necessary to accommodate changes in patient population, care delivery systems, processes that affect the delivery, and level of patient care required.

### **Appendix A: Scope of Services for Ancillary and Support Services**

Other hospital services that support the comfort and safety of patients are coordinated and provided in a manner that ensures direct patient care and services are maintained in an uninterrupted, efficient, and continuous manner. These support services will be fully integrated with the patient services departments of the hospital:

<b>Department</b>	<b>Service</b>
Cancer Diagnostic Center	Offers a platform for expert evaluation and access to the appropriate diagnostic testing so that a timely and precise cancer diagnosis can be made from the beginning. The center is staffed by a team of oncology-trained advanced practice providers and nurses. Starting with initial consultation, the team will manage each patient's entire diagnostic journey. This includes identifying and prioritizing the patient's needs and concerns and coordinating the appropriate testing and evaluation. If cancer is confirmed, the team will schedule the patient with the appropriate James multidisciplinary, subspecialized cancer team based on his or her type of cancer.
Central Sterile Supply	Coordinates the comprehensive cleaning, decontamination, assembly and dispensing of surgical instruments, equipment, and supplies needed for regular surgical procedures in related departments.

Chaplaincy and Clinical Pastoral Education	Assist patients, their loved ones, and hospital personnel in meeting spiritual needs through professional pastoral and spiritual care and education.
Clinical Engineering	Routine equipment evaluation, maintenance, and repair of electronic equipment, evaluation of patient owned equipment. <i>Refer to James Hospital Policy 04-08 "Equipment Safety for Patient Care Areas."</i>
Cell Therapy Laboratory	Responsible for the processing, cryopreservation, and storage of cells for patients undergoing bone marrow or peripheral blood stem cell transplantation or receiving CAR-T therapy.
Clinical Call Center	Nurse-run telephone triage department that receives and manages telephone calls regarding established James patients outside normal business hours. The call center operates 24 hours a day and seven days of the week inclusive of holidays.
Communications and Marketing	Responsible for developing strategies and programs to promote the organization's overall image, brand, reputation, and specific products and services to targeted internal and external audiences. Manages all media relations, advertising, internal communications, special events, digital and social properties, collateral materials, and publications for the hospital.
Decedent Affairs	Provide support to the loved ones of patients who died and assist them with completing required disposition decisions. Ensure notification of the CMS designated Organ Procurement Agency – Lifeline of Ohio (Lifeline). Promote and facilitate organ/eye/tissue donation by serving as the OSU Hospital Lifeline Liaison. Analyze data provided by Lifeline regarding organ/tissue/eye donation.
Diagnostic Testing Areas	Provide tests based on verbal, electronic, or written consult requests. Final reports are included in the patient record.
Early Response Team (ERT)	Provide timely diagnostic and therapeutic intervention before there is a cardiac or respiratory arrest or an unplanned transfer to the Intensive Care Unit. The team is comprised of rapid response RNs trained in ACLS and Respiratory Therapist who are trained to assist patient care staff when there are signs that a patient's health is declining.
Educational Development and Resources	Provides and promotes ongoing development and training experiences to all members of The James Cancer Hospital community; provide staff enrichment programs, organizational development, leadership development, orientation and training, skills training, continuing education, competency assessment and development, literacy programs and student affiliations.
Endoscopy	Provide services to patients requiring a nonsurgical review of their digestive tract.
Environmental Services (EVS)	Provide housekeeping/cleaning and disinfecting of all areas of the hospital, including ORs, patient rooms, and nursing unit environments.

Epidemiology	Enhance the quality of patient care and the work environment by minimizing the risk of acquiring infection within the hospital and ambulatory settings.
Facilities Operations	Provide oversight, maintenance and repair of the building's life safety, fire safety, and utility systems. Provides preventative, repair, and routine maintenance in all areas of all buildings serving patients, guests, and staff.
Financial Services	Assist managers in preparation and management of capital and operational budgets; provide comprehensive patient billing services and collaborates with patients and payers to facilitate meeting all payer requirements for payment.
Human Resources (HR)	Serve as a liaison for managers regarding all human resources information and services; assist departments with restructuring efforts; provide proactive strategies for managing planned change within the health system; assist with Employee/Labor Relations issues; assists with performance management process; develops compensation strategies; develop hiring strategies and coordinates process for placements; provide strategies to facilitate sensitivity to issues of cultural diversity; provide human resources information to employees, and established equity for payroll.
Immediate Care Center (ICC)	Patients are seen for symptom management related to their disease, or treatment of their disease, and any acute needs requiring evaluation by an advanced practice provider (APP), subsequent treatments, and/or supportive care infusion therapy. Patient visits may include diagnostic, interpretive analysis, and minor invasive procedures. Referrals to other physicians, home care and hospice agencies, dieticians etc. are made by our APPs in collaboration with the primary team.
Information Systems	Assist departments to explore, deploy and integrate reliable, state-of-the-art information systems technology solutions to manage change.
Laboratory	Provide laboratory testing of ambulatory patients with a diagnosis of malignant disease and those that require urgent medical treatment given by the emergency department. Lab Reports are included in the patient record.
Materials Management	Supply stock in patient care areas.
Medical Information Management (MIM)	Maintain patient records serving the needs of the patient, provider, institution and various third parties to health care in the inpatient and ambulatory setting.
Nutrition Services	Provide nutrition care and food service to The James and ambulatory site patients, staff, and visitors. Clinical nutrition assessment and consultation are available in both inpatient and outpatient settings. The department provides food service to inpatients and selected ambulatory settings.
Oncology Laboratories	Provide clinical laboratory support services for medical, surgical blood & marrow transplantation and radiation oncology units.
Pathology	The Molecular Pathology Laboratory provides testing of inpatient and ambulatory patients with a diagnosis of malignant disease and/or genetic

	disease. Final Reports are included in the patient record.
James Patient Access Services (JPAS)	Coordinate registration/admissions with nursing management.
Patient Care Resource Management (PCRM) and Social Services	Provide personalized care coordination and resource management. with patients and families. Provide discharge planning, coordination of external agency contacts for patient care needs and crisis intervention and support for patients and their families. Provide services upon phone/consult request of physician, nurse or the patient or family.
Patient Education	Provide easy-to-understand educational resources that facilitate patient learning and encourage the patient to take an active role in their care. These resources are evidence- based, comply with national standards for health literacy/plain language/accessibility and meet Joint Commission and organizational standards. Based on their assessment, clinicians use patient education resources to assist in patient and caregiver understanding and to reinforce the learning provided during their hospital stay or clinic visit.
Patient Experience	Develop programs for support of patient relations and customer service and information desk. Volunteers do wayfinding, host visitors in waiting areas, serve as patient/family advisors and assist staff. Volunteer Services serves as a liaison for the Service Board auxiliary, which annually grants money to department-initiated projects, enhancing the patient and family experience.
Perioperative Services	Provide personalized care of the patient requiring surgical services, from pre-anesthesia through recovery, for the ambulatory and inpatient surgical patient. Ambulatory surgical center at our James Outpatient Care Center providing outpatient surgical options for James patients.
Pharmacy	Patient care services are delivered via specialty practice pharmacists and clinical generalists. Each practitioner promotes optimal medication use and assists in achieving the therapeutic goals of the patients. Areas of service include, but are not limited to: Oncology, Breast Oncology, Hematology, Blood & Marrow Transplant, Gynecologic Oncology, Pain and Palliative Care, Anticoagulation Management, Infectious Disease, and Intensive Care.
Operations Improvement/Process Engineers	Operations Improvement Process Engineers utilize industrial engineering knowledge and skills, as well as LEAN and Six Sigma methods to provide internal consulting, coaching, and training services for all departments across all parts of The James Cancer Hospital to develop, implement, and monitor more efficient, cost-effective business processes and strategies.
Observation Unit	Provide additional bed capacity to expand care for oncology patients needing non-inpatient level of care.
Pulmonary Diagnostics Lab	Provide services to patients requiring an evaluation of the respiratory system including pulmonary function testing, bronchoscopy, and other diagnostic/interventional pulmonary procedures.

Quality and Patient Safety	Provide integrated quality management and facilitate continuous quality improvement efforts throughout the Hospital. Focus on the culture of safety and work with teams to provide information on trends and improvement opportunities.
Radiation Oncology	Responsible for clinical care related to the application of radiation treatments. Innovative proton therapy center opened December of 2023 in collaboration with Childrens Hospital.
Radiology Services	Provide state-of-the-art radiological diagnostic and therapeutic testing and treatment. Services offered by the Radiology Imaging Department range from general radiography and fluoroscopy to new and advanced interventional procedures, contrast imaging, which include, but not limited to CT, MRI, IVP, etc., in which contrast agents are administered by IV certified radiology technologists.
Rehabilitation Services	Physical therapists, occupational therapists, speech and language pathologists and recreational therapists, evaluate, formulate a plan of care, and provide treatment based on physician referral and along with the interdisciplinary medical team for appropriate treatment and education needed for the established discharge plan.
Respiratory Therapy (RT)	Provide respiratory therapeutic interventions and diagnostic testing, by physician order including ventilator support, bronchodilator therapy, and pulmonary hygiene.
Safety	Hospital safety personnel handle issues associated with licensing and regulations, such as EPA, OSHA, and fire regulations.
Security	Provide a safe and secure environment for patients, visitors, and staff members by responding to emergencies such as workplace violence, fires, bomb threats, internal and external disasters, armed aggressors, or any other incident that needs emergency response.
Social Work Services	Social Work Services are provided to patients/families to meet their medically related social and emotional needs as they impact on their medical condition, treatment, recovery, and safe transition from one care environment to another. Social workers provide psychosocial assessment and intervention, crisis intervention, financial counseling, discharge planning, health education, provision of material resources and linkage with community agencies. Members of the treatment team can request consults for patients, or their loved ones.
Staff Development and Education	Provide and promote ongoing employee development and training related to oncology care, provides clinical orientation, and continuing education of staff.
Transfer Center	Coordinate with inpatient units and ancillary departments to ensure patient flow efficiency and timely access for patients who seek care. Provide transparency real-time across the Medical Center on capacity

	and all ADT (Admission, Discharge, and Transfer) activity. Timely and accurate patient placement based on level of care and service line is expedited through a capacity management technology platform.
Transportation	Supply patients with a secure and proficient transport within the Wexner Medical Center by transferring patients between rooms/floors within the hospitals, taking patients to and from test sites, and discharging patients to Dodd Rehabilitation Center, On-Site Hospice, and the Morgue.
Wound Care	Wound Care includes diagnosis and management for skin impairments.

**SCOPE OF CARE**

THE OHIO STATE UNIVERSITY AMBULATORY SURGERY CENTER  
OUTPATIENT CARE NEW ALBANY

Synopsis: Approval of the annual review of the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the scope of care describes services related to elective outpatient procedures at The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany; and

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany;

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the scope of care for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany.

# OSU AMBULATORY SURGERY CENTER

## Scope of Care – Outpatient Care New Albany

### Clinical Departments

#### Approved By:

 Recoverable Signature

X Jarrett A. Heard 6/24/24

Dr. J. Heard, MD, MBA  
Medical Director of Ambulatory Perioperativ...  
Signed by: heard.27@osu.edu

X Sheryl Burtch 6/24/24

Sheryl Burtch DNP, MA, RN, NEA-BC

**Department/ Patient Care Unit Name:** The Ohio State University Ambulatory Surgery Center – Outpatient Care New Albany. The Center is an Ambulatory Surgery Center which provides for services related to elective outpatient procedures.

#### Types (and age range) of patients served:

- 18 or more years of age.
- Patients aged 13 to 17 with the following requirements please follow below approval process:
  1. Treating physician has admitting privileges at an age appropriate inpatient center
  2. Permission from Medical Director or Designee
  3. Minimum Height/ Weight requirements: 5’0” and 100 pounds. Variance shall require medical director (or designee) approval.
  4. All patients will have an anesthesia evaluation at the Pre-Procedure Preparation. Variance shall require medical director (or designee) approval.
  5. Pediatric BMI limit is 40.0.
  6. An accompanying responsible adult, preferably the custodial parent or legal guardian, must remain present in the building. A custodial parent or legal guardian must be available by phone during the surgery admission. For the Extended Recovery Unit, an accompanying responsible adult must remain present in the building overnight with the patient.

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### Physical Status:

- ASA I-II.
- ASA III without signs or symptoms of uncontrolled or decompensated conditions.
- ASA IV without signs or symptoms of uncontrolled or decompensated conditions and anesthesia limited to Monitored Anesthesia Care (MAC).
- ASA III or IV patients may not have straight Local without Anesthesia care; they may have MAC or General Anesthesia at the discretion of the Anesthesiologist.
- General and MAC Anesthesia will be administered by Department of Anesthesia providers. Conscious sedation will be administered by any individual provider credentialed to do so.

### Procedure Length

- Procedures requiring more than 6 hours of total OR time will need prior authorization by the Medical Director or designee.
- Patients anticipated to have an extended PACU length of stay will need prior authorization by the Medical Director or designee.
- These cases will be scheduled no later than the first case in a physician's block and will be scheduled to end by 3:00pm.

### DNR:

- For patient admitted to the surgery center with an active DNR order, the advance directive should be discussed with the patient and/or their family members or caregivers, the surgeon/proceduralist and anesthesia providers to determine whether the do-not-resuscitate orders are suspended or maintained for the surgery or procedure. **Ideally, this should occur before the day of surgery, after the CompAC visit has been completed.**
  - When a patient chooses to **suspend a DNR order for a procedure or surgery**, they must sign one of the DNR Suspension Informed Consents based on their surgery or procedure (DNR Suspension during Surgery Informed Consent or DNR Suspension during Moderate and/or Deep Sedation Informed Consent). If the decision is to suspend the DNR, a provider or their proxy must place an order in IHIS to update the patient's code status. The attending physician or their designee must discuss the process for reinstating the pre-existing DNR orders (a new code status order to reinstate the patient's previous DNRCC [DNR-Comfort Care or DNRCC-A or DNR Comfort Care – Arrest]).
  - **The patient's DNR order takes effect when the patient is discharged from PACU. The patient's code status is updated in IHIS when the order is released.**
  - The patient may choose to have a **limited attempt at resuscitation defined with regard to specific procedures:** The patient or designee may elect to continue to refuse certain specific resuscitation procedures (for example, chest compressions, defibrillation or tracheal intubation). The anesthesiologist should inform the patient or designee about which procedures are 1) essential to the

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success of the anesthesia and the proposed procedure, and 2) which procedures are not essential and may be refused. After agreement by the patient and providers, the DNR Suspension During Surgery Informed Consent or DNR Suspension during Moderate and/or Deep Sedation Informed Consent must be signed by the patient or their representative, the surgeon and attending anesthesiologist. Documentation should include the discussion as to what measures the patient will allow during the procedure (i.e., oxygen administration, sedation, management of blood pressure and heart rate variations, etc.).

- An Ethics Consult can be requested if discussion is needed regarding DNR reinstatement or suspension.

#### Malignant Hyperthermia:

Patients with a personal or family history of MH must be reviewed by the Medical Director or Designee.

#### Morbid Obesity:

Patients will be considered with identified criteria - Variance shall require medical director (or designee) approval.

- All patients must have current height & weight in IHIS before scheduled at the ASC.
- Patients with BMI > 40.0 may not be performed in the prone position if anesthetized and unable to move themselves into that position.
- Patients with BMI > 45.0 may not be performed in the lateral position if anesthetized and unable to move themselves into that position.
- Patients with a BMI 45.0-55.0 will be considered for general anesthesia, needing review and final approval from the medical director or designee. If BMI is greater than 55.0, procedure planned should require minimal sedation. Elective conversion to General Anesthesia will not be an option. If General Anesthesia conversion is an anticipated option, the surgery/procedure should not be scheduled at the ASC.
- Endoscopy patient BMI limit is 55.0 regardless of positioning. For those with BMI between 45-55, they will need review and final approval from the medical director or designee.
- No patient with BMI > 65.0 will be accepted at the ASC.
- No pediatric (age < 18 years) patient with BMI > 40.0 will be accepted at the ASC.
- Recorded BMI at the time of Pre-Procedure Preparation/ComPAC appointment will be considered in evaluation of cases being cancelled on day of surgery by Attending Surgeon/Proceduralist and Anesthesia.

#### Hemodialysis:

Hemodialysis patients cannot have procedure/surgery and hemodialysis scheduled on the same day. Either the date of procedure/surgery or dialysis must be changed if they are scheduled for the same day.

#### Ambulation:

Patients must be able to ambulate with minimal assistance including ability to stand up and pivot to cart.

- Procedures will not be performed with patient's personal medical equipment (i.e. wheelchairs).

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Anesthesia:

General and MAC Anesthesia will be administered by Department of Anesthesia providers. Conscious sedation will be administered by any individual provider credentialed to do so.

Difficult Airway:

Patients with a history of difficult airway / intubation must complete a Pre-Procedure Preparation/ComPAC evaluation and be approved by the Medical Director or Designee.

Pacemakers / Defibrillators:

- Patients with isolated pacemakers must have the device evaluated by their Cardiologist within twelve (12) months prior to Date of Service. Documentation of interrogation must be readily available.
- Patients with pacemakers will not be considered for ESWL procedures without OSU Pacer Clinic personnel on site throughout the surgical procedure.
- Patients with AICD's are considered for MAC Anesthesia/conscious sedation only. Patients must be evaluated by their cardiologist within six (6) months prior to Date of Service. Documentation of interrogation must be readily available and there should be no change in patient's clinical status since last cardiac evaluation. If placing a magnet would deprogram the AICD, these patients would not be candidates for the ASC.

**Reference:**

Crossley, George H. et al "The Heart Rhythm Society (HRS)/American Society of." *Heart Rhythm* 8.7 (2011): 1114-140. Print.  
Michael, Platonov A., MD, Anne Gillis, MD, and Katherine M. Kavanagh, MD. "Pacemakers, Implantable Cardioverter/Defibrillators." *Journal of Endourology* 22.2 (2008): 243-47. Print.

Obstructive Sleep Apnea:

Anesthesiology services will evaluate the appropriateness of outpatient procedures/surgery, given the patient's OSA history, the proposed procedure and the patient's co-morbidities.

- Patients with known diagnosis of OSA that have optimized co-morbid medical conditions will be considered.
- Patients with a presumed diagnosis of OSA based on screening (STOP Bang) questionnaire, and with optimized co-morbid conditions, will be considered for the OSC if postoperative pain can be managed predominantly with non-opioid analgesia.

**Reference:**

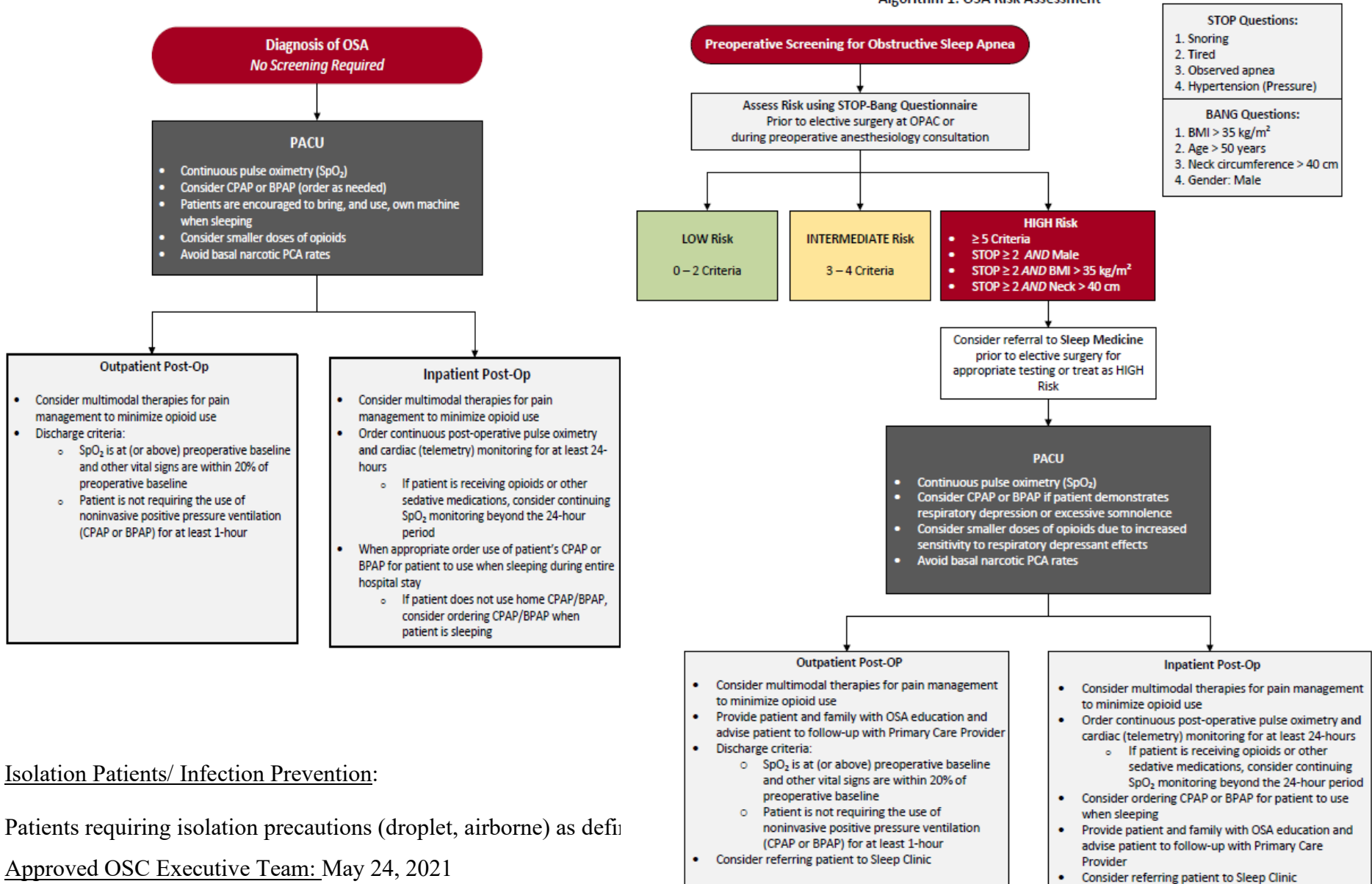
Stein, E., Das, A., Guertin, M., Dalton, R., Springer, A., Rogers, B., & Heavener, D. (2021). *Perioperative assessment and management of obstructive sleep apnea (OSA): OSUWMC Clinical Practice Guideline.*

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Algorithm 1: OSA Risk Assessment



Isolation Patients/ Infection Prevention:

Patients requiring isolation precautions (droplet, airborne) as defi

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or Designee.

Patients requiring contact isolation precautions may be considered as defined by medical center guidelines using appropriate PPE.

Patients with wounds that are bleeding or draining will have sites contained with an occlusive dressing and treated with standard precautions.

[Management of MRSA in Ambulatory Surgical Facilities. \(n.d.\). Management of MRSA in Ambulatory Surgical Facilities. Retrieved from http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%20%282%29/Pages/61.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%20%282%29/Pages/61.aspx)

[Guide to Infection Prevention In Outpatient Settings: Minimum Expectations for Safe Care. \(n.d.\). CDC.Gov. Retrieved from](#)

#### Pregnancy:

- No patient with a known pregnancy or positive pregnancy test may be treated at the ASC.
- All patients of childbearing age with female reproductive organs will submit a urine pregnancy test on the day of surgery. Every attempt will be made to collect urine specimen. If the patient is unable to void, refuses to void, or the patient's power of attorney refuses the pregnancy test, a pregnancy test waiver consent form may be signed by the patient or the patient's power of attorney after a discussion of risks and signature from the anesthesiologist and attending proceduralist.

#### Developmental Disabilities/Special Needs:

The ASC will be provided an updated History & Physical that includes diagnosis of specific conditions/ syndromes. Along with the H&P, the "Functional Ability Assessment" will be completed. All Developmentally Disabled/ Special Needs patients require Anesthesia approval prior to scheduling.

#### Toxicology Screen:

All patients who appear to be intoxicated and who test positive on Date of Service for methamphetamines, amphetamines, cocaine &/or alcohol will have their procedure cancelled. Patients testing positive for other drugs will be evaluated on an individual basis.

#### Preoperative Evaluation:

Patients may undergo pre-operative testing according to the current Pre-Anesthetic Testing Algorithm. Complete pre-operative services are available by a Pre-Procedure Preparation/ComPAC appointment.

#### Accompanying Adult:

Patients who have undergone minor, superficial procedures **without sedation** may be discharged at the discretion of their admitting physician. If the procedure performed involves the hand, eye, or foot & impairs their visual acuity, or hand/ foot dexterity to the degree that they cannot

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operate a motor vehicle, the patient will not be permitted to drive when discharged.

All other patients will require an accompanying adult (18 or more years of age) to provide patient transportation upon discharge. The ASC will recommend that the adult representative remain at the ASC throughout the procedure. Patients will be made aware that the absence of an accompanying adult may result in their procedure being cancelled. Patients found to be without transportation after their procedure will be discharged according to current medical center policy.

**Scope and complexity of patient’s care needs:**

Four operating rooms located on the second floor of The Ohio State University Outpatient Care New Albany servicing the following specialties: General Surgery, Colorectal, Gynecology, Ophthalmology, Plastic Surgery, Otolaryngology and Urology. Four endoscopy procedure rooms located on the second floor of The Ohio State University Outpatient Care New Albany servicing from Gastroenterology, Hepatology and Nutrition (GHN), General Surgery and open access referrals.

The Center is staffed from 0600AM-to 1700PM Monday through Friday, primarily for adult patients requiring surgical intervention under local anesthesia, conscious sedation, monitored anesthesia care, regional anesthesia or general anesthesia.

Patients are admitted to the Center on an ambulatory basis. Patients are required to have the ability to understand and carry out their discharge instructions or have a responsible adult which will assist them in fulfilling these needs.

All procedures performed at the Ambulatory Surgery Center are part of the Core Privileges approved by Ohio State University Wexner Medical Center.

The following types of procedures are not performed at the Center:

- Are associated with the risk of extensive blood loss.
- Require major or prolonged invasion of body cavities.
- Directly involve major blood vessels.
- Are an emergency or life threatening in nature.
- Noted on the CMS Inpatient Only List. This list will be reviewed and updated annually.

**Methods used to assess and meet patient’s care needs:**

Care of all patients experiencing surgical intervention is based on the nursing process and standards from AORN, ASPSN, SGNA and other National Peri-operative organizations supporting the service lines of the Center. Preoperatively, the RN verifies the patient, identifies the

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patient's special needs, completes a patient assessment and develops a plan of care. Intra-operatively, the RN implements the patient's plan of care and documents on the appropriate medical records (e.g.: Op-Time and hospital approved documents).

### **Methods used to determine the appropriateness, clinical necessity and timeliness of support services provided directly or through referral**

The Circulating RN works collaboratively with the proceduralists, surgeons, anesthesiologists, PACU RN, and the Pre-op Holding RN in assessing, prioritizing and meeting the patient's individual needs. Based on the scheduled procedure and communication with the physician/surgeon and anesthesia, specific patient concerns regarding safety, infection control, positioning, and psychosocial needs are anticipated and met (e.g.: preparation of OR environment for latex allergy patient, isolation protocols implemented, limitation of patients range of motion, need for an interpreter or caregiver for MR/DD patients). The continued need for support is communicated to the receiving unit via the oral transfer report and IHIS documentation. A collaborative effort to improve this communication is ongoing. The success of this method is determined by the achievement of positive patient outcomes, reflected by PI monitors and retrospective chart reviews.

In the event of an identified patient need to receive services not provided at the ASC, the patient will be transferred to the Wexner Medical Center for subsequent evaluation.

### **Standards of practice/ practice guidelines, when available**

The Ambulatory Surgery Center provides services related to elective outpatient procedures in the fields of General Surgery, GHN, Gynecology, Ophthalmology, Plastic Surgery, Otolaryngology, and Urology at 6100 N. Hamilton Road, Westerville Ohio 43081. The OSUWMC Board of Directors, the OSUWMC Medical Staff, in conjunction with the Ambulatory Executive Director, Ambulatory Medical Director, Senior Director, Associate and Administrative Directors & Nurse Manager assess, plan, implement, and evaluate the delivery of care and services. The Ambulatory leadership team is responsible for ensuring that the delivery of care provided is consistent with the mission, standards, and policies established for patient care. The Ambulatory leadership team promotes an environment that fosters empowerment through active participation in strategic planning and development of processes that ensure adequacy of services and resources to meet the current and projected community needs, policy establishment, and professional growth.

The objective of The Ohio State University Ambulatory Surgery Center is to deliver excellent surgical, procedural, and anesthesia services to those we serve in accordance with the standards set forth by The Joint Commission, CMS Conditions of Participations for Hospitals and The Vision and Mission statements of The Ohio State University Wexner Medical Center. The Scope of Care is designed to provide appropriate care and services for all patients in a timely manner.

Utilizing a multi-disciplinary approach in the delivery of patient care, our services promote continuous quality and performance improvement activities provided in an environment where collaboration and multi-disciplinary approaches to problem identification and resolution are the

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expectation. Important criteria and thresholds are measured and continuously monitored through our Quality and Performance Improvement process to optimize patient outcomes and assure the highest level of satisfaction for all of our customers. Results of our Quality and Performance Improvement activities are used to improve patient outcomes enhance our services and our staff performance.

Understanding that the provision of health care services is dynamic and fluid; the Scope of Care will be *reviewed at least annually* and revised as needed to reflect the changing patient needs, community changes, and or facility needs and initiatives.



**SCOPE OF CARE**

THE OHIO STATE UNIVERSITY AMBULATORY SURGERY CENTER  
OUTPATIENT CARE DUBLIN

Synopsis: Approval of the annual review of the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the scope of care describes services related to elective outpatient procedures at The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin; and

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the scope of patient care services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the scope of care for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin.

**OSU AMBULATORY SURGERY CENTER**  
**Scope of Care – Outpatient Care Dublin**  
**Clinical Departments**

**Approved By:**

X Jarrett A. Heard 6/24/24

Dr. J. Heard, MD, MBA  
Medical Director of Ambulatory Perioperative...

X Sheryl Burtch 06.24.24

Sheryl Burtch DNP, MA, RN, NEA-BC  
Senior Director Perioperative Services

**Department/ Patient Care Unit Name:** The Ohio State University Outpatient Care Dublin - Ambulatory Surgery Center. The Center is an Ambulatory Surgery Center of OSUWMC which provides for services related to elective outpatient procedures.

**Types (and age range) of patients served:**

- 18 or more years of age.
- Patients aged 13 to 17 with the following requirements please follow below approval process:
  1. Treating physician has admitting privileges at an age-appropriate inpatient center
  2. Permission from Medical Director or Designee
  3. Minimum Height/ Weight requirements: 5'0" and 100 pounds. Variance shall require medical director (or designee) approval.
  4. All patients will have an anesthesia evaluation at the Pre-Procedure Preparation. Variance shall require medical director (or designee) approval.
  5. Pediatric BMI limit is 40.0.

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6. An accompanying responsible adult, preferably the custodial parent or legal guardian, must remain present in the building. A custodial parent or legal guardian must be available by phone during the surgery admission. For the Extended Recovery Unit, an accompanying responsible adult must remain present in the building overnight with the patient.

#### Physical Status:

- ASA I-II.
- ASA III without signs or symptoms of uncontrolled or decompensated conditions.
- ASA IV without signs or symptoms of uncontrolled or decompensated conditions and anesthesia limited to Monitored Anesthesia Care (MAC).
- ASA III or IV patients may not have straight Local without Anesthesia care; they may have MAC or General Anesthesia at the discretion of the Anesthesiologist.
- General and MAC Anesthesia will be administered by Department of Anesthesia providers. Conscious sedation will be administered by any individual provider credentialed to do so.

#### Procedure Length

- Procedures requiring more than 6 hours of total OR time will need prior authorization by the Medical Director or designee.
- Patients anticipated to have an extended PACU length of stay will need prior authorization by the Medical Director or designee.
- These cases will be scheduled no later than the first case in a surgeon's block and will be scheduled to end by 3:00pm

#### DNR:

- For patient admitted to the surgery center with an active DNR order, the advance directive should be discussed with the patient and/or their family members or caregivers, the surgeon/proceduralist and anesthesia providers to determine whether the do-not-resuscitate orders are suspended or maintained for the surgery or procedure. **Ideally, this should occur before the day of surgery, after the CompAC visit has been completed.**
  - When a patient chooses to **suspend a DNR order for a procedure or surgery**, they must sign one of the DNR Suspension Informed Consents based on their surgery or procedure (DNR Suspension during Surgery Informed Consent or DNR Suspension during Moderate and/or Deep Sedation Informed Consent). If the decision is to suspend the DNR, a provider or their proxy must place an order in IHIS to update the patient's code status. The attending physician or their designee must discuss the process for reinstating the pre-existing DNR orders (a new code status order to reinstate the patient's previous DNRCC [DNR-Comfort Care or DNRCC-A or DNR Comfort Care – Arrest]).
  - **The patient's DNR order takes effect when the patient is discharged from PACU. The patient's code status is updated in IHIS when the order is released.**
  - The patient may choose to have a **limited attempt at resuscitation defined with regard to specific procedures:** The patient or

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designee may elect to continue to refuse certain specific resuscitation procedures (for example, chest compressions, defibrillation or tracheal intubation). The anesthesiologist should inform the patient or designee about which procedures are 1) essential to the success of the anesthesia and the proposed procedure, and 2) which procedures are not essential and may be refused. After agreement by the patient and providers, the DNR Suspension During Surgery Informed Consent or DNR Suspension during Moderate and/or Deep Sedation Informed Consent must be signed by the patient or their representative, the surgeon and attending anesthesiologist. Documentation should include the discussion as to what measures the patient will allow during the procedure (i.e., oxygen administration, sedation, management of blood pressure and heart rate variations, etc.).

- An Ethics Consult can be requested if discussion is needed regarding DNR reinstatement or suspension.

#### Malignant Hyperthermia:

Patients with a personal or family history of MH must be reviewed by the Medical Director or Designee.

#### Morbid Obesity:

Patients will be considered with identified criteria - Variance shall require medical director (or designee) approval.

- All patients must have current height & weight in IHIS before scheduled at the ASC.
- Patients with BMI > 40.0 may not be performed in the prone position if anesthetized and unable to move themselves into that position.
- Patients with BMI > 45.0 may not be performed in the lateral position if anesthetized and unable to move themselves into that position.
- Shoulder patients must have a BMI ≤ 45.
- Patients with a BMI 45.0-55.0 will be considered for general anesthesia, needing review and final approval from the medical director or designee. If BMI is greater than 55.0, procedure planned should require minimal sedation. Elective conversion to General Anesthesia will not be an option. If General Anesthesia conversion is an anticipated option, the surgery/procedure should not be scheduled at the ASC.
- Endoscopy patient BMI limit is 55.0 regardless of positioning. For those with BMI between 45-55, they will need review and final approval from the medical director or designee.
- No patient with BMI > 65.0 will be accepted at the ASC.
- No pediatric (age < 18 years) patient with BMI > 40.0 will be accepted at the ASC.
- Recorded BMI at the time of Pre-Procedure Preparation/ComPAC appointment will be considered in evaluation of cases being cancelled on day of surgery by Attending Surgeon/Proceduralist and Anesthesia.

#### Hemodialysis:

Hemodialysis patients cannot have surgery and hemodialysis scheduled on the same day. Either the date of surgery or dialysis must be changed if they are scheduled for the same day.

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### Ambulation:

Patients must be able to ambulate with minimal assistance including ability to stand up and pivot to cart

- Procedures will not be performed with patient's personal medical equipment (i.e. wheelchairs)
- Physical Therapy will be available for patients in Extended Recovery for total joint procedures.

### Anesthesia:

General and MAC Anesthesia will be administered by providers from Department of Anesthesiology. Conscious sedation will be administered by any individual provider credentialed to do so.

### Difficult Airway:

Patients with a history of difficult airway / intubation must complete a Pre-Procedure Preparation/ComPAC evaluation and approved by the Medical Director or Designee.

### Pacemakers / Defibrillators:

- Patients with isolated pacemakers must have the device evaluated by their Cardiologist within twelve (12) months prior to Date of Service. Documentation of interrogation must be readily available.
- Patients with pacemakers will not be considered for ESWL procedures without OSU Pacer Clinic personnel on site throughout the surgical procedure.
- Patients with AICD's are considered for MAC Anesthesia/conscious sedation only. Patients must be evaluated by their cardiologist within six (6) months prior to Date of Service. Documentation of interrogation must be readily available and there should be no change in patient's clinical status since last cardiac evaluation. If placing a magnet would deprogram the AICD, these patients would not be candidates for the ASC.

### ***Reference:***

Crossley, George H. et al "The Heart Rhythm Society (HRS)/American Society of." *Heart Rhythm* 8.7 (2011): 1114-140. Print.

Michael, Platonov A., MD, Anne Gillis, MD, and Katherine M. Kavanagh, MD. "Pacemakers, Implantable Cardioverter/Defibrillators." *Journal of Endourology* 22.2 (2008): 243-47. Print.

### Obstructive Sleep Apnea:

Anesthesiology services will evaluate the appropriateness of outpatient procedures/surgery, given the patient's OSA history, the proposed procedure, and the patient's co-morbidities.

- Patients with known diagnosis of OSA that have optimized co-morbid medical conditions will be considered.
- Patients with a presumed diagnosis of OSA based on screening (STOP Bang) questionnaire, and with optimized co-morbid conditions, will be considered for the OSC if postoperative pain can be managed predominantly with non-opioid analgesia.

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Date Last Revised: 3/8/2023

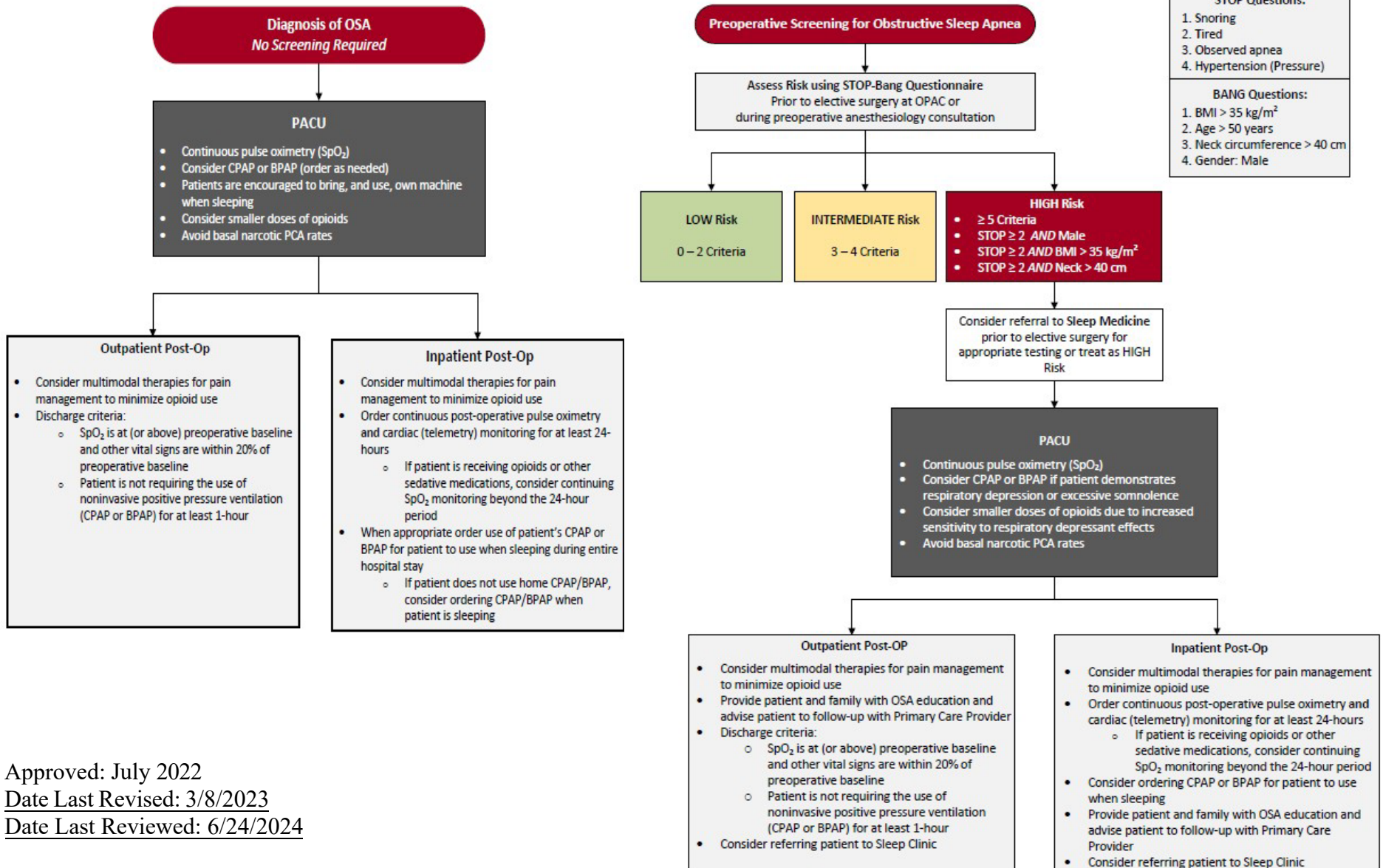
Date Last Reviewed: 6/24/2024

**Reference:**

Stein, E., Das, A., Guertin, M., Dalton, R., Springer, A., Rogers, B., & Heavener, D. (2021). *Perioperative assessment and management of obstructive sleep apnea (OSA): OSUWMC Clinical Practice Guideline.*

<https://onesource.osumc.edu/sites/ebm/Documents/Guidelines/ObstructiveSleepApnea>

Algorithm 1: OSA Risk Assessment



Approved: July 2022

Date Last Revised: 3/8/2023

Date Last Reviewed: 6/24/2024

### Isolation Patients/ Infection Prevention:

Patients requiring isolation precautions (droplet, airborne) as defined by medical center guidelines will need approval by the Medical Director or Designee.

Patients requiring contact isolation precautions may be considered as defined by medical center guidelines using appropriate PPE.

Patients with wounds that are bleeding or draining will have sites contained with an occlusive dressing and treated with standard precautions.

[Management of MRSA in Ambulatory Surgical Facilities. \(n.d.\). \*Management of MRSA in Ambulatory Surgical Facilities\*. Retrieved from <http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%282%29/Pages/61.aspx>](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7%282%29/Pages/61.aspx)

[Guide to Infection Prevention In Outpatient Settings: Minimum Expectations for Safe Care. \(n.d.\). \*CDC.Gov\*. Retrieved from](#)

### Pregnancy:

- No patient with a known pregnancy or positive pregnancy test may be treated at the ASC.
- All patients of childbearing age with female reproductive organs will submit a urine pregnancy test on the day of surgery. Every attempt will be made to collect urine specimen. If the patient is unable to void, refuses to void, or the patient's power of attorney refuses the pregnancy test, a pregnancy test waiver consent form may be signed by the patient or the patient's power of attorney after a discussion of risks and signature from the anesthesiologist and attending proceduralist.

### Developmental Disabilities/Special Needs:

The ASC will be provided an updated History & Physical that includes diagnosis of specific conditions/ syndromes. Along with the H&P, the "Functional Ability Assessment" will be completed. All Developmentally Disabled/ Special Needs patients require Anesthesia approval prior to scheduling.

### Toxicology Screen:

All patients who appear to be intoxicated and who test positive on Date of Service for methamphetamines, amphetamines, cocaine &/or alcohol will have their procedure cancelled. Patients testing positive for other drugs will be evaluated on an individual basis.

### Preoperative Evaluation:

Patients may undergo pre-operative testing according to the current Pre-Anesthetic Testing Algorithm. Complete pre-operative services are available by a Pre-Procedure Preparation/ComPAC appointment.

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### Accompanying Adult:

Patients who have undergone minor, superficial procedures **without sedation** may be discharged at the discretion of their admitting physician. If the procedure performed involves the hand, eye, or foot & impairs their visual acuity, or hand/ foot dexterity to the degree that they cannot operate a motor vehicle, the patient will not be permitted to drive when discharged.

All other patients will require an accompanying adult (18 or more years of age) to provide patient transportation upon discharge. The ASC will recommend that the adult representative remain at the ASC throughout the procedure. Patients will be made aware that the absence of an accompanying adult may result in their procedure being cancelled. Patients found to be without transportation after their procedure will be discharged according to current medical center policy.

### **Scope and complexity of patient's care needs:**

Six operating rooms located on the second floor of The Ohio State University Outpatient Care Dublin Ambulatory Surgery Center servicing the following specialties: Urology, Vascular, Otolaryngology, Hand & Upper Extremity, Orthopaedic Joints, Orthopaedic Spine, Endoscopy and Interventional Radiology, Pain Management, and Podiatry. Six endoscopy procedure rooms located on the second floor of The Ohio State University Outpatient Care New Albany servicing from Gastroenterology, Hepatology and Nutrition (GHN), and open access referrals. The Center is staffed from 0600AM-to 1700PM Monday through Friday, primarily for adult patients requiring surgical intervention under local anesthesia, conscious sedation, monitored anesthesia care, regional anesthesia or general anesthesia.

Patients are admitted to the ASC on an ambulatory basis. The patients are required to have the ability to understand and carry out their discharge instructions or have a responsible adult which will assist them in fulfilling these needs.

All procedures performed at the Ambulatory Surgery Center are part of the Core Privileges approved by Ohio State University Wexner Medical Center.

The following types of procedures are not performed at the Center:

- Are associated with the risk of extensive blood loss.
- Require major or prolonged invasion of body cavities.
- Directly involve major blood vessels.
- Are an emergency or life threatening in nature
- Noted on the CMS Inpatient Only List. This list will be reviewed and updated annually.

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**Methods used to assess and meet patient's care needs:**

Care of all patients experiencing surgical intervention is based on the nursing process and standards from AORN, ASPSN, SGNA and other National Peri-operative organizations supporting the service lines of the Center. Preoperatively, the RN verifies the patient, identifies the patient's special needs, completes a patient assessment and develops a plan of care. Intra-operatively, the RN implements the patient's plan of care and documents on the appropriate medical records (e.g.: Op-Time and hospital approved documents).

**Methods used to determine the appropriateness, clinical necessity and timeliness of support services provided directly or through referral**

The Circulating RN works collaboratively with the proceduralists, surgeons, anesthesiologists, PACU RN, and the Pre-op Holding RN in assessing, prioritizing and meeting the patient's individual needs. Based on the scheduled procedure and communication with the physician/surgeon and anesthesia, specific patient concerns regarding safety, infection control, positioning, and psychosocial needs are anticipated and met (e.g.: preparation of OR environment for latex allergy patient, isolation protocols implemented, limitation of patients range of motion, need for an interpreter or caregiver for MR/DD patients). The continued need for support is communicated to the receiving unit via the oral transfer report and IHIS documentation. A collaborative effort to improve this communication is ongoing. The success of this method is determined by the achievement of positive patient outcomes, reflected by PI monitors and retrospective chart reviews.

In the event of an identified patient need to receive services not provided at the ASC, the patient will be transferred to the Wexner Medical Center for subsequent evaluation.

**Standards of practice/ practice guidelines, when available**

The Ambulatory Surgery Center provides services related to elective outpatient procedures in the fields of Urology, Vascular, Otolaryngology, Hand & Upper Extremity, Orthopaedic Joints, Orthopaedic Spine, Endoscopy and Interventional Radiology, Pain Management, and Podiatry in Outpatient Care at Dublin Ambulatory Surgery Center - 6700 University Blvd, Dublin, Ohio 43016. The OSUWMC Board of Directors, the OSUWMC Medical Staff, in conjunction with the Ambulatory Executive Director, Ambulatory Medical Director, Senior Director, Associate and Administrative Directors, & Nurse Manager assess, plan, implement, and evaluate the delivery of care and services. The Ambulatory leadership team is responsible for ensuring that the delivery of care provided is consistent with the mission, standards, and policies established for patient care. The Ambulatory leadership team promotes an environment that fosters empowerment through active participation in strategic planning and development of processes that ensure adequacy of services and resources to meet the current and projected community needs, policy establishment, and professional growth.

The objective of the Outpatient Care Dublin Ambulatory Surgery Center is to deliver excellent surgical, procedural, and anesthesia services to those we serve in accordance with the standards set forth by The Joint Commission, CMS Conditions of Participations for Hospitals and The

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Vision and Mission statements of The Ohio State University Wexner Medical Center. The Scope of Care is designed to provide appropriate care and services for all patients in a timely manner.

Utilizing a multi-disciplinary approach in the delivery of patient care, our services promote continuous quality and performance improvement activities provided in an environment where collaboration and multi-disciplinary approaches to problem identification and resolution are the expectation. Important criteria and thresholds are measured and continuously monitored through our Quality and Performance Improvement process to optimize patient outcomes and assure the highest level of satisfaction for all our customers. Results of our Quality and Performance Improvement activities are used to improve patient outcomes enhance our services and our staff performance.

Understanding that the provision of health care services is dynamic and fluid; the Scope of Care will be *reviewed at least annually* and revised as needed to reflect the changing patient needs, community changes, and or facility needs and initiatives.

**DIRECT PATIENT CARE SERVICES CONTRACTS AND PATIENT IMPACT SERVICE CONTRACTS  
EVALUATION**

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

Synopsis: Approval of the annual review of the direct patient care service contracts and patient impact service contracts for the hospitals at the Ohio State University Hospitals d/b/a OSU Wexner Medical Center, including: Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the Ohio State University Hospitals direct patient care services contracts and patient impact service contracts are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for inpatient and outpatient care at University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital; and

WHEREAS the annual review of these contracts was approved by the Ohio State University Hospital Medical Staff Administrative Committee on June 12, 2024; and

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the direct patient care service contracts and patient impact service contracts for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the direct patient care service contracts and patient impact service contracts for University Hospital, Ohio State Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital as outlined in the attached University Hospitals Contracted Services Annual Evaluation Report.

# Contracted Services Evaluation 2023



THE OHIO STATE  
UNIVERSITY

WEXNER MEDICAL CENTER

# Background

## Joint Commission Standard

**LD.04.03.09: Care, treatment, and services provided through contractual agreement are provided safely and effectively.**

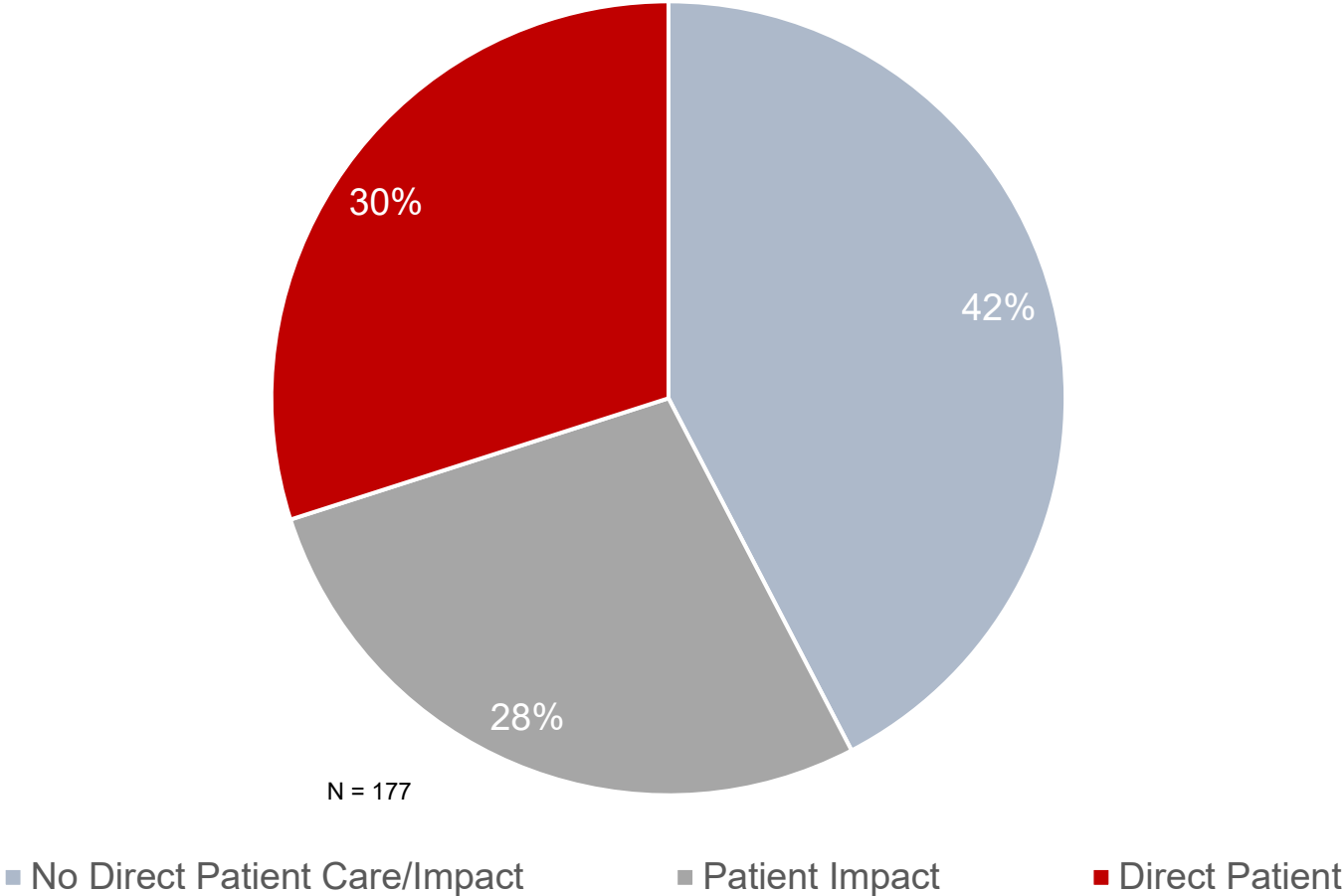
## Centers for Medicaid and Medicare Services Standard

**482.12(e): The governing body be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including ones for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.**

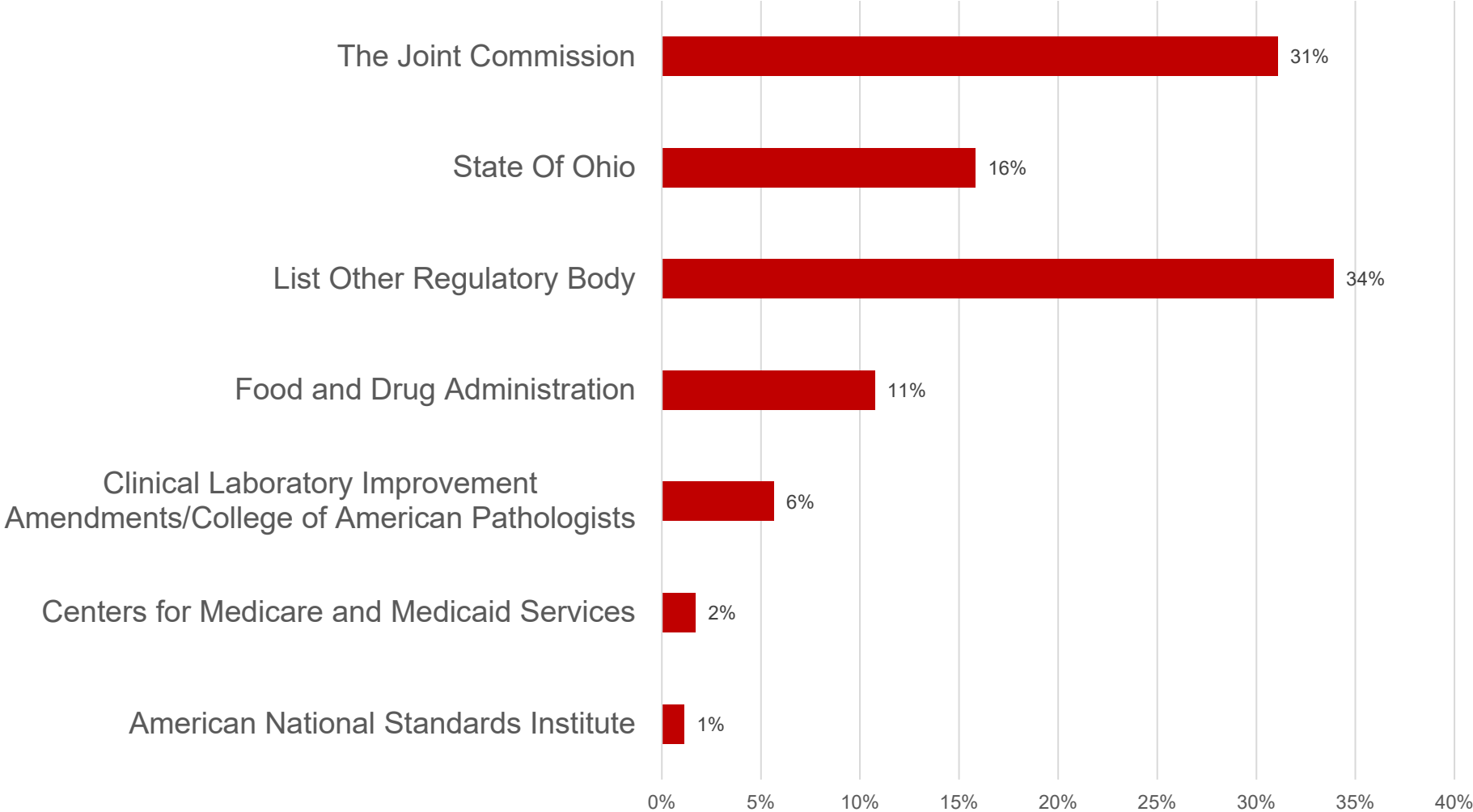
OSUWMC/The James Process:

- Annual Evaluation
- Qualtrics
- Direct Patient Care and Patient Impact Services contracts included

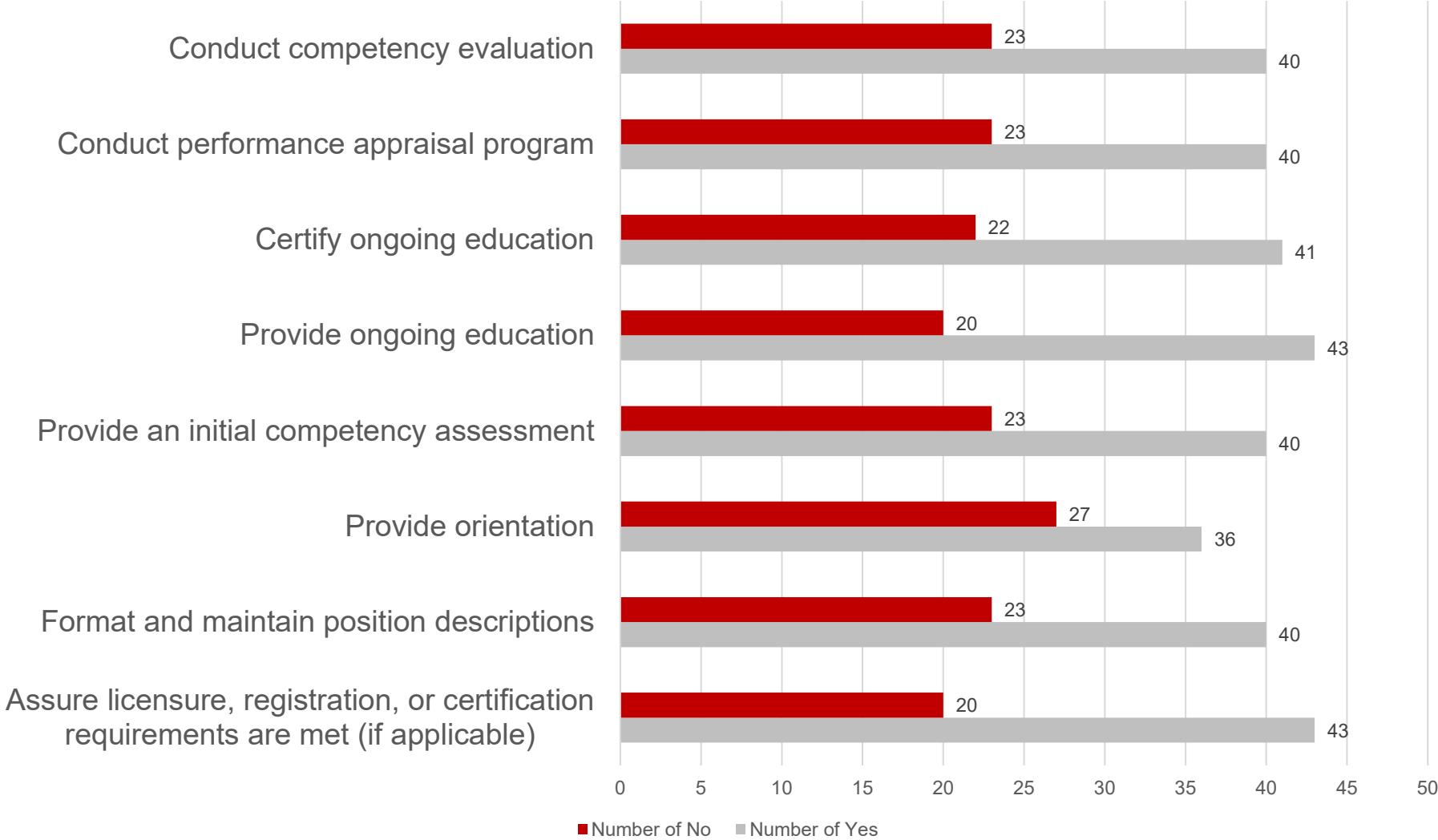
# Percentage of Contracts by Category



# Regulation of Contracted Services

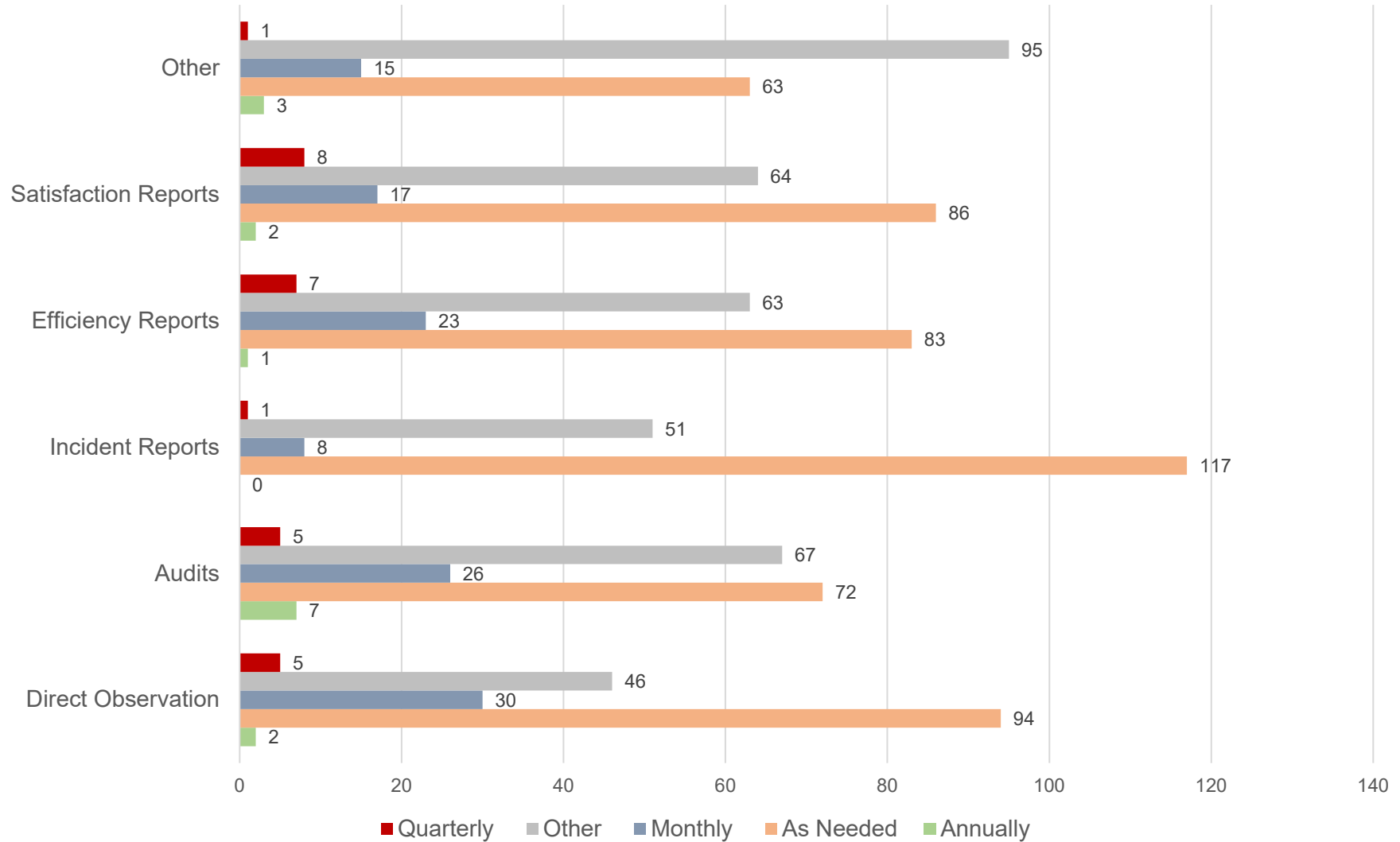


# Compliance Activities





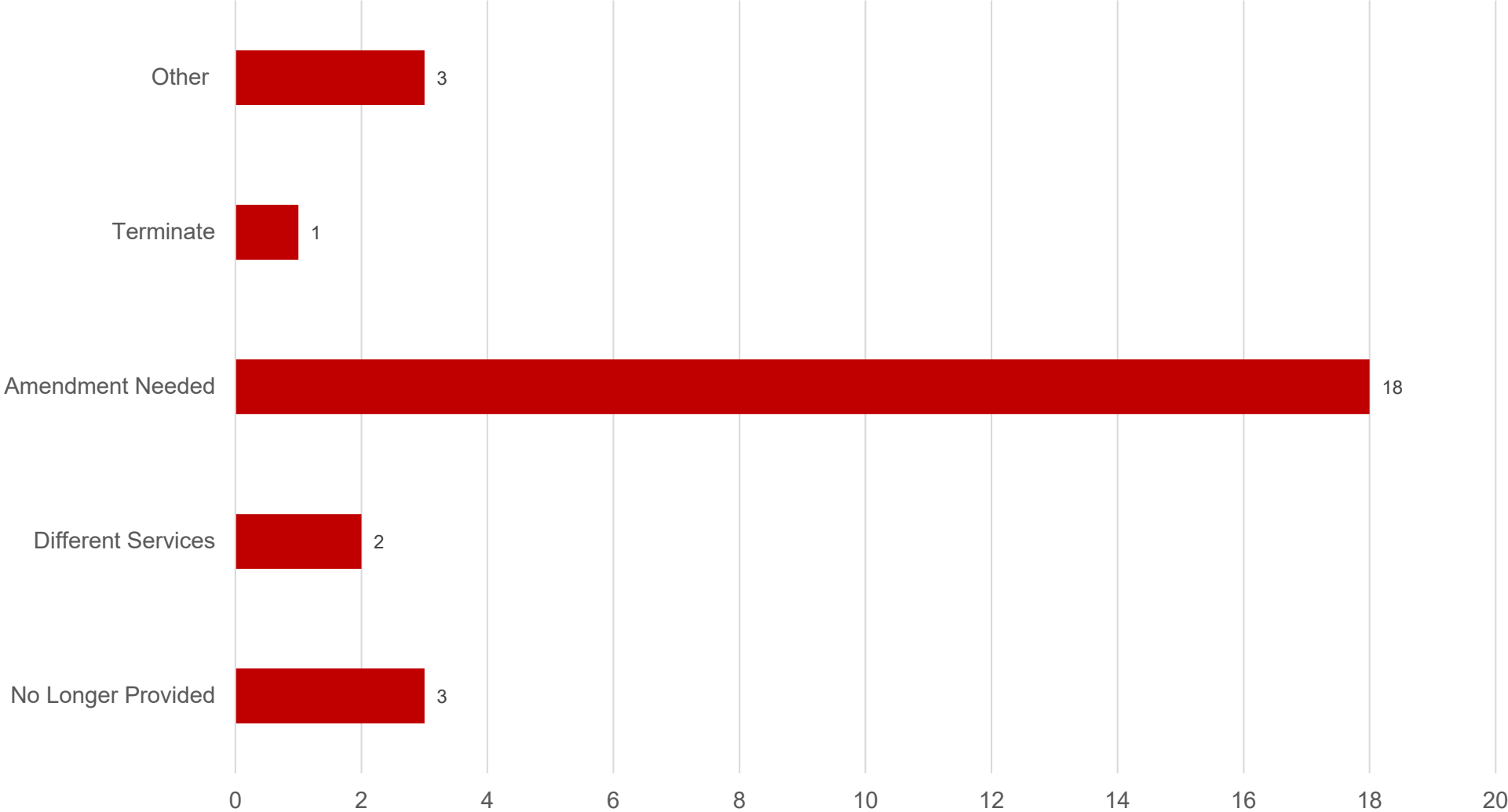
# Data Collection



# Improvements Made Within The Past Year

- 37% reported improvements in the past year
- Improvement Highlights:
  - Better Technician
  - Increased cleanliness
  - Align with medical center standards
  - Updated guidelines
  - Productivity reports
  - Streamlined communication to prevent miscommunication
  - New CE topics. Modules added.
  - Increased fulfillment rates
  - Improvements in online ordering system

# Follow Up Needed



# Between Provider Numbers

- OSUWMC purchases 20 services from The James
  - Services include:
    - High Level Disinfection and Ambulatory Sterilization
    - Pharmacy Services
    - Pastoral Care
    - Materials Management
- The James purchases 24 services from UH
  - Services include:
    - MIM
    - Security
    - Legal Services
    - Clinical Engineering

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# Summary

- Opportunities
  - Regular metrics reporting
  - Standardize quality expectations
  - Increased evaluation response rates
  - Increase knowledge and purpose of annual evaluation

## Annual External Vendor Relationship feedback

[Note: for the purposes of the UH MSAC review, we are required to assess the adequacy of services provided by The James as an external entity. The converse process will occur at James MSAC]

Contract Name	Contract Description
Abbott m2000	Equipment Service
Abigail Merriam	James Care for Life
Acelis	VAD equipment and monitoring for VAD patients
Agility Health	Medical equipment provider
Air Force One	HVAC Solutions
AKSM (American Kidney Stone Management)	Provider of lithotripsy services
Alternate Solutions Homecare of Columbus, LLC	Home Care Referrals
American Red Cross	Therapeutic Apheresis
AMN Healthcare	Temporary Staffing
APFS STAFFING INC	Coding Temporary Support
ARUP	Reference lab
ASIST Translation Services LLC	Interpreting services
Aya Healthcare	Temporary Staffing
Be the Match Biotherapies, LLC	Cell therapy product
Bellingham Aviation Services, Inc.	Transportation services
Biomérieux Inc.	Microbiology Service Contract
Blood Center of Wisconsin reference lab	Reference lab
Brandy Meats	Food supplier
Buckeye Transplant	Process of screening organ donors, providing 24/7 services
Cameron J. Hunt	Chaplaincy Service Contract
Cardinal Health 105	Pharmacy
CDUYOGA1 LLC	Yoga Services
Celgene	Apheresis master service agreement; defines how team does apheresis, how to ship the product, track the product, how to infuse the product
CEMS of Ohio Inc	Education
Chanl Health	Telehealth application
Chem Aqua	Water treatment
Cincinnati Children's Hospital	Reference lab
Coca- Cola	Beverage Supplier
Commercial Parts & Services of Ohio inc	Service for repair and cooking equipment; ice machine cleaning and sanitizing

<b>Contract Name</b>	<b>Contract Description</b>
Comtex	Linen services
Copan, WASP	Lab Service Contract
CorroHealth	Coding Temporary Support
CVS Health (2002.16124C - CVS Patient Navigation for CHF Care Redesign)	Patient navigation for OSU Congestive Heart Failure patients
DASCO Home Medical Equipment	Provider of home medical supplies
David Wilson	Chaplaincy Service Contract
Day Funeral Service	Funeral and cremation service provider
Deaf Services Center	Interpreting services
Debra-Kuemple INC	HVAC, preventative maintenance
DispatchHealth	In-home medical care provider
E4 SERVICES HOLDINGS LLC	Coding Temporary Support
EDM Xpress Cleaning Solutions, LLC	Cleaning services
Elford	Facilities Contractor
Emory University	Reference Lab
EXCITE IT PARTNERS LLC	Coding Temporary Support
Fairfield Inn by Marriott; OSU Patient Housing	Patient Housing
Fairfield Medical Center	Provides rehab locally for OSUWMC LVRS patients
ForTec Medical Svcs	Laser Rental and Technician Labor Services
Franklin County Department of Job and Family Services	Case Management
Fresenius	Lab Service Contract
Gamida Cell, Inc.	Cell therapy product
Geiger Brothers	HVAC, preventative maintenance
GeneDX	Reference lab
Genesis Health Care System	Provides rehab locally for OSUWMC LVRS patients
Getinge	Occasional rental of Getinge Cardiohelp perfusion systems for the purpose of increasing demand of transporting patient to OSUWMC
Guardianship Service Board	Care Management
Hagerty Consulting	Financial Services Consultant
Hardin Memorial Hospital	Provides rehab locally for OSUWMC LVRS patients
Heartistic Transformations Art Therapy	James Care for Life
HIMAGINE SOLUTIONS LLC	Coding Temporary Support
HMPC/Limbach	HVAC Contractor
Iovance Biotherapeutics	Trade Agreement for manufacturer and deliver of autologous cellular immunotherapies
J&J Coatings	Facilities Contractor

<b>Contract Name</b>	<b>Contract Description</b>
Janet Wiltjer	James Care for Life
Janssen Pharmaceuticals	This agreement allows OSU to expand its CAR-T program by offering a new FDA approved treatment for cell therapy.
Jeffrey Robert Adair	Chaplaincy Service Contract
Jennifer Gebhart	James Care for Life
Joanna Samuelson	Chaplaincy Service Contract
Johnson Controls	HVAC PM and Repair
Kathrynn Thompson	James Care for Life
Kelly Vaughn	James Care for Life
Kettering Medical Center	Provides rehab locally for OSUWMC LVRS patients
Kite Pharma	Autologous cell therapy products
Knox Community Hospital	Provides rehab locally for OSUWMC LVRS patients
Kristin Schoeff	James Care for Life
Lane Champa	James Care for Life
Langer Biomechanics	Rehabilitation Services Vendor
Language Line/ Pacific Interpreters	Interpreting services
Laurel Healthcare Company	Provide pre-certification services who have not yet received authorization from third party payor and Traditional, direct bill agreement; focused on SNF LOS and readmissions
Lepi	General contractor for environmental cleanup situations
LGC CLINICAL DIAGNOSTICS INC	Lab Service Contract
Lifeline of Ohio	Organ Procurement Organization
LungGPS dba Superdimension Inc	LungGPS Patient Management Platform
Lyft	Transportation services for patients
MAKO Surgical Corp	Surgical services vendor
Mary Rutan Hospital	Provides rehab locally for OSUWMC LVRS patients
MAXIM HEALTHCARE SERVICES	Coding Temporary Support
Mayo Collaborative Services INC	Lab Service Contract
MCG	Care Management
MedFlight	Not-for-profit, air and ground critical care transportation company
MediaLab	Lab Service Contract
MEDOVENT SOLUTIONS	Coding Temporary Support
Medtronic	Clinical Engineering Service Agreement
Memorial Health System	Provides rehab locally for OSUWMC LVRS patients
Memorial Hospital	Provides rehab locally for OSUWMC LVRS patients
Messer (Linde)	Medical gases



<b>Contract Name</b>	<b>Contract Description</b>
Mid-American Cleaning Contractors	Custodial services for Ambulatory, Rehab
Midwest	Elevator PMs and repair (not including ATS)
Midwest Medical Transport	Transportation company
National Marrow Donor Program	Blood and Marrow Transplant Program
Nationwide Children's Hospital	Reference Lab
Nationwide Organ Recovery Transport (NORA)	Transplant for air and ground
Norwood Staffing Solutions LLC	Coding Temporary Support
Novartis Pharmaceuticals	Pharmaceutical products
Nuvasive	Provides rehab locally for OSUWMC LVRS patients
Ohio Health Marion General	Provides rehab locally for OSUWMC LVRS patients
Ohio Heating	Commercial and residential HVAC, boilers, building automation, commercial refrigeration, fabrication and food service equipment.
One Medical	Provide clinical care through improved access and quality, develop primary care and specialty care connections
OPTIV SECURITY INC	IT Contractor
Orlando Bread	Food supplier
Patricia Riley	James Care for Life
PBJ Connections	James Care for Life
Plunketts	Facilities Contractor
Prof Medical Assoc/Laser Training Institute	Preventative Maintenance
ProFlow Drain Cleaning	Drain Cleaning
Prometheus	Reference lab
Ray A. Vance	Chaplaincy Service Contract
Robert Daron Larson	James Care for Life
Roberts Electric Service group	Facilities Contractor
SBH	Pharmacy vendor
SecureWorks, Inc.	IT Contractor
Security 101	Security Contractor
Sentry Imaging Services LLC	Radiology Contractor
Siemens Healthcare	Building automation systems
Siemens Medical Solutions	Temporary Staffing for Radiology
SIGNATURE PERFORMANCE INC	Coding Temporary Support
SIPS Consults Corp	Central Sterile Supply Travelers
Southeastern Ohio Regional Medical Center	Provides rehab locally for OSUWMC LVRS patients

<b>Contract Name</b>	<b>Contract Description</b>
Southwest General Health Center	Pulmonary rehab vendor
Stericycle	EVS vendor
The Kings Clean, LLC	Cleaning services
The Wasserstrom Company	Nutrition services vendor
Thomas Door	Fire door certification; preventative maintenance/repair
TLC Bed Bug K9 Inspection Service (A&R Pest Control)	Facilities Contractor
Towne Park Holdings (Valet)	Valet
TP Mechanical	HVAC, preventative maintenance
TxJet, Inc.	Transplant for air and ground
UC Health LLC	Provides rehab locally for OSUWMC LVRS patients
UNITED AUDIT SYSTEMS INC	Coding Temporary Support
University Hospitals Health System	Provides rehab locally for OSUWMC LVRS patients
UPMC	Lab Service Contract
US Foods	Food supplier
Us Together	Interpreting services
Versiti Blood Center	Transfusion service reference laboratory
Vitalant	Collects blood from volunteer donors and provides blood, blood products and services

### Services OSUWMC Purchases from The James

<b>Service</b>	<b>Description</b>
Apheresis Nurse Services	On call, emergency Apheresis services for patients based on need
Chemotherapy Nurse Float Pool Services	Patients receiving chemotherapy outside of The James
Emergency Oncology Services	Oncology nurses, PCA, UCA, Patient Flow Coordinators, SANE nurses for ED oncology pod on 24/7 basis
Environmental Management Services	Provides custodial/janitorial workers at Primary Care New Albany, Dodd/Davis, Harding Hospital, Primary Care Westerville, Primary Care Pickerington, Primary Care Dublin and McCampbell Hall
Equipment Distribution Services	Maintain equipment stock, monitor inventory levels and manages all equipment needs; collaborates with purchasing and clinical engineering

<b>Service</b>	<b>Description</b>
High-Level Disinfection and Ambulatory Sterilization Services	High-level disinfection and sterilization services
Interventional Radiology Call Services	Radiologic services based on need outside of normal business hours
Interventional Radiology Technician Services	Radiologic services based on need
Laboratory Services	Lab services as defined by the Test Catalog of The James laboratories; Emergency Laboratory Services
Materials Management Services	Supplies acquisitions and inventory control; software execution; supply rooms for Critical Care, Progressive Care and Emergency Departments.
Nutrition Services	Provide meals to patients, staff, and visitors
Nursing Float Pool Services	Nursing services through James float pool
Pastoral Care Services	0.10 FTE Chaplain and 0.40 FTE residents providing direct pastoral / spiritual support to patients and families of OSUWMC
Perioperative Policy and Procedure Support Services	Research, edit, update and educate on perioperative policies and procedures
Pharmacy Services	Administrative and operational support; clinical pharmacist support and Quality and Safety Support
Radiologic Services	MR, CT, X-ray, Fluoroscopy, Interventional Radiology, Ultrasound, Nuclear Medicine at The James or Spielman Breast Center
Wound Ostomy Services	Wound ostomy services

### **Services The James purchases from OSUWMC**

<b>Service</b>	<b>Description</b>
Apheresis and Dialysis Nurse Services	Apheresis and dialysis nursing coverage
Acute Hemodialysis Nurse Services	As ordered by a nephrologist, Acute Hemodialysis Services are provided to The James' patients on a daily basis during normal business hours; Emergency Acute Hemodialysis Services are available, via on call
Central Sterile Processing Services	All duties related to cleaning and decontamination of general and specialty surgical instruments, power equipment,

Service	Description
	endoscopes, as well sterilization, preparation & packaging, and delivery of surgical instruments and supplies to the James operating room
Clinical Engineering Services	Assurance of the accuracy, safety, and proper performance of electrical and non-electrical medical equipment
Credentialing Services	Facilitate initial appointments, reappointments, and privileging of Medical Staff, Limited Staff and Advance Practice Providers in addition to regulatory compliance.
Fetal and Uterine Nurse Monitoring Services	Fetal and Uterine Monitoring Services include, but are not limited to, fetal movement assessment, auscultation, electronic fetal monitoring, non-stress test, contraction stress test, fetal biophysical profile, and modified biophysical profile
Heart and Vascular Services	Provide cardiovascular imaging testing, vascular studies, MRI/MRAs, CT/CTAs; TEEs; nuclear studies; stress testing
Infusion Nurse Services	Infusion nursing services coverage
Interventional Radiology Call Services	Provide a call team, consisting of one (1) IR nurse and one (1) IR Technician, to cover all of The James' after hours calls and services
Interventional Radiology Technician Services	Confirm and review order from an authorized practitioner; manage supplies; assist in preparation for procedures, obtain radiographic procedural imaging for patients
Laboratory Services	Laboratory tests and emergency laboratory services
Legal Services	On-call legal and risk management consultative services; provision of legal consultation and legal review of new-risk related policies and policy changes for The James.
Medical Information Management Services	Provide storage and retrieval, document imaging, regulatory and compliance in documentation and completion of medical records, hospital coding of diagnoses and procedures, protected health information privacy, medical record forms management and electronic health record support and development
Nursing Float Pool Services	Provide RNs in the event of unexpected surges in case volume or low staff numbers
Nutrition Services	Responsible for daily operation of enumerated dietary services for The James and has associated responsibility for implementing The James's vision and direction for The James's Nutrition Services.
Occupational Health and Wellness	Provide new hire screening, faculty and staff injuries, manage blood and body fluid exposures, annual vaccinations
Pastoral Care Services	0.30 FTE staff member shall be dedicated to providing Pastoral Care Services
Pharmacy Services	Administrative support and leadership, drug dispensing and compounding, dispensing technology and maintenance, clinical pharmacy services, cost monitoring, Epic applications, medication error reporting

<b>Service</b>	<b>Description</b>
Physician Advisor Services	Provide second-level medical necessity of review of appropriate level of care cases
Radiologic Services	Supply diagnostic and therapeutic radiology services to The James
Registration Services	Provide a complete registration for The James' patients in OSUWMC's and The James' joint EMR system according to organizational guidelines
Rehabilitation Services	Oversees James Acute Rehab team
Respiratory and Pulmonary Services	Delivery of all inhaled respiratory therapy medications, airway clearance techniques, ventilator management, nocturnal and continuous bilevel positive airway pressure, continuous positive airway pressure, and non-invasive mechanical ventilation.
Security Services	Provide safe and secure environment to staff, patients and visitors in all areas of The James.
Solid Organ Transplant Nursing Services	Provides nursing support if solid organ transplant recipient admitted to The James.

**DIRECT PATIENT CARE SERVICES CONTRACTS AND PATIENT IMPACT SERVICE CONTRACTS  
EVALUATION**

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER  
ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

Synopsis: Approval of the annual review of the direct patient care services contracts and patient impact service contracts for the Ohio State Comprehensive Cancer Center — James Cancer Hospital and Solove Research Institute, is proposed.

WHEREAS the mission of The James is to eradicate cancer from individuals' lives by generating knowledge and integrating groundbreaking research with excellence in education and patient-centered care; and

WHEREAS The James direct patient care services contracts and patient impact service contracts are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for inpatient and outpatient care at The James; and

WHEREAS the annual review of these contracts was approved by The James Medical Staff Administrative Committee on June 21, 2024; and

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the annual review of the direct patient care service contracts and patient impact service contracts for The James:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the direct patient care service contracts and patient impact service contracts for The James as outlined in the attached The James Contracted Services Annual Evaluation Report.

# Contracted Services Evaluation 2023



**THE OHIO STATE  
UNIVERSITY**

WEXNER MEDICAL CENTER

# Background

## Joint Commission Standard

**LD.04.03.09: Care, treatment, and services provided through contractual agreement are provided safely and effectively.**

## Centers for Medicaid and Medicare Services Standard

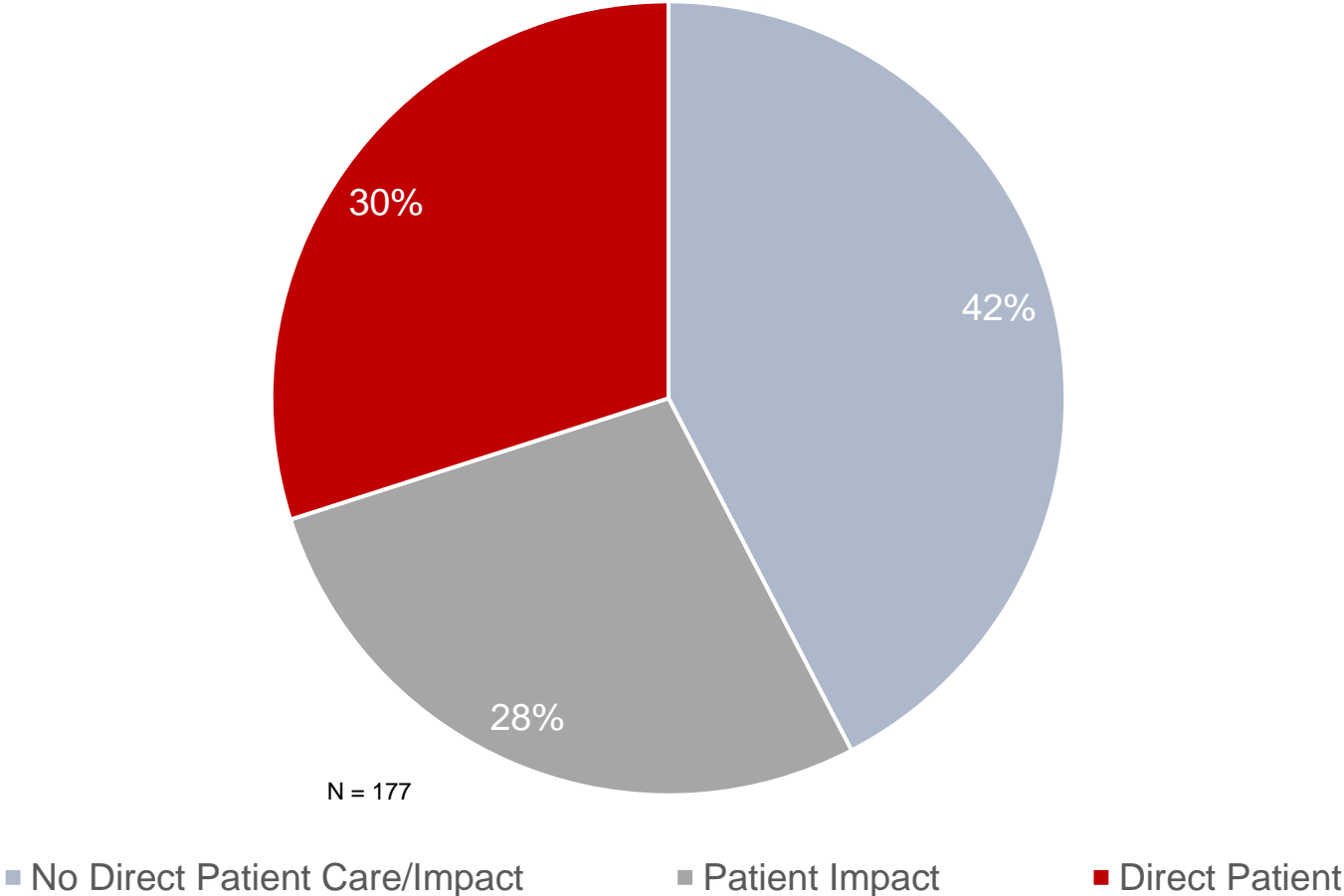
**482.12(e): The governing body be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including ones for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.**

OSUWMC/The James Process:

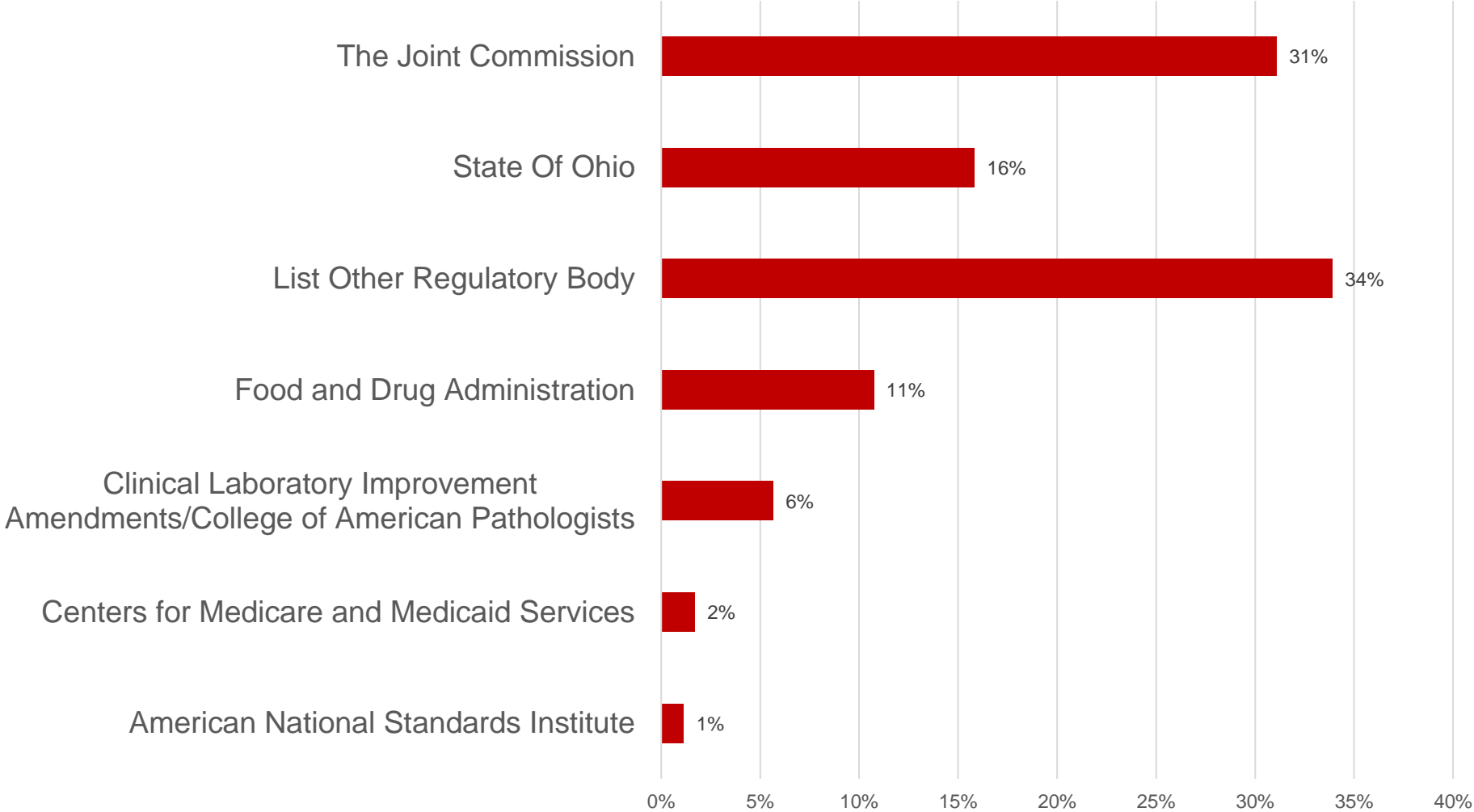
- Annual Evaluation
- Qualtrics
- Direct Patient Care and Patient Impact Services contracts included



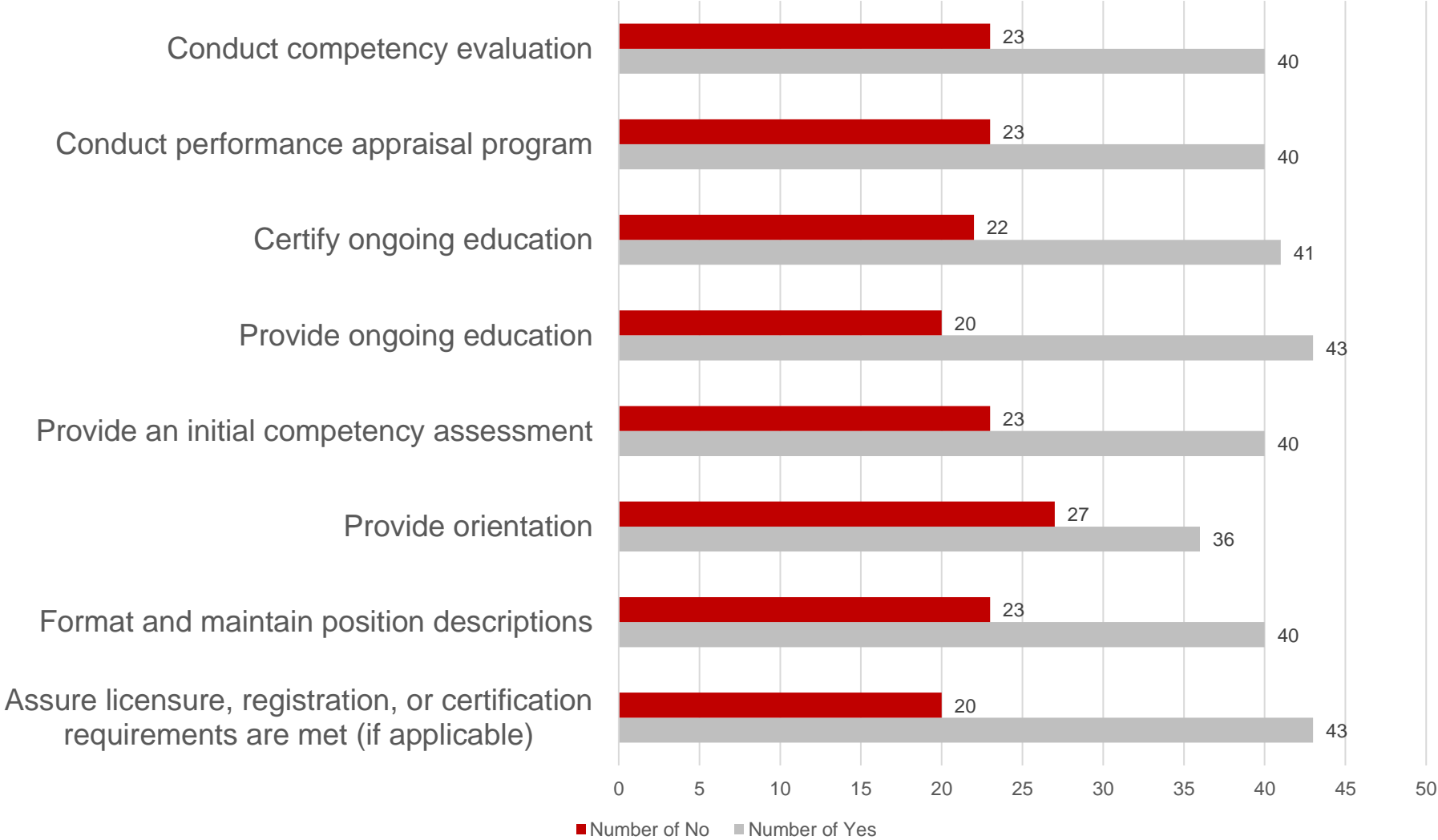
# Percentage of Contracts by Category



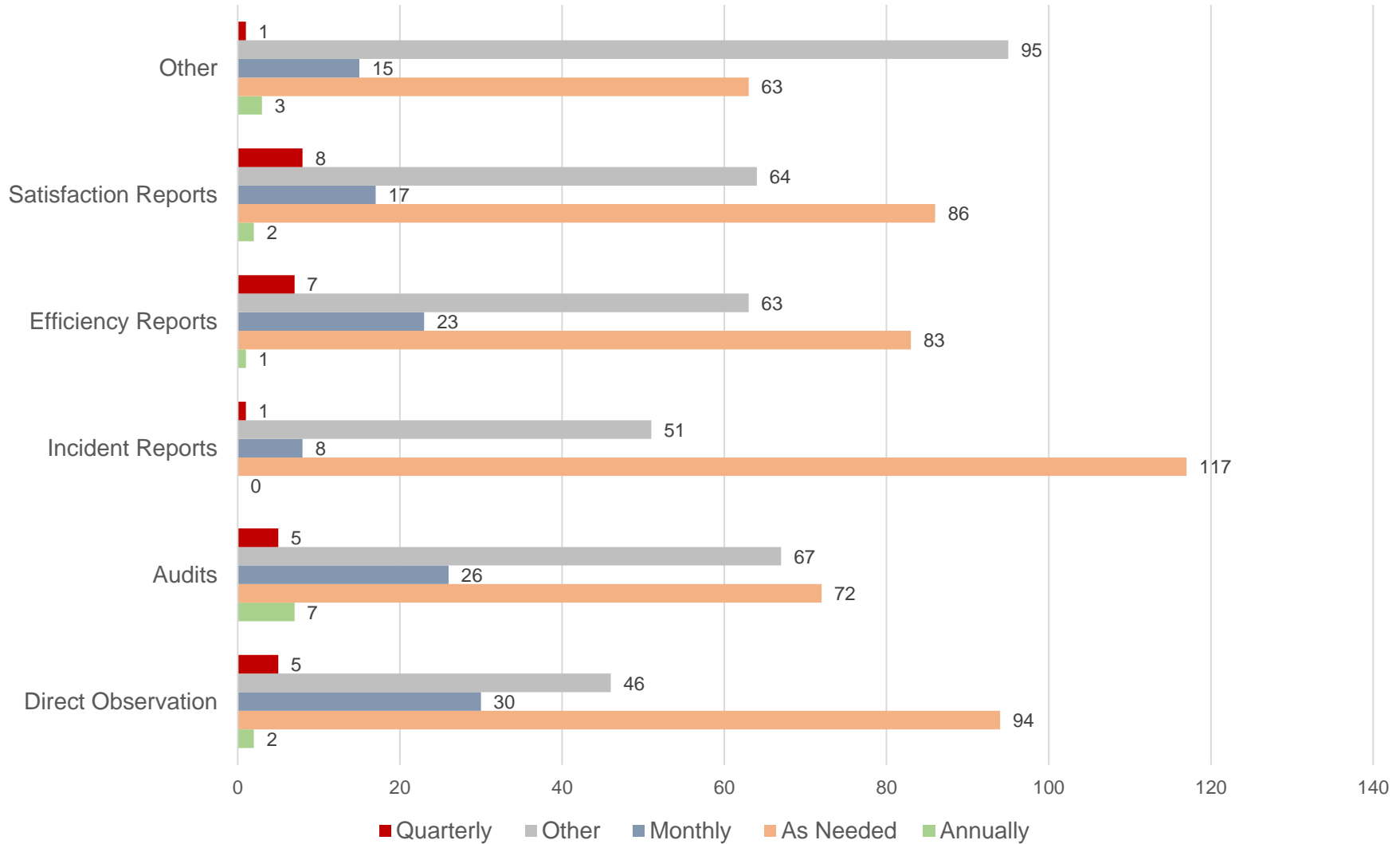
# Regulation of Contracted Services



# Compliance Activities



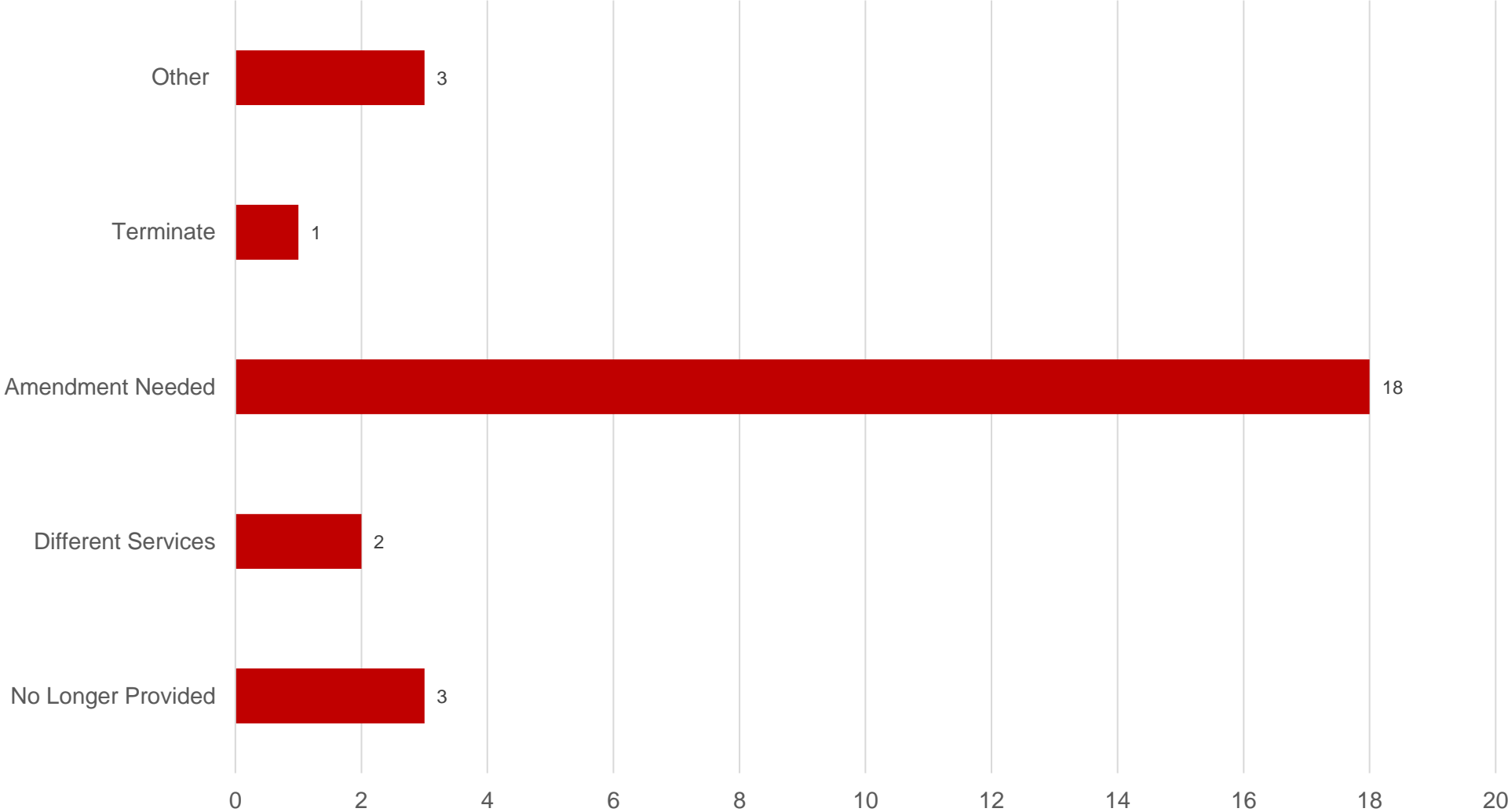
# Data Collection



# Improvements Made Within The Past Year

- 37% reported improvements in the past year
- Improvement Highlights:
  - Better Technician
  - Increased cleanliness
  - Align with medical center standards
  - Updated guidelines
  - Productivity reports
  - Streamlined communication to prevent miscommunication
  - New CE topics. Modules added.
  - Increased fulfillment rates
  - Improvements in online ordering system

# Follow Up Needed



# Between Provider Numbers

- OSUWMC purchases 20 services from The James
  - Services include:
    - High Level Disinfection and Ambulatory Sterilization
    - Pharmacy Services
    - Pastoral Care
    - Materials Management
- The James purchases 24 services from UH
  - Services include:
    - MIM
    - Security
    - Legal Services
    - Clinical Engineering

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# Summary

- Opportunities
  - Regular metrics reporting
  - Standardize quality expectations
  - Increased evaluation response rates
  - Increase knowledge and purpose of annual evaluation



## Annual External Vendor Relationship feedback

[Note: for the purposes of the James MSAC review, we are required to assess the adequacy of services provided by OSUWMC as an external entity. The converse has already occurred at UH MSAC]

Contract Name	Contract Description
Abbott m2000	Equipment Service
Abigail Merriam	James Care for Life
Acelis	VAD equipment and monitoring for VAD patients
Agility Health	Medical equipment provider
Air Force One	HVAC Solutions
AKSM (American Kidney Stone Management)	Provider of lithotripsy services
Alternate Solutions Homecare of Columbus, LLC	Home Care Referrals
American Red Cross	Therapeutic Apheresis
AMN Healthcare	Temporary Staffing
APFS STAFFING INC	Coding Temporary Support
ARUP	Reference lab
ASIST Translation Services LLC	Interpreting services
Aya Healthcare	Temporary Staffing
Be the Match Biotherapies, LLC	Cell therapy product
Bellingham Aviation Services, Inc.	Transportation services
Biomérieux Inc.	Microbiology Service Contract
Blood Center of Wisconsin reference lab	Reference lab
Brandy Meats	Food supplier
Buckeye Transplant	Process of screening organ donors, providing 24/7 services
Cameron J. Hunt	Chaplaincy Service Contract
Cardinal Health 105	Pharmacy
CDUYOGA1 LLC	Yoga Services
Celgene	Apheresis master service agreement; defines how team does apheresis, how to ship the product, track the product, how to infuse the product
CEMS of Ohio Inc	Education
Chanl Health	Telehealth application
Chem Aqua	Water treatment
Cincinnati Children's Hospital	Reference lab
Coca- Cola	Beverage Supplier
Commercial Parts & Services of Ohio inc	Service for repair and cooking equipment; ice machine cleaning and sanitizing

<b>Contract Name</b>	<b>Contract Description</b>
Comtex	Linen services
Copan, WASP	Lab Service Contract
CorroHealth	Coding Temporary Support
CVS Health (2002.16124C - CVS Patient Navigation for CHF Care Redesign)	Patient navigation for OSU Congestive Heart Failure patients
DASCO Home Medical Equipment	Provider of home medical supplies
David Wilson	Chaplaincy Service Contract
Day Funeral Service	Funeral and cremation service provider
Deaf Services Center	Interpreting services
Debra-Kuemple INC	HVAC, preventative maintenance
DispatchHealth	In-home medical care provider
E4 SERVICES HOLDINGS LLC	Coding Temporary Support
EDM Xpress Cleaning Solutions, LLC	Cleaning services
Elford	Facilities Contractor
Emory University	Reference Lab
EXCITE IT PARTNERS LLC	Coding Temporary Support
Fairfield Inn by Marriott; OSU Patient Housing	Patient Housing
Fairfield Medical Center	Provides rehab locally for OSUWMC LVRS patients
ForTec Medical Svcs	Laser Rental and Technician Labor Services
Franklin County Department of Job and Family Services	Case Management
Fresenius	Lab Service Contract
Gamida Cell, Inc.	Cell therapy product
Geiger Brothers	HVAC, preventative maintenance
GeneDX	Reference lab
Genesis Health Care System	Provides rehab locally for OSUWMC LVRS patients
Getinge	Occasional rental of Getinge Cardiohelp perfusion systems for the purpose of increasing demand of transporting patient to OSUWMC
Guardianship Service Board	Care Management
Hagerty Consulting	Financial Services Consultant
Hardin Memorial Hospital	Provides rehab locally for OSUWMC LVRS patients
Heartistic Transformations Art Therapy	James Care for Life
HIMAGINE SOLUTIONS LLC	Coding Temporary Support
HMPC/Limbach	HVAC Contractor
Iovance Biotherapeutics	Trade Agreement for manufacturer and deliver of autologous cellular immunotherapies
J&J Coatings	Facilities Contractor

<b>Contract Name</b>	<b>Contract Description</b>
Janet Wiltjer	James Care for Life
Janssen Pharmaceuticals	This agreement allows OSU to expand its CAR-T program by offering a new FDA approved treatment for cell therapy.
Jeffrey Robert Adair	Chaplaincy Service Contract
Jennifer Gebhart	James Care for Life
Joanna Samuelson	Chaplaincy Service Contract
Johnson Controls	HVAC PM and Repair
Kathrynn Thompson	James Care for Life
Kelly Vaughn	James Care for Life
Kettering Medical Center	Provides rehab locally for OSUWMC LVRS patients
Kite Pharma	Autologous cell therapy products
Knox Community Hospital	Provides rehab locally for OSUWMC LVRS patients
Kristin Schoeff	James Care for Life
Lane Champa	James Care for Life
Langer Biomechanics	Rehabilitation Services Vendor
Language Line/ Pacific Interpreters	Interpreting services
Laurel Healthcare Company	Provide pre-certification services who have not yet received authorization from third party payor and Traditional, direct bill agreement; focused on SNF LOS and readmissions
Lepi	General contractor for environmental cleanup situations
LGC CLINICAL DIAGNOSTICS INC	Lab Service Contract
Lifeline of Ohio	Organ Procurement Organization
LungGPS dba Superdimension Inc	LungGPS Patient Management Platform
Lyft	Transportation services for patients
MAKO Surgical Corp	Surgical services vendor
Mary Rutan Hospital	Provides rehab locally for OSUWMC LVRS patients
MAXIM HEALTHCARE SERVICES	Coding Temporary Support
Mayo Collaborative Services INC	Lab Service Contract
MCG	Care Management
MedFlight	Not-for-profit, air and ground critical care transportation company
MediaLab	Lab Service Contract
MEDOVENT SOLUTIONS	Coding Temporary Support
Medtronic	Clinical Engineering Service Agreement
Memorial Health System	Provides rehab locally for OSUWMC LVRS patients
Memorial Hospital	Provides rehab locally for OSUWMC LVRS patients
Messer (Linde)	Medical gases

<b>Contract Name</b>	<b>Contract Description</b>
Mid-American Cleaning Contractors	Custodial services for Ambulatory, Rehab
Midwest	Elevator PMs and repair (not including ATS)
Midwest Medical Transport	Transportation company
National Marrow Donor Program	Blood and Marrow Transplant Program
Nationwide Children's Hospital	Reference Lab
Nationwide Organ Recovery Transport (NORA)	Transplant for air and ground
Norwood Staffing Solutions LLC	Coding Temporary Support
Novartis Pharmaceuticals	Pharmaceutical products
Nuvasive	Provides rehab locally for OSUWMC LVRS patients
Ohio Health Marion General	Provides rehab locally for OSUWMC LVRS patients
Ohio Heating	Commercial and residential HVAC, boilers, building automation, commercial refrigeration, fabrication and food service equipment.
One Medical	Provide clinical care through improved access and quality, develop primary care and specialty care connections
OPTIV SECURITY INC	IT Contractor
Orlando Bread	Food supplier
Patricia Riley	James Care for Life
PBJ Connections	James Care for Life
Plunketts	Facilities Contractor
Prof Medical Assoc/Laser Training Institute	Preventative Maintenance
ProFlow Drain Cleaning	Drain Cleaning
Prometheus	Reference lab
Ray A. Vance	Chaplaincy Service Contract
Robert Daron Larson	James Care for Life
Roberts Electric Service group	Facilities Contractor
SBH	Pharmacy vendor
SecureWorks, Inc.	IT Contractor
Security 101	Security Contractor
Sentry Imaging Services LLC	Radiology Contractor
Siemens Healthcare	Building automation systems
Siemens Medical Solutions	Temporary Staffing for Radiology
SIGNATURE PERFORMANCE INC	Coding Temporary Support
SIPS Consults Corp	Central Sterile Supply Travelers
Southeastern Ohio Regional Medical Center	Provides rehab locally for OSUWMC LVRS patients

<b>Contract Name</b>	<b>Contract Description</b>
Southwest General Health Center	Pulmonary rehab vendor
Stericycle	EVS vendor
The Kings Clean, LLC	Cleaning services
The Wasserstrom Company	Nutrition services vendor
Thomas Door	Fire door certification; preventative maintenance/repair
TLC Bed Bug K9 Inspection Service (A&R Pest Control)	Facilities Contractor
Towne Park Holdings (Valet)	Valet
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TxJet, Inc.	Transplant for air and ground
UC Health LLC	Provides rehab locally for OSUWMC LVRS patients
UNITED AUDIT SYSTEMS INC	Coding Temporary Support
University Hospitals Health System	Provides rehab locally for OSUWMC LVRS patients
UPMC	Lab Service Contract
US Foods	Food supplier
Us Together	Interpreting services
Versiti Blood Center	Transfusion service reference laboratory
Vitalant	Collects blood from volunteer donors and provides blood, blood products and services

## Services The James purchases from OSUWMC

Service	Description
Apheresis and Dialysis Nurse Services	Apheresis and dialysis nursing coverage
Acute Hemodialysis Nurse Services	As ordered by a nephrologist, Acute Hemodialysis Services are provided to The James' patients on a daily basis during normal business hours; Emergency Acute Hemodialysis Services are available, via on call
Central Sterile Processing Services	All duties related to cleaning and decontamination of general and specialty surgical instruments, power equipment, endoscopes, as well sterilization, preparation & packaging, and delivery of surgical instruments and supplies to the James operating room
Clinical Engineering Services	Assurance of the accuracy, safety, and proper performance of electrical and non-electrical medical equipment
Credentialing Services	Facilitate initial appointments, reappointments, and privileging of Medical Staff, Limited Staff and Advance Practice Providers in addition to regulatory compliance.
Fetal and Uterine Nurse Monitoring Services	Fetal and Uterine Monitoring Services include, but are not limited to, fetal movement assessment, auscultation, electronic fetal monitoring, non-stress test, contraction stress test, fetal biophysical profile, and modified biophysical profile
Heart and Vascular Services	Provide cardiovascular imaging testing, vascular studies, MRI/MRAs, CT/CTAs; TEEs; nuclear studies; stress testing
Infusion Nurse Services	Infusion nursing services coverage
Interventional Radiology Call Services	Provide a call team, consisting of one (1) IR nurse and one (1) IR Technician, to cover all of The James' after hours calls and services
Interventional Radiology Technician Services	Confirm and review order from an authorized practitioner; manage supplies; assist in preparation for procedures, obtain radiographic procedural imaging for patients
Laboratory Services	Laboratory tests and emergency laboratory services
Legal Services	On-call legal and risk management consultative services; provision of legal consultation and legal review of new-risk related policies and policy changes for The James.
Medical Information Management Services	Provide storage and retrieval, document imaging, regulatory and compliance in documentation and completion of medical records, hospital coding of diagnoses and procedures, protected health information privacy, medical record forms management and electronic health record support and development
Nursing Float Pool Services	Provide RNs in the event of unexpected surges in case volume or low staff numbers

Nutrition Services	Responsible for daily operation of enumerated dietary services for The James and has associated responsibility for implementing The James's vision and direction for The James's Nutrition Services.
Occupational Health and Wellness	Provide new hire screening, faculty and staff injuries, manage blood and body fluid exposures, annual vaccinations
Pastoral Care Services	0.30 FTE staff member shall be dedicated to providing Pastoral Care Services
Pharmacy Services	Administrative support and leadership, drug dispensing and compounding, dispensing technology and maintenance, clinical pharmacy services, cost monitoring, Epic applications, medication error reporting
Physician Advisor Services	Provide second-level medical necessity of review of appropriate level of care cases
Radiologic Services	Supply diagnostic and therapeutic radiology services to The James
Registration Services	Provide a complete registration for The James' patients in OSUWMC's and The James' joint EMR system according to organizational guidelines
Rehabilitation Services	Oversees James Acute Rehab team
Respiratory and Pulmonary Services	Delivery of all inhaled respiratory therapy medications, airway clearance techniques, ventilator management, nocturnal and continuous bilevel positive airway pressure, continuous positive airway pressure, and non-invasive mechanical ventilation.
Security Services	Provide safe and secure environment to staff, patients and visitors in all areas of The James.
Solid Organ Transplant Nursing Services	Provides nursing support if solid organ transplant recipient admitted to The James.

**Services OSUWMC Purchases from The James**

<b>Service</b>	<b>Description</b>
Apheresis Nurse Services	On call, emergency Apheresis services for patients based on need
Chemotherapy Nurse Float Pool Services	Patients receiving chemotherapy outside of The James
Emergency Oncology Services	Oncology nurses, PCA, UCA, Patient Flow Coordinators, SANE nurses for ED oncology pod on 24/7 basis
Environmental Management Services	Provides custodial/janitorial workers at Primary Care New Albany, Dodd/Davis, Harding Hospital, Primary Care Westerville, Primary Care Pickerington, Primary Care Dublin and McCampbell Hall

Service	Description
Equipment Distribution Services	Maintain equipment stock, monitor inventory levels and manages all equipment needs; collaborates with purchasing and clinical engineering
High-Level Disinfection and Ambulatory Sterilization Services	High-level disinfection and sterilization services
Interventional Radiology Call Services	Radiologic services based on need outside of normal business hours
Interventional Radiology Technician Services	Radiologic services based on need
Laboratory Services	Lab services as defined by the Test Catalog of The James laboratories; Emergency Laboratory Services
Materials Management Services	Supplies acquisitions and inventory control; software execution; supply rooms for Critical Care, Progressive Care and Emergency Departments.
Nutrition Services	Provide meals to patients, staff, and visitors
Nursing Float Pool Services	Nursing services through James float pool
Pastoral Care Services	0.10 FTE Chaplain and 0.40 FTE residents providing direct pastoral / spiritual support to patients and families of OSUWMC
Perioperative Policy and Procedure Support Services	Research, edit, update and educate on perioperative policies and procedures
Pharmacy Services	Administrative and operational support; clinical pharmacist support and Quality and Safety Support
Radiologic Services	MR, CT, X-ray, Fluoroscopy, Interventional Radiology, Ultrasound, Nuclear Medicine at The James or Spielman Breast Center
Wound Ostomy Services	Wound ostomy services



**CONTRACTED SERVICES**

THE OHIO STATE UNIVERSITY AMBULATORY SURGERY CENTER  
OUTPATIENT CARE NEW ALBANY

Synopsis: Approval of the annual review of the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the contracted services are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for the mission of The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany; and

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care New Albany.

**Annual Contractor/Vendor for Review New Albany Ambulatory Surgery Center**

<b>Contracted Services</b>
Management
Laboratory
Radiologic
Central Sterile Processing
Medical Information Management
Nutrition
Registration and Scheduling
Clinical Engineering
Legal
Pharmacy
Epidemiology
Patient Experience

**CONTRACTED SERVICES**

THE OHIO STATE UNIVERSITY AMBULATORY SURGERY CENTER  
OUTPATIENT CARE DUBLIN

Synopsis: Approval of the annual review of the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin, is proposed.

WHEREAS the mission of the Ohio State University Hospitals is to improve people's lives through the provision of high-quality patient care; and

WHEREAS the contracted services are evaluated annually to review the scope, nature, and quality of services provided to clinical departments and personnel who provide care and services for the mission of The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin; and

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the annual review of the contracted services for The Ohio State University Ambulatory Surgery Center — Outpatient Care Dublin.

**Annual Contractor/Vendor for Review Dublin Ambulatory Surgery Center**

<b>Contracted Services</b>
Management
Laboratory
Radiologic
Central Sterile Processing
Medical Information Management
Nutrition
Registration and Scheduling
Clinical Engineering
Legal
Pharmacy
Epidemiology
Patient Experience

**AMENDMENTS TO THE BYLAWS OF THE MEDICAL STAFF**

OHIO STATE UNIVERSITY HOSPITALS d/b/a OSU WEXNER MEDICAL CENTER

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

WHEREAS a summary of the proposed amendments to the Bylaws of the Medical Staff of The Ohio State University Hospitals is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed amendments to the Bylaws of the Medical Staff of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff Bylaws Committee on May 29, 2024; and

WHEREAS the proposed amendments to the Bylaws of the Medical Staff of The Ohio State University Hospitals were approved by the University Hospitals Medical Staff Administrative Committee on June 12, 2024:

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the amendments to the Bylaws of the Medical Staff of The Ohio State University Hospitals plan for patient care services:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the amendments to the Bylaws of the Medical Staff for the Ohio State University Hospitals, including Ohio State University Hospital, Ohio State Richard M. Ross Heart Hospital, Ohio State Harding Hospital, and Ohio State East Hospital.

## UH Medical Staff Bylaws-Proposed Changes

Approved: UH MSAC 6/12/2024  
UH Bylaws Committee 5/29/2024  
UH Medical Staff Vote 7/10/2024  
Quality & Professional Affairs Committee  
Wexner Medical Center Board  
Ohio State University Board of Trustees

*The proposed changes outlined below may be referenced in multiple sections of the bylaws, which have been updated accordingly in the full redlined document.*

### 43-06 Hearing and appeal process

#### Section (A)(2)(g) Right to hearing and to an appeal

- Removes the community affiliate B medical staff member from being entitled to a hearing in favor of termination language outlined in 43-07 (C)(3)

### 43-07 Categories of the medical staff

#### Section (C) Community affiliate B

- Addition of language excluding Community Affiliate B from assignment to a clinical department
- Assignment by the Chief Medical Officer for the clinical duties of the department to the chief physician of the affiliated entity (OSUP)
- Addition of termination of medical staff membership language outlining automatic termination upon loss of employment with affiliated entity

#### Section (E) Community affiliate D

- Replacement of the word “grandfathering” with “historical.”

### 43-08 Organization of the medical staff

#### Section (A)

- Removes community affiliate B from the requirement to be assigned to a clinical department in favor of assigning to the chief physician of the affiliated entity

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

#### Section (A)(7) Chief of staff

- Updates medical staff committee appointment language to follow the process outlined in (D)(1) of rule 3335-43-10

#### Section (C) Representatives of the medical staff elected at-large

- Increases number of medical staff representatives elected at large from three to six

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

#### Section (E)(1) Medical staff administrative committee

- Adds language to include the chief physician of the affiliated entity and increases the medical staff representatives from three to six. Also, clarifies language allowing CEO to send designee to improve alignment with updated Joint Commission standard.
- Removes language allowing the CEO of Ohio state university hospitals to invite any member of their staff to represent him/her at a meeting or to attend any meeting
- Adds language to allow virtual meeting attendance

#### Section (F) Credentialing committee of the hospitals of the Ohio state university

- (3)(a) Licensed health care professionals subcommittee
  - Replaces outdated cross-reference with (D)(1) of rule 3335-43-10
- (G)(1) Committee for practitioner health.
  - Replaces outdated cross-reference with (D)(1) of rule 3335-43-10
- (H)(1) Medical staff bylaws committee.
  - Replaces outdated cross-reference with (D)(1) of rule 3335-43-10
- (I)(1) Infection prevention committee.
  - Replaces outdated cross-reference with (D)(1) of rule 3335-43-10
- (L)(1) Quality Leadership Council.
  - Replaces outdated cross-reference with (D)(1) of rule 3335-43-10
- (N)(1) Clinical resource utilization policy group.
  - Replaces outdated cross-reference with (D)(1) of rule 3335-43-10
- (O)(1) Clinical practice guideline committee.
  - Replaces outdated cross-reference with (D)(1) of rule 3335-43-10

### 3335-43-11 History and physical

#### Section (A) History and physical examination.

- (1)(b): Updates language to “Undergoing outpatient/ambulatory procedures **requiring anesthesia or sedation**.”
- (3): Updates language to “For patients undergoing outpatient/ambulatory procedures **requiring anesthesia or sedation** or outpatient/ambulatory surgery, the history and physical examination shall include at a minimum:”
- (5)(d) Updates language in first sentence to: “Admitted patients or patients undergoing a procedure **requiring anesthesia or sedation** or surgery, the history and physical examination may be performed or updated up to thirty days prior to admission or the procedure/surgery.”
  - (5)(d)(i) Updates language to: “For patients undergoing an outpatient procedure **requiring anesthesia or sedation** or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history, and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health-care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.



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

Updated August 15, 2023

**3335-43-01 Medical staff name.**

The board of trustees of the Ohio state university, by official action on September 13, 1963, established "the Ohio state university hospitals." In accordance with Chapters 3335-93-01 to 3335-93-03 and 3335-101-04 of the Administrative Code, the Ohio state university Wexner medical center board (herein called Wexner medical center board) has delegated to the medical staff of the Ohio state university hospitals the responsibility to prepare and recommend adoption of these bylaws. "The medical staff of the Ohio state university hospitals" shall be the name of the hospitals' medical staff organization.

(Board approval date: 5/14/2010, 11/7/2014)

**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) To strive to maintain quality standards of patient care for all patients admitted to the Ohio state university hospitals, consistent with an active teaching environment, realizing that the care and treatment of the individual patient is the medical responsibility of the member of the attending, community affiliate A and community affiliate D medical staff to whose care the patient is admitted or transferred.
- (B) To support educational and research programs; elevate and advance the educational standards of our professions, including, but not limited to, pre- and post-M.D. students, nurse students, graduate nurse students, students of the allied medical professions, and students of other health professional colleges; and provide research programs to enhance and advance the educational and patient-care programs.
- (C) To provide a means whereby medical problems may be reviewed; policies and procedures discussed; and to provide a means for establishing and maintaining standards of professional, medical and educational performance, organization, and discipline within the medical staff and harmonious cooperation and understanding among the units comprising the Ohio state university hospitals.
- (D) To provide service, education and research programs to benefit the mental, physical, and environmental health of the citizens of the state of Ohio; dedicate itself to be responsive to the needs of its patients and to communicate effectively concerning matters of patient care; and encourage dissemination of medical knowledge to health professionals and the public, and conduct research for the prevention and treatment of disease.
- (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, 4/6/2018, 8/15/2023)



**3335-43-03 Patients.**

- (A) The continuous care and treatment of individual patients is the medical responsibility of the member of the attending, community affiliate A and community affiliate D medical staff to whose care the patient is admitted or transferred within the Ohio state university hospitals and to licensed health care professionals being granted clinical privileges under these bylaws.
- (B) There shall be only one category or classification of patients in the Ohio state university hospitals, and those patients are the private patients of the medical staff under whose care they are admitted. Patients admitted to the Ohio state university hospitals who, at the time of admission, have not requested or selected a member of the medical staff to attend them shall be assigned by the chief of the appropriate clinical division or department or their designees, to a member of the medical staff for their care and treatment.
- (C) All patients admitted to the Ohio state university hospitals should cooperate and be an integral part of the teaching program of the college of medicine. Should a patient, or on the behalf of the patient, the patient's representative, refuse to participate or cooperate in the teaching program of the Ohio state university hospitals or the college of medicine, the medical staff member responsible for the care and treatment of the patient will encourage participation in the Ohio state university's teaching programs, but will simultaneously inform patients, or when appropriate, the patient's representative, of their right to refuse participation. Students, including pre- and post-M.D., but not limited thereto, shall be under the direction and control of the members of the medical staff to whom the patient is assigned upon admission to the Ohio state university hospitals or transfer within the Ohio state university hospitals' services. The Ohio state university hospitals respect the patient's right to participate in decisions about his or her care, treatment and services, and further respects the patient's right to refuse care treatment and services, in accordance with law and regulation.

(Board approval dates: 6/7/2002, 2/2/2007, 9/19/2008, 4/8/2011, 11/7/2014, 8/15/2023)

**3335-43-04 Membership.**

- (A) Qualifications.
  - (1) Membership on the medical staff of the Ohio state university hospitals 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, the Wexner medical center board 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, 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 procedures as all other applicants for the medical staff.
  - (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. 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.

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 approved by the medical staff administrative committee or as required by the Wexner medical center to meet accreditation standards, federal regulations, or quality and safety goals is required for medical staff members with clinical privileges in addition to conflict of interest disclosure. 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 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 participation in all governmental programs is fully reinstated, the affected medical staff member or credentialed provider shall be eligible to apply for membership and clinical privileges at that time.
- (4) An applicant for membership shall at the time of appointment or reappointment, be and remain board certified in his or her primary area of practice at the Ohio state university hospitals. This Board certification must be approved by at least one of the American board of medical specialties, or other applicable certifying boards, including certifying boards if applicable for doctors of osteopathy, podiatry, psychology, and dentistry. All applicants must be and remain certified within the specific areas for which they have requested clinical privileges. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for medical staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training. Applicants must maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at reappointment. Failure to meet or maintain board certification shall result in immediate termination of membership on the medical staff of the Ohio state university hospitals.
- (5) All applicants must demonstrate recent clinical activity in their primary area of practice during the last two years to satisfy minimum threshold criteria for privileges within their clinical departments.
- (6) Waiver requests for the threshold eligibility requirements listed in paragraphs (A)(3) to (A)(5) of this rule may be requested and considered as follows:
  - (a) A request for a waiver will only be considered if the applicant provides information sufficient to satisfy his or her burden of demonstrating that his or her qualifications are equivalent to or exceed the criterion in question and that there are exceptional circumstances that warrant a waiver. The clinical department chief must endorse the request for waiver in writing to the credentialing committee.
  - (b) The credentialing committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the relevant department chiefs, and the best interests of the hospital and the communities it serves. The credentialing committee will forward its recommendation, including the basis for such, to the medical staff administrative committee.
  - (c) The medical staff administrative committee will review the recommendation of the credentialing committee and make a recommendation to the quality and professional affairs committee of the Ohio state university Wexner medical center and the Wexner medical center board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.
  - (d) The Ohio state university Wexner medical center board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and does not give rise to a right to a hearing. The prospective applicant who requested the waiver in a particular case is not intended to set a precedent for any other applicant. A determination to grant a waiver does not mean that an appointment will be granted. Waivers of threshold eligibility criteria will not be granted routinely. No applicant is entitled to a waiver or to a hearing if a waiver is not granted.

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Updated August 15, 2023

- (e) Waiver requests for the threshold eligibility requirement listed in paragraph (A)(3) of this rule may only be considered for applicants who have voluntarily opted out of governmental health care programs. Applicants who have been excluded or suspended shall be ineligible to request a waiver.
  - (f) Waivers to requirements prescribed by regulatory accrediting or other external agencies will not be granted.
- (7) Any medical staff member whose membership has been terminated pursuant to paragraph (A)(3) or (A)(4) of this rule shall not be entitled to request a hearing and appeal in accordance with rule 3335-43-06 of the Administrative Code. Any licensed health care professional whose clinical privileges have been terminated pursuant to paragraph (A)(4) of this rule may not request an appeal in accordance with paragraph (G)(3) of rule 3335-43-07 of the Administrative Code.
- (8) No applicant shall be entitled to medical staff membership and or clinical privileges merely by the virtue of fulfilling the above qualifications or holding a previous appointment to the medical staff.
- (B) Application for membership.

Initial application for medical staff membership for all categories of the medical staff shall be made by the applicant to the chief of the clinical department on forms prescribed by the medical staff administrative committee stating the qualifications and references of the applicant and giving an account of the applicant's current licensure, relevant professional training and experience, current competence and ability to perform the clinical privileges requested. All applications for appointment must specify the clinical privileges requested. Applications may be made only if the applicant meets the qualifications outlined in paragraph (A) of this rule. The application shall include written statements of the applicant to abide by the bylaws, rules and regulations and policies and procedures of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university. The applicant shall produce a government-issued photo identification to verify his/her identity pursuant to hospital/medical staff policy. The applicant shall agree that membership on the medical staff requires participation in the peer review process of evaluating credentials, medical staff membership and clinical privileges, and that a condition for membership requires mutual covenants between all members of the medical staff to release one another from civil liability in this review process as long as the peer review was taken in the reasonable belief that it was in furtherment of quality health care based upon a reasonable review and appropriate procedural due process. In order to optimize the clinical organization resource utilization and planning of the Ohio state university hospitals, the chief of the clinical department may require that the community affiliate D medical staff member identify categories of diagnosis, extent of anticipated patient activity, and service areas to be utilized and may prepare a statement of participation for the applicant, which shall be made a part of the application for appointment. A separate record shall be maintained for each applicant requesting appointment to the medical staff.

- (C) Terms of appointment. Initial appointment to the medical staff shall be for a period not to exceed thirty-six months. During the first six months of the initial appointment, except for 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 of the chief of the clinical department with oversight by the credentials committee and the medical staff administrative committee. Following the six-month FPPE period, the chief of the clinical department 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

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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) Ethics and ethical relationship. The code of ethics as adopted, or as may be amended, by the American medical association, the American dental association, the American psychological association, American osteopathic association and the American podiatric medical association shall govern the professional ethical conduct of the respective members of the medical staff.
- (E) Procedure for appointment.
  - (1) The written and signed application for membership on the medical staff shall be presented to the applicable chief of the clinical department. The applicant shall include in the application a signed statement indicating the following:
    - (a) If the applicant should be accepted to membership on the medical staff, the applicant agrees to be governed by the bylaws, rules and regulations of the medical staff, the Wexner medical center board and the board of trustees of the Ohio state university.
    - (b) The applicant consents to be interviewed in regard to the application.
    - (c) The applicant authorizes the Ohio state university hospitals to consult with members of the medical staffs of other hospitals with which the applicant has been or has attempted to be associated, and with others who may have information bearing on the applicant's competence, character and ethical qualifications.
    - (d) The applicant consents to the Ohio state university hospitals' inspection of all records and documents that may be material to the evaluation of the applicant's professional qualifications and competence to carry out the clinical and educational privileges for which the applicant is seeking as well as the applicant's professional ethical qualifications for medical staff membership.
    - (e) The applicant releases from any liability:
      - (i) All representatives of university hospitals for acts performed in connection with evaluating the applicant's credentials or releasing information to other institutions for the purpose of evaluating the applicant's credentials in compliance with these bylaws performed in good faith; and
      - (ii) All third parties who provide information, including otherwise privileged and confidential information, to members of the medical staff, the Ohio state university hospitals staff, Ohio state university Wexner medical center board members and members of the Ohio state university board of trustees concerning the applicant's credentials performed in good faith.
    - (f) The applicant has an affirmative duty to disclose any prior termination, voluntary or involuntary, current loss, restriction, denial, or the voluntary or involuntary relinquishment of any of the following: professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.
    - (g) The applicant further agrees to disclose to the chief medical officer of the Ohio state university hospitals the initiation of any process which could lead to such loss or restriction of the applicant's professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.

- (h) The applicant agrees that acceptance of membership on the medical staff of the Ohio state university hospitals authorizes the Ohio state university hospitals to conduct any appropriate health assessment including but not limited to drug or alcohol screens on a practitioner at any time during the normal pursuit of medical staff duties, based upon reasonable cause as determined by the chief of the practitioner's clinical department or the chief medical officer of the Ohio state university hospitals or their authorized designees.
- (2) The purpose of the health assessment shall be to ensure that the member of the medical staff is able to fully perform and discharge the clinical, educational, administrative and research responsibilities which the member is permitted to exercise by reason of medical staff membership. If, at the time of the initial request for a health assessment, and at any time a medical staff member refuses to participate as needed in a health assessment, including but not limited to a drug or alcohol screening, this shall result in automatic lapse of membership, privileges, and prerogatives until remedied by compliance with the requested health assessment. Upon request of the medical staff administrative committee or Wexner medical center board, the applicant will provide documentation the applicant's physical and mental status with sufficient adequacy to demonstrate that any patient treated by the applicant will receive care of a generally professionally recognized level of quality and efficiency. The conditions of this paragraph shall be deemed continuing and may be applicable to issues of continued good standing as a member of the medical staff.
- (3) An application for membership on the medical staff shall be considered complete when all the information requested on the application form is provided, the application is signed by the applicant and the information is verified. A completed application must contain:
  - (a) Peer recommendation from at least three individuals with "first hand" knowledge about the applicant's clinical and professional skills.
  - (b) Evidence of required immunizations.
  - (c) Evidence of current professional medical malpractice liability coverage required for the exercise of clinical privileges.
  - (d) Satisfaction of ECFMG requirements, if applicable. If an individual receives a conceded eminence certificate or a clinical research faculty certificate from the state medical board of Ohio, the requirement for ECFMG certification may be waived at the discretion of the Wexner medical center board.
  - (e) Verification by primary source documentation of:
    - (i) Current and previous state licensure;
    - (ii) Faculty appointment (not required for community affiliate B, community affiliate C, community affiliate D or contracted category);
    - (iii) DEA registration when required for exercise of clinical privileges;
    - (iv) Graduation from an accredited medical or professional school;
    - (v) Successful completion or record of post graduate medical or professional education; and
    - (vi) Board certification active candidacy for board certification (may not be required for community affiliate B, community affiliate C and community

affiliate D categories). or applicant qualifies for a waiver pursuant to paragraph (A)(6) of rule 3335-43-04 of the Administrative Code.

- (f) Information from the national practitioner data bank.
  - (g) Verification that the applicant has not been excluded from any federally funded health care program.
  - (h) Complete disclosure by applicant of all past and current claims, suits, and settlements, if any.
  - (i) Completion of a criminal background investigation that meets the requirements of the Wexner medical center.
  - (j) Completion of drug testing for substances required for individuals applying for clinical privileges and in accordance with Wexner medical center approved testing protocols.
  - (k) Verification of completion of annual educational requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office.
  - (l) Demonstration of recent active clinical practice during the last two years required for exercise of clinical privileges.
  - (m) Attestation of current Ohio automated Rx reporting system ("OARRS") account for all applicants who have a DEA registration.
- (4) The chief of the applicable clinical department shall be responsible for investigating and verifying the character, qualifications, and professional standing of the applicant by making inquiry of the primary source of such information and shall within thirty days of receipt of the complete application, submit a report of those findings along with a recommendation on membership and clinical privileges to the chief medical officer of the Ohio state university hospitals.
- (5) The chief medical officer shall receive all initial signed and verified applications from the chief of the clinical department and 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 chief medical officer shall forward all complete applications to the credentials committee. The applicant shall have the burden of producing information for an adequate evaluation of applicant's qualifications for membership and for the clinical privileges requested. If the applicant fails to complete the prescribed forms or fails to provide the information requested within sixty days of receipt of the signed application, processing of the application shall cease and the application shall be deemed to have been voluntarily withdrawn which action is not subject to hearing or appeal pursuant to rule 3335-43-06 of the Administrative Code.

If the chief of the applicable clinical department does not submit a report and recommendation on a timely basis, the completed application shall be forwarded to the chief medical officer for presentation to the credentials committee on the same basis as other applicants.

- (6) Completed applications shall be acted upon as follows:

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- (a) By the credentials committee within thirty days after receipt of a completed application from the chief medical officer.
- (b) By the medical staff administrative committee within thirty days after receipt of a completed application and the report and recommendation of the credentials committee.
- (c) By the quality and professional affairs committee through the expedited credentialing process or Wexner medical center board within sixty days after receipt of a completed application and the report and recommendation of the medical staff administrative committee.

All applications shall be acted upon by the Ohio state university Wexner medical center board within one hundred twenty days of receipt of a completed application. These time periods are deemed guidelines only and do not create any right to have an application processed within these precise periods. These periods may be stayed or altered pending receipt and verification of further information requested from the applicant, or if the application is deemed incomplete at any time. If the procedural rights specified in rule 3335-43-06 of the Administrative Code are activated, the time requirements provided therein govern the continued processing of the application.

- (7) The credentials committee shall review the application, evaluate and verify the supporting documentation, references, licensure, the chief of the clinical department's report and recommendation, and other relevant information. The credentials committee shall examine the character, professional competence, professional conduct, qualifications and ethical standing of the applicant and shall determine, through information contained in personal references and from other sources available to the credentials committee, including an appraisal from the chief of the clinical department in which clinical privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the category of medical staff membership and clinical privileges requested.

The credentials committee shall, within thirty days from receipt of a complete application, make a recommendation to the chief medical officer that the application be accepted, rejected, or modified. The chief medical officer shall forward the recommendation of the credentials committee to the medical staff administrative committee. The credentials committee or the chief medical officer may recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session. 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 chief medical officer, along with the recommendation of the chief medical officer to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Ohio state university Wexner medical center board has acted, the chairperson of the board shall instruct the chief medical officer to transmit the final decision to the chief of the clinical department and applicant and, if appropriate, to the director of the applicable clinical division.

- (8) At any time the medical staff administrative committee first recommends non-appointment of an initial applicant for medical staff membership or recommends denial of any clinical privileges requested by the applicant, the medical staff administrative committee shall require the chief medical officer to notify the applicant by certified return receipt mail that the applicant may request an evidentiary hearing as provided in paragraph (D) of rule 3335-43-06 of the Administrative Code. The applicant shall be notified of the requirement to request a hearing as provided by paragraph (B) of rule 3335-43-06 of the Administrative Code. If a hearing is properly requested, the applicant shall be subject to the rights and responsibilities of rule 3335-43-06 of the Administrative Code. If an applicant fails to properly request a hearing, the



medical staff administrative committee shall accept, reject, or modify the application for appointment to membership and clinical privileges.

The final recommendation of the medical staff administrative committee shall be directly communicated to the Wexner medical center board by the chief medical officer, who shall make a separate recommendation to the Wexner medical center board.

When the Ohio state university Wexner medical center board has acted, the chairperson of the board shall instruct the chief medical officer to transmit the final decision to the chief of the clinical department and applicant and, if appropriate, to the director of the applicable clinical division. The chairperson of the board shall also notify the dean of the college of medicine and the chief executive officer of the Ohio state university hospitals of the decision of the board.

(F) Procedure for reappointment.

- (1) At least ninety days prior to the end of the medical staff member's appointment period, the chief of the clinical department shall provide each medical staff member with an application for reappointment to the medical staff on forms prescribed by the medical staff administrative committee. The reappointment application shall include all information necessary to update and evaluate the qualifications of the medical staff member. The chief of the clinical department shall review the information available on each medical staff member, and the chief of the clinical department shall make recommendations regarding reappointment to the medical staff and for granting clinical privileges for the ensuing appointment period. The chief of the clinical department's recommendation shall be transmitted in writing along with the signed and completed reappointment forms to the chief medical officer at least forty-five days prior to the end of the medical staff member's appointment period.

The terms of paragraphs (A), (B), (C), (D), (E)(1), and (E)(2) of this rule shall apply to all applicants for reappointment. Reappointment to the medical staff shall be done on a regular basis for a period not to exceed thirty-six months. Only completed applications for reappointment shall be considered by the credentials committee. An application for reappointment is complete when all the information requested on the reappointment application form is provided, the reappointment form is signed by the applicant, and the information is verified, and no need for additional or clarifying information is identified. A completed reappointment application form must contain:

- (a) Evidence of required immunizations if applicable since last appointment.
- (b) Evidence of current professional medical malpractice liability insurance required for the exercise of clinical privileges.
- (c) Verification of primary source documentation of:
  - (i) State licensure;
  - (ii) DEA registration when required for clinical privileges;
  - (iii) Successful completion or record of additional post graduate medical or professional education; and
  - (iv) Board certification, re-certification, or continued active candidacy for certification (may not be required for community affiliate category) or applicant qualifies for a waiver pursuant to paragraph (A) (4) of rule 3335-43-06 of the Administrative Code.

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- (d) Information from the national practitioner data bank.
  - (e) Verification that the applicant has not been excluded from any federally funded health care program.
  - (f) Specific requests for any changes in clinical privileges sought at reappointment with supporting documentation as required by credentialing guidelines.
  - (g) Specific requests for any changes in medical staff category.
  - (h) A summary of the member's clinical activity during the previous appointment period.
  - (i) Patterns of care as demonstrated through quality assurance records.
  - (j) Verification of completion of annual educational requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office.
  - (k) Complete disclosure by medical staff members of claims, suits, and settlements, if any.
  - (l) Continuing medical education and applicable continuing professional education activities. Documentation of category one CME that at least in part relates to the individual medical staff member's specialty or sub-specialty area and are consistent with the licensing requirements of the applicable Ohio state licensing board shall be required.
  - (m) Attestation of current OARRS account for all applicants who have a DEA registration.
- (2) The member for reappointment shall be required to submit any reasonable evidence of current ability to perform the clinical privileges requested. The chief of the clinical department shall review and evaluate the reappointment application and the supporting documentation. The chief of the clinical department shall evaluate all matters relevant to recommendation, including the member's professional competence; clinical judgment; clinical or technical skills; ethical conduct; participation in medical staff affairs; compliance with the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university; cooperation with the Ohio state university hospitals' personnel and the use of the Ohio state university hospitals' facilities for patients; relations with other physicians, other health professionals or other staff, and maintenance of a professional attitude toward patients; and the responsibility to the Ohio state university hospitals and the public.
- (3) The chief medical officer shall forward the reappointment forms and the recommendations of the chief of the clinical department 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 clinical privileges. The credentials committee shall review each member's performance-based profile to ensure that the same level of quality of care is delivered by all medical staff members with similar delineated clinical privileges across all clinical departments and across all categories of medical staff membership.

The credentials committee shall forward its recommendations to the chief medical officer at least thirty days prior to the end of the period of appointment. The chief medical officer shall transmit the completed reappointment application and the recommendation of the credentials

committee to the medical staff administrative committee.

Failure of the member to submit a reappointment application shall be deemed a voluntary resignation from the medical staff and shall result in automatic expiration of membership and all clinical privileges at the end of the medical staff member's current appointment period, which action shall not be subject to a hearing or appeal pursuant to rule 3335-43-06 of the Administrative Code. A request for reappointment subsequently received from a member who has been automatically expired shall be processed as a new appointment.

Failure of the chief of the clinical department to act timely on an application for reappointment shall be the same as provided in paragraph (E)(5) of this rule.

- (4) 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 medical staff membership. The medical staff administrative committee shall accept, reject, or modify the request for reappointment in the same manner and with the same authority as an original application for medical staff membership. The recommendation of the medical staff administrative committee regarding reappointment of a member shall be communicated by the chief medical officer, along with the recommendation of the chief medical officer, to the quality and professional affairs committee of the Wexner medical center board, and thereafter to the Wexner medical center board. When the Ohio state university Wexner medical center board has acted, the chairperson of the board shall instruct the chief medical officer to transmit the final decision to the chief of the clinical department and applicant and, if appropriate, to the director of the applicable clinical division.
  - (5) When the decision of the medical staff administrative committee results in a decision of non-reappointment or reduction, suspension or revocation of clinical privileges, the medical staff administrative committee shall instruct the chief medical officer to give written notice to the affected member of the decision, the stated reason for the decision, and the member's right to a hearing pursuant to paragraphs (A) and (B) of rule 3335-43-06 of the Administrative Code. This notification and an opportunity to exhaust the appeal process shall occur prior to an adverse decision unless the provisions outlined in paragraph (D) of rule 3335-43-05 of the Administrative Code apply. The notice by the chief medical officer shall be sent certified return receipt mail to the affected member's last known address as determined by the Ohio state university records.
  - (6) If the affected member of the medical staff does not make a written request for a hearing to the chief medical officer within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any hearing or appeal as provided in rule 3335-43-06 of the Administrative Code to which the staff member might otherwise have been entitled on the matter.
  - (7) If a timely, written request for hearing is made, the procedures set forth in rule 3335-43-06 of the Administrative Code shall apply.
- (G) Resumption of clinical activities 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 of 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.

(Board approval dates: 9/1/1999, 10/1/1999, 10/5/2001, 6/7/2002, 9/6/2002, 3/5/2003, 5/30/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 2/1/2008, 9/19/2008, 9/18/2009, 10/29/2009, 5/14/2010, 4/8/2011, 8/31/2012, 2/1/2013, 1/31/2014, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018, 8/15/2023)

**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.
- (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.

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- (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 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:
    - (a) The matter warrants no further action;
    - (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
    - (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.
- (B) Formal peer review.
- (1) Formal peer review may be initiated when a member of the medical staff of the Ohio state university hospitals:
    - (a) Fails to adhere to standards of patient care and professional conduct appropriate for a physician practicing in an academic medical center as determined by the medical staff;
    - (b) Is disruptive to the operation of the Ohio state university hospitals;
    - (c) Violates the bylaws, rules and regulations of the medical staff, the Ohio state university Wexner medical center board, or the board of trustees of the Ohio state university;
    - (d) Violates state or federal law; or
    - (e) Is responsible for acts or omissions detrimental to patient safety or to the quality or efficiency of patient care within the Ohio state university hospitals; or
    - (f) Is responsible for acts or omissions damaging to the reputation of the medical staff of the Ohio state university hospitals.

Formal peer review may be initiated by a chief of a clinical department, the chief medical officer, any member of the medical staff, the chief executive officer of the Ohio state university hospitals, the dean of the college of medicine, any member of the board of the Ohio state

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university hospitals, or the vice president for health services. All requests for formal peer review shall be in writing, shall be submitted to the chief medical officer, and shall specifically state the conduct or activities which constitute grounds for the requested action.

- (2) The chief medical officer shall promptly deliver a written copy of the request for formal peer review to the affected member of the medical staff, in a confidential manner. The chief medical officer shall then conduct a preliminary review to verify the facts related to the request for formal peer review, and within thirty days, make a written determination. If the chief medical officer decides that no further action is warranted, the chief medical officer shall notify the person(s) who filed the request for formal peer review and the member accused, in writing, that no further action will be taken.
- (3) Whenever the chief medical officer determines that formal peer review is warranted, he or she shall refer the request for formal peer review to the formal peer review committee. The affected member of the medical staff shall be notified of the referral to the formal peer review committee, and be informed that these medical staff bylaws shall govern all further proceedings.
- (4) The executive vice president for health sciences or designee shall exercise any or all duties or responsibilities assigned to the chief medical officer under these rules for implementing corrective action and appellate procedure if:
  - (a) The chief medical officer is the medical staff member charged;
  - (b) The chief medical officer has a financial interest or a relationship with any person that may have an improper effect on the exercise of his or her judgment in the matter, or may be perceived to have such an effect.
- (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. 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 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 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

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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.

- (8) If the affected member of the medical staff does not make a written request for a hearing to the chief medical officer within thirty-one days after receipt of the adverse decision, he or she shall be deemed to have waived the right to any review by the medical staff administrative committee to which the staff member might otherwise have been entitled on the matter.
- (9) If a timely, written request for hearing is made, the procedures set forth in rule 3335-43-06 of the Administrative Code shall apply.

(C) Composition of formal peer review committee.

- (1) When the determination that formal peer review is warranted is made, the chief of the clinical department shall select three members of the medical staff to serve on a formal peer review committee.
- (2) Whenever the questions raised concern the clinical competence of the member under review, the chief of the clinical department shall select members of the medical staff to serve on the formal peer review committee who shall have similar levels of training and qualifications as the member who is subject to formal peer review.
- (3) An external peer review consultant may serve as a member of the peer review committee whenever:
  - (a) A determination is made by the chief of the clinical department and the chief medical officer that the clinical expertise needed to conduct the review is not available on the medical staff;
  - (b) The objectivity of the review may be compromised; or
  - (c) Whenever the chief medical officer determines that an external review is otherwise advisable.

If an external reviewer is recommended, the chief of the clinical department shall make a written recommendation to the chief medical officer for selection of an external reviewer. The chief medical officer shall make the final selection of an external reviewer.

(D) Summary suspension.

- (1) Notwithstanding the provisions of this rule, a member of the medical staff shall have all or

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any portion of his or her clinical privileges suspended or appointment terminated by the chief medical officer or the chief of the member's clinical department whenever such action must be taken immediately, when there is imminent danger to patients or to the patient care operations. Such summary suspension shall become effective immediately upon imposition and the medical staff member shall be subsequently notified in writing of the suspension by the chief medical officer. Such notice shall be issued by certified return mail to the affected medical staff member's last known address as determined by university records.

- (2) A medical staff member whose privileges have been summarily suspended or whose appointment has been terminated shall be entitled to a hearing and appeal of the suspension pursuant to rule 3335-43-06 of the Administrative Code. If the affected member of the medical staff does not make a written request for a hearing to the chief medical officer within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any review by the medical staff administrative committee to which the staff member might otherwise have been entitled on the matter. If a timely, written request for a hearing is made, the procedures of rule 3335-43-06 of the Administrative Code shall apply.
- (3) Immediately upon the imposition of a summary suspension, the chief medical officer or the appropriate chief of a clinical department shall have the authority to provide for alternative medical coverage for the patients of the suspended medical staff member who remain in the Ohio state university hospitals 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) Notwithstanding the provisions of this rule, a temporary lapse of a medical staff member's admitting privileges, effective until medical records are completed, may be imposed automatically by the chief medical officer after a warning, in writing, of delinquency for failure to complete medical records as defined by the rules and regulations of the medical staff. The chief medical officer shall notify the chief executive officer of the Ohio state university hospitals of the action taken.
- (2) Action by the Ohio state boards of licensure revoking or suspending a medical staff member's license or placing the member upon probation shall automatically impose the same restrictions to that member's Ohio state university hospitals' privileges.
- (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 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 immediately and automatically terminate, unless resignation in lieu of automatic terminations is permitted to rule 3335-43-04(A)(3).
- (5) If a medical staff member pleads guilty to or is found guilty of a felony which involves: violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; fraud, bribery, evidence tampering, or perjury; or a drug offense, the medical staff member's



appointment and privileges shall be immediately and automatically terminated.

- (6) Whenever a medical staff member's drug enforcement administration (DEA) or other controlled substances number is revoked, he or she shall be immediately and automatically divested of his or her right to prescribe medications covered by the number.
  - (7) When a medical staff member's DEA or other controlled substances number is suspended or restricted in any manner, his or her right to prescribe medications covered by the number is similarly automatically suspended or restricted during the term of the suspension or restriction.
  - (8) No medical staff member shall be entitled to the procedural rights set forth in rule 3335-43-06 of the Administrative Code as a result of an automatic suspension or termination. As soon as practicable after the imposition of an automatic suspension, the medical staff administrative committee shall convene to determine if further corrective action is necessary. Any further action with respect to an automatic suspension must be taken in accordance with this rule.
  - (9) Resignation, termination, or non-reappointment to the faculty of the Ohio state university shall result in immediate termination of membership on the medical staff of the Ohio state university hospitals.
- (F) Reporting responsibility.

When a decision on corrective action is taken which constitutes a "formal disciplinary action" as may be defined in Ohio state law, or as may be required to be reported pursuant to federal law, including the health care quality improvement act, the chief medical officer shall ensure that a report of said action is made in order to maintain compliance with applicable state or federal law or regulations. The chief medical officer shall ensure that such reports are amended as may be required to reflect subsequent actions taken under the hearing and appeal rights afforded in these bylaws.

When applicable, any recommendations or actions that are the result of a review or hearing and appeal shall be monitored by the chief medical officer on an ongoing basis through the Ohio state university hospitals' quality management activities.

(Board approval dates: 6/7/2002, 5/6/2005, 2/1/2008, 9/19/2008, 9/18/2009, 5/14/2010, 4/8/2011, 11/7/2014, 11/6/2015, 4/6/2018)

**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, 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.
  - (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 ~~community affiliate B and~~ community affiliate C medical staff appointments upon approval by the Wexner medical center board.
- (3) All hearings and appeals 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.

- (1) The request for a hearing shall be submitted in writing by the affected medical staff member to the chief medical officer within thirty days of notification by the chief medical officer of the intended action. The chief medical officer shall forward the request to the medical staff administrative committee along with instructions to convene a hearing.
- (2) The failure of a medical staff member to request a hearing, to which the member is entitled by these bylaws within the time and in the manner herein provided, shall be deemed a waiver of the right to any review by the medical staff administrative committee. The chief medical officer shall then implement the decision and that action shall become and remain effective against the medical staff member in the same manner as a final decision of the Ohio state university Wexner medical center board as provided for in paragraph (F) of rule 3335-43-05 of the Administrative Code. The chief medical officer shall promptly inform the affected medical staff member that the proposed decision, which had entitled the medical staff member to a hearing, has now become final.

(C) Notice of hearing.

- (1) After receipt of a timely request for hearing by the chief medical officer from a medical staff member entitled to such hearing, the medical staff administrative committee shall be notified of the request for hearing by the chief medical officer and shall at the next scheduled meeting take the following action:
  - (a) Instruct the chief medical officer and chief of staff to jointly appoint within seven days a hearing committee, consisting of five members of the medical staff who are not members of the medical staff administrative committee, are not direct competitors, do not have a conflict of interest, and who have not previously participated in the formal peer review of the matter under consideration.
  - (b) Instruct the hearing committee to schedule and arrange for a hearing which hearing shall be conducted not less than thirty days nor more than sixty days from the date of the receipt of the request for hearing by the chief medical officer; provided, however, that a hearing for a medical staff member who is under suspension, which is then in effect, shall be held as soon as arrangements may be reasonably made.
- (2) The medical staff member shall be given at least ten days prior notice of the scheduled hearing, provided that this notice may be waived in writing by the medical staff member.

Notice shall be by certified return receipt mail to the staff member at the staff member's last known address as reflected by university records. The notice of hearing shall state in concise language the acts or omissions with which the medical staff member is charged; a list of representative medical records or documents being used; names of potential witnesses to be called; and any other reason or evidence that may be considered by the hearing committee during the hearing.

(D) Conduct of hearing.

- (1) The hearing committee shall select a chairperson from the committee to preside over the hearing. The chairperson may require a representative for the individual and for the medical staff administrative committee (or the Wexner medical center board) to participate in a pre-hearing conference. At the pre-hearing conference, the chairperson shall resolve all procedural questions, including any objections to exhibits or witnesses, the role of legal counsel, and determine the time to be allotted to each witness's testimony and cross-examination.

The hearing committee shall have benefit of Ohio state university legal counsel. The hearing committee may grant continuances, recesses, and the chairperson may excuse a member of the hearing committee from attendance temporarily for good cause, provided that there shall be at no time less than four members of the hearing committee present unless the affected staff member waives this requirement.

All members of the hearing committee must be present to deliberate and vote. No member may vote by proxy. The person who has taken action from which the affected staff member has requested the hearing shall not participate in the deliberation or voting of the hearing committee. The hearing shall be a de novo hearing, although evidence of the prior recommendations and decisions may be presented.

- (2) An accurate record of the hearing shall be kept. The mechanism for taking the record shall be by the use of a professional stenographer. This record shall be available to the affected member of the medical staff upon request at the member's expense.
- (3) The personal presence of the medical staff member for whom the hearing has been scheduled shall be required. A medical staff member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived all rights to appear and to have a hearing before the medical staff administrative committee in the same manner as provided in paragraph (B) of this rule, and to have accepted the adverse recommendation or decision involved and the same shall therein become and remain in effect as provided in paragraph (B) of this rule. The medical staff administrative committee may, in its own discretion, order the hearing committee to proceed with the hearing without the medical staff member and impose a sanction which is greater or lesser than that originally imposed.
- (4) The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or presentation of evidence. Any relevant matters upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The member of the medical staff for whom the hearing is being held shall, prior to, or during the hearing, be entitled to submit memoranda concerning any issues of procedure or of fact and such memoranda shall become a part of the hearing record.
- (5) The affected medical staff member shall have the following rights: to be represented by an attorney at law and to call and examine witnesses; to introduce evidence; to cross-examine any witnesses on any matter relevant to the issue of the hearing; and to challenge any witness and to rebut any evidence. If the medical staff member does not testify in his or her

own behalf, the staff member may be called and examined as if under cross-examination.

- (6) The hearing committee shall request the person who has taken the action from which the affected staff member has requested the hearing to present evidence to the hearing committee in support of the adverse recommendation. The hearing committee may proceed to hear evidence and testimony from either party in whatever order the hearing committee deems appropriate. The hearing committee may call its own witnesses, may recall any parties witnesses, and may question witnesses as it deems appropriate. All parties shall be responsible to secure the attendance of their own witnesses. All witnesses and evidence received by the hearing committee shall be open to challenge and cross-examination by the parties. Witnesses shall not be placed under oath. At the close of the evidence the hearing committee may request each party to make summary statements, either oral or written. The hearing committee may request legal representation from the Ohio state university.
- (7) The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing committee shall make its best effort to expeditiously determine the issues presented. The hearing committee may elect to limit its proceedings when sufficient material has been received. The parties may be required by the hearing committee to provide evidence in oral or written form. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the medical staff member for whom the hearing was convened.
- (8) Within sixty days after its appointment, the hearing committee shall forward its written report and recommendation together with the transcript of the hearing and all other documentation provided by the parties to the medical staff administrative committee. The affected medical staff member shall be notified of the recommendation of the hearing committee including a statement of the basis for the recommendation. The medical staff administrative committee shall accept, reject, or modify the recommendation of the hearing committee. The medical staff administrative committee may conduct further hearings as it deems necessary or may remand the matter back to the hearing committee for further action as directed. The medical staff administrative committee may impose a greater or lesser sanction than that recommended by the hearing committee.
- (9) The medical staff administrative committee shall submit a written report, including its recommendation to the chairperson of the Wexner medical center board within fourteen days of the final vote by the medical staff administrative committee. An adverse action which must be reported to the state medical board or the federal government, including the national practitioner data bank, shall entitle an affected medical staff member to the procedures of this rule. The affected member of the medical staff shall be notified of the decision of the medical staff administrative committee by the chief medical officer.
- (10) The decision and record of the medical staff administrative committee shall be transmitted to the quality and professional affairs committee of the Wexner medical center board, which shall, subject to the affected member's right to appeal and implementation of paragraph (E) of this rule, consider the matter at its next scheduled meeting, or at a special meeting to be held no less than thirty days following receipt of the transmittal. The quality and professional affairs committee may accept, reject, or modify the decision of the medical staff administrative committee. The quality and professional affairs committee may remand that matter back to the medical staff administrative committee for further action as directed.
- (11) The recommendation of the quality and professional affairs committee shall be promptly considered by the Wexner medical center board, at its next scheduled meeting. The Wexner medical center board may accept, reject, or modify the recommendation of the quality and professional affairs committee. The Wexner medical center board may remand the matter

back to the medical staff administrative committee for further action as directed.

- (12) A copy of the Wexner medical center board decision shall be sent certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records.
- (E) Appeal process.
- (1) Within thirty days after receipt of a notice by an affected medical staff member of the decision of the medical staff administrative committee, the member may, by written notice to the chairperson of the Ohio state university Wexner medical center board, request an appeal. The appeal shall only be held on the record before the medical staff administrative committee.
  - (2) If an appeal is not requested within thirty days, the affected medical staff member shall be deemed to have:
    - (a) Waived the member's right to appeal, and
    - (b) Accepted the adverse decision.
  - (3) The appeal shall be conducted by the quality and professional affairs committee of the Wexner medical center board.
  - (4) The affected medical staff member shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the medical staff administrative committee. The staff member shall then submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the quality and professional affairs committee no later than seven days following the date of the affected member's notice of appeal.
  - (5) New or additional matters not raised during the hearing or in the medical staff administrative committee hearings shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.
  - (6) Within fourteen days following submission of the written statement by the affected medical staff member, the quality and professional affairs committee shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the medical staff administrative committee for further review and recommendation. Such referral to the medical staff administrative committee may include a request for further investigation.
  - (7) Any final decision by the Wexner medical center board shall be communicated by the chief medical officer and by certified return receipt mail to the affected medical staff member at that member's last known address as determined by university records. The chief medical officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief executive officer of the Ohio state university hospitals and the vice president for health services, chief of staff, the chief of the clinical department, and the person(s) who initiated the request for formal peer review. The chief medical officer shall take immediate steps to implement the final decision.

(Board approval dates: 6/7/2002, 5/6/2005, 2/1/2008, 9/19/2008, 9/18/2009, 5/14/2010, 4/8/2011, 11/7/2014, 11/6/2015, 4/6/2018, 8/15/2023)

**3335-43-07 Categories of the medical staff.**

The medical staff of the Ohio state university hospitals shall be divided into nine categories: attending, community affiliate A, community affiliate B, community affiliate C, community affiliate D, consulting, contracted, physician scholar 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 but are otherwise subject to the provisions of these bylaws.

(A) Attending.

- (1) Qualifications: The attending medical staff shall consist of those faculty members of the colleges of medicine and dentistry to whom clinical teaching responsibilities are assigned in the Ohio state university hospitals and who satisfy the requirements and qualifications for membership set forth in rule 3335-43-04 of the Administrative Code. The assignment of teaching responsibility is the prerogative of the chief of the clinical department or the chief's designee.

- (2) Prerogatives.

An attending medical staff member may:

- (a) Admit patients consistent with their clinical privileges and the balanced teaching and patient care responsibilities of the Ohio state university hospitals. When, in the judgment of the chief of the clinical department, a balanced teaching program is jeopardized, following consultation with the dean of the college of medicine; and the Ohio state university hospitals' chief executive officer, and with the concurrence of a majority of the medical staff administrative committee, the chief of the clinical department may restrict an attending medical staff member's ability to admit patients. Imposition of such restrictions shall not entitle the attending medical staff member to a hearing or appeal pursuant to rule 3335-43-06 of the Administrative Code.
- (b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.
- (c) Vote on all matters presented at general and special meetings of the medical staff and of the department and committees of which he or she is a member unless otherwise provided by resolution of the medical staff, clinical department, or committee and approved by the medical staff administrative committee.
- (d) Hold office in the medical staff organization and in the clinical department and committees of which he or she is a member, unless otherwise provided by resolution of the medical staff, clinical department, or committee and approved by the medical staff administrative committee.

- (3) Responsibilities.

Each member of the attending medical staff with clinical privileges shall:

- (a) Meet the basic responsibilities set forth in rules 3335-43-02 and 3335-43-03 of the Administrative Code.
- (b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the Ohio state university hospitals for whom the member is providing care, or arrange a suitable alternative for such care and supervision.

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- (c) Actively participate in such quality evaluation and monitoring activities as required by the medical staff, and discharge such medical staff functions as may be required from time to time.
- (d) Satisfy the requirements set forth in rule 3335-43-11 of the Administrative Code for attendance at staff and departmental meetings and meetings of those committees of which he or she is a member and for payment of membership dues.
- (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. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services which the limited staff member is competent to perform under supervision.
- (f) Supervise other licensed healthcare professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed healthcare professional to perform only those services which the licensed healthcare professional is privileged to perform.
- (g) Take call as assigned by the chief of the clinical department.

(B) Community Affiliate A.

- (1) **Qualifications:** The community affiliate A medical staff shall consist of physicians and other licensed healthcare professional who do not meet the criteria for attending medical staff appointment. This category includes community physicians and physicians employed by an affiliate entity who have clinical activity required for membership and actively participate in teaching programs.
- (2) **Prerogatives.**

The community affiliate A medical staff may:

- (a) Exercise such clinical privileges as are granted pursuant to these bylaws.
  - (b) Admit, consistent with their clinical privileges, patients who complement the clinical teaching program.
  - (c) Attend meetings as a member of the medical staff and the clinical department of which he or she is a member and any medical staff or the Ohio state university hospitals education programs. The community affiliate A medical staff member may vote on medical staff policies, bylaws, rules and regulations and for elected officials of the medical staff. Members of the community affiliate A medical staff may be appointed to serve on medical staff committees as provided by these bylaws.
- (3) **Responsibilities:** Each member of the community affiliate A medical staff with clinical privileges shall be required to have a faculty appointment and discharge the basic responsibilities specified in paragraph (B)(3) of this rule.

(C) Community affiliate B.

- (1) **Qualifications:** The community affiliate B medical staff shall consist of those doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who are employed by an affiliate entity, do not have patient activity at university hospitals but who are enrolled under institutional managed care contracts or other contractual arrangements and who work at facilities not owned by the Wexner medical center. Community affiliate B medical

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staff members shall not be required to obtain appointment to the faculty of the Ohio state university and will not possess clinical privileges. Community affiliate B medical staff shall not be eligible to hold office or required to pay medical staff dues and shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws. Community affiliate B medical staff shall not be assigned to a clinical department under rule 3335-43-08 of the Administrative Code.

(2) Appointment and Reappointment: For purposes of processing applications for appointment and reappointment of community affiliate B medical staff, the duties of the chief of the clinical department set forth in rule 3335-43-04 of the Administrative Code shall be assigned by the chief medical officer to be performed by the chief physician of the affiliate entity or authorized designee. To perform these duties on behalf of community affiliate B medical staff, the chief physician or authorized designee must be an active member of the medical staff under these bylaws and will also serve as a voting member on the Medical Staff Administrative Committee.

(2)(3) Termination of medical staff membership: The medical staff membership of a community B affiliate physician shall automatically terminate upon loss of employment with the affiliate entity. This automatic termination shall not entitle the community B affiliate physician to any of the hearing processes set forth in rule 3335-43-06 of the Administrative Code.

(D) Community affiliate C.

(1) Qualifications: The community affiliate C medical staff shall consist of those physicians and other licensed healthcare professionals who do not qualify for attending medical staff appointment and shall not possess clinical privileges. This category is comprised of referring physicians who desire to be associated with the Ohio state university hospitals to refer and follow patients. Community affiliate C medical staff members shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws, shall not be eligible to hold office and are not required to pay medical staff dues.

(2) Prerogatives.

Community affiliate C medical staff members may:

- (a) Have access to the Ohio state university hospitals and shall be given notice of all medical staff activities and meetings.
- (b) Attend meetings as a member of the medical staff and the clinical departments of which he or she is a member and any medical staff or the Ohio state university hospitals education programs.
- (c) The grant of community affiliate C medical staff appointment to physicians is a courtesy only and may be terminated by the Wexner medical center board upon recommendation of the medical staff administrative committee without the right to a hearing or appeal.

(E) Community affiliate D.

This is a closed medical staff category that was created as a one-time historicalgrandfathering category for medical staff members of the Ohio state university hospitals east prior to July 1, 2007.

(1) Qualifications: Community affiliate D medical staff shall consist of those doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who:

- (a) Do not qualify for an attending medical staff appointment; and
- (b) Are community affiliate D members seeking reappointment; and
- (c) Satisfy the requirements and qualifications set forth in rule 3335-43-04 of the Administrative Code and are already appointed to the community affiliate D medical



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staff pursuant to these bylaws.

- (2) A community affiliate D medical staff member shall meet and maintain the same standards for quality patient care applicable to all members of the medical staff. Community affiliate D medical staff members shall be subject to these bylaws and the rules and regulations of the medical staff except as provided in this paragraph. The community affiliate D medical staff member shall not be required to obtain appointment to the faculty of the Ohio state university. The community affiliate D medical staff member shall not be subject to the requirement for board certification within the community affiliate D medical staff member's respective area of practice if that requirement was waived when he or she became a member of the Ohio state

university east medical staff. Teaching and research accomplishments shall not be required in determining the qualifications of applicants to this category of the medical staff.

- (3) To optimize the clinical organization, resource utilization, and planning of the hospitals, the chief of the clinical department may require that the applicant for community affiliate D medical staff membership to identify categories of diagnosis, extent of anticipated patient activity, and service areas to be utilized and may prepare a statement of participation for the applicant which will be made a part of the application for appointment.
- (4) Prerogatives.

A community affiliate D medical staff member may:

- (a) Admit patients consistent with the limitations of bed and service allocations established by the medical directors and approved by the medical staff administrative committee, and the Wexner medical center board. If, in the judgment of the medical directors, a balanced teaching program is jeopardized, following consultation with the chief of the clinical department, and with the concurrence of a majority of the medical staff administrative committee, the medical director may restrict admissions of members of the community affiliate D medical staff. Patients admitted under the care of the community affiliate medical staff D will not be required to participate in the educational mission of the Ohio state university hospitals. Ordinarily, no coverage by the limited medical staff will be afforded, with the exception of emergency medical services.
  - (b) Exercise the clinical privileges granted, have access to all medical records, and be entitled to utilize the facilities of the Ohio state university hospitals incidental to the clinical privileges granted pursuant to these bylaws.
  - (c) Attend teaching and educational conferences approved by the Ohio state university, attend medical staff social functions, and participate as providers in the Ohio state university or the Ohio state university hospitals affiliated health plans.
- (5) Responsibilities:.

Each member of the community affiliate D medical staff shall:

- (a) Participate in the management of and represent the interests of the clinical department for which he or she is granted clinical privileges. The community affiliate D medical staff member shall comply with all provisions of these bylaws and rules and regulations of the medical staff, unless expressly exempted under this rule.
- (b) The community affiliate D medical staff member shall comply with all the Ohio state university hospitals' policies and accreditation standards, and shall be subject to the same quality evaluation, monitoring, and resource management requirements as other members of the medical staff.
- (c) Be responsible within the member's area of professional competence for the continuous care and supervision of each patient in the Ohio state university hospitals for whom the member is providing care, or arrange a suitable alternative for such care and supervision.
- (d) Not be eligible to vote on medical staff policies, rules and regulations, or bylaws or to hold office. Members of the community affiliate D medical staff may serve on non-elected medical staff committees as provided by these bylaws.

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- (e) Be subject to payment of medical staff dues or assessments as approved by the medical staff.

(F) Consulting.

- (1) Qualifications. The consulting medical staff shall consist of those faculty members of the colleges of medicine and dentistry who:
  - (a) Satisfy the requirements and qualifications for membership set forth in rule 3335-43-04 of the Administrative Code.
  - (b) Are consultants of recognized professional ability and expertise who provide a service not readily available from the attending medical staff. These practitioners provide services at the Ohio state university hospitals only at the request of attending or community affiliate A members of the medical staff.
  - (c) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of the Ohio state university hospitals. The practitioner shall also hold at such other hospital the same privileges, without restriction, that he/she is requesting at the Ohio state university hospitals. An exception to this qualification may be made by the Wexner medical center board provided the practitioner is otherwise qualified by education, training and experience to provide the requested service.

(2) Prerogatives.

Consulting medical staff members may:

- (a) Exercise the clinical privileges granted for consultation purposes on an occasional basis when requested by an attending or community affiliate A medical staff member.
- (b) Have access to all medical records and be entitled to utilize the facilities of the Ohio state university hospitals incidental to the clinical privileges granted pursuant to these bylaws.
- (c) Not admit patients to the Ohio state university hospitals.
- (d) Not vote on medical staff policies, rules and regulations, or bylaws, and may not hold office.
- (e) Must actively participate in such quality evaluation and monitoring activities as required by the medical staff and as outlined in the medical staff policy entitled "Consulting medical staff member policy."
- (f) Attend medical staff meetings, but shall not be entitled to vote at such meetings or hold office.
- (g) Attend department meetings, but shall not be entitled to vote at such meetings or serve as chief of a clinical department.
- (h) Serve as a non-voting member of a medical staff committee; provided, however, that he/she may not serve as a committee chair or as a member of the medical staff administrative committee.

(3) Responsibilities.

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Each member of the consulting medical staff shall:

- (a) Meet the basic responsibilities set forth in rules 3335-43-02 and 3335-43-03 of the Administrative Code.
- (b) Be exempt from all medical staff dues.

(G) Contracted.

- (1) Qualifications: contracted medical staff shall consist of those members who meet the requirements for medical staff membership and are providing services to Wexner medical center patients exclusively through a contract with the Wexner medical center. Contracted medical staff members shall meet and maintain the same standards for quality patient care applicable to all members of the medical staff and shall be subject to these bylaws and the rules and regulations of the medical staff except as provided in this paragraph.

Contracted medical staff shall not be required to obtain appointment to the faculty of the Ohio state university. Contracted medical staff shall not be eligible to vote on medical staff policies, rules and regulations, or bylaws, shall not be eligible to hold office or required to pay medical staff dues.

- (2) Prerogatives.

Contracted medical staff may:

- (a) Exercise such clinical privileges as are granted pursuant to these bylaws.
- (3) Any contracted medical staff member whose membership has been terminated due to loss of contract and/or clinical privileges shall not be entitled to request a hearing and appeal in accordance with rule 3335-43-06 of the Administrative Code.

(H) 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 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.

(I) 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.

- (a) The limited staff shall consist of doctors of medicine, osteopathic medicine, dentists and practitioners of podiatry or psychology who are accepted in good standing by a program director into a post-doctoral graduate medical education program and appointed to the limited staff in accordance with these bylaws.
- (b) The limited staff shall maintain compliance with the requirements of state law, including regulations adopted by the Ohio state university Wexner medical center board, or the limited staff member's respective licensing board.
- (c) Members of the limited staff shall possess a valid training certificate or an unrestricted Ohio license from the applicable state board based on eligibility criteria defined by that state board. All members of the limited staff shall be required to successfully obtain an Ohio training certificate prior to beginning training within a program.

(2) Responsibilities.

Each member of the limited staff shall:

- (a) Be responsible to respond to all questions and to complete all forms as may be required by the credentials committee.
- (b) Participate fully in the teaching programs, conferences, and seminars of the clinical department in which he or she is appointed in accordance with accreditation standards and policies and procedures of the graduate medical education committee and approved clinical training programs.
- (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 or community affiliate A 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 or community affiliate A 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 or community affiliate A medical staff. The limited staff member shall follow all rules and regulations of the service to which the limited staff member is assigned, as well as the general rules of the Ohio state university hospitals pertaining to limited staff. Specifically, a limited staff member shall consult with the attending or community affiliate A member of the medical staff responsible for the care of the patient before the limited staff member undertakes a procedure or treatment that carries a significant, material-risk to the patient unless the consultation would cause a delay that would jeopardize the life or health of the patient.
- (d) Serve as a member of various medical staff committees in accordance with established committee composition as described in these bylaws and/or the rules and regulations of the medical staff. The limited staff member shall not be eligible to vote or hold elected office in the medical staff organization but may vote on committees to which the limited staff member is assigned.
- (e) Be expected to make regular satisfactory professional progress including anticipated certification by the respective specialty or sub-specialty program of post-doctoral training in which the limited staff member is enrolled. Evaluation of professional growth and appropriate humanistic qualities shall be made on a regular schedule by

the clinical departmental chief, program director, teaching faculty or evaluation committee in accordance with accreditation standards and policies and procedures of the approved training programs.

- (f) Appeal by a member of the limited staff of probation, lack of 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 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.

Termination of employment from the limited staff member's residency or fellowship training program shall result in automatic termination of the limited staff member's appointment pursuant to these bylaws.

- (4) Temporary appointments.

- (a) Limited staff members who are Ohio state university faculty may be granted an early commencement or an extension of appointment upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, when it is necessary for the limited staff member to begin his or her training program prior to or extend his or her training program beyond a regular appointment period. These appointments shall not exceed sixty days.
- (b) Temporary appointments may be granted upon the recommendation of the chief of the clinical department, with prior concurrence of the medical directors, for limited staff members who are not Ohio state university faculty but who, pursuant to education affiliate agreements approved by the university, need to satisfy approved graduate medical education clinical rotation requirements. These appointments shall not exceed a total of one hundred twenty days in any given post-graduate year. In such cases, the mandatory requirement for a faculty appointment may be waived. All other requirements for limited staff member appointment must be satisfied.

- (5) Supervision.

Limited staff members shall be under the supervision of an attending or community affiliate 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 community affiliate 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 community affiliate A medical staff member. Any concerns or problems that arise in the limited staff member's performance should be directed to the attending or community affiliate A 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 or community affiliate A medical staff member.

- (b) All records of limited staff member cases must document involvement of the attending or community affiliate 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.

(J) Temporary medical staff appointment.

- (1) External peer review. When peer review activities are being conducted by someone other than a current member of the medical staff, the chief medical officer may admit a practitioner to the medical staff for a limited period of time. Such membership is solely for the purpose of conducting peer review in a particular evaluation and this temporary membership automatically expires upon the member's completion of duties in connection with such peer review. Such appointment does not include clinical privileges, and is for a limited purpose.
- (2) Proctoring. Temporary privileges may be extended to visiting medical faculty for special clinical or educational activities as provided by the Ohio state medical or dental board. When medical staff members require proctoring for the purposes of gaining experience to become credentialed to perform a procedure, a visiting physician may apply for temporary privileges per the prescribed medical staff proctoring policy.

(K) Clinical privileges.

- (1) Delineation of clinical privileges.

- (a) Every person practicing at the Ohio state university hospitals by virtue of medical staff membership, faculty appointment, contract or under authority granted in these bylaws shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically applied for and granted to the staff member or other licensed health care professional by the Ohio state university Wexner medical center board after recommendation from the medical staff administrative committee.

Each clinical department shall develop specific clinical criteria and standards for the evaluation of clinical privileges with emphasis on invasive or therapeutic procedures or treatment which present 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.

- (b) Requests for the exercise and delineation of clinical privileges must be made as part of each application for appointment or reappointment to the medical staff on the forms prescribed by the medical staff administrative committee. Every person in an administrative position who desires clinical privileges shall be subject to the same procedure as all other applicants. Requests for clinical privileges must be submitted to the chief of the clinical department in which the clinical privileges will be exercised. Clinical privileges requested other than during appointment or reappointment to the medical staff shall be submitted to the chief of the clinical department and such request must include documentation of relevant training or experience supportive of the request.
- (c) The chief of the clinical department shall review each applicant's request for clinical privileges and shall make a recommendation regarding clinical privileges to the chief medical officer. Requests for clinical privileges shall be evaluated based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information, including the direct observation and review of records of the applicant's performance by the clinical department in which the clinical

privileges are exercised. Whenever possible the review should be of primary source information.

- (d) The applicant shall have the burden of establishing the applicant's qualifications and competency in clinical privileges requested and shall have the burden of production of adequate information for the proper evaluation of qualifications.
  - (e) The applicant's request for clinical privileges and the recommendation of the chief of the clinical department shall be forwarded to the credentials committee and shall be processed in the same manner as applications for appointment and reappointment pursuant to rule 3335-43-04 of the Administrative Code.
  - (f) Medical staff members who are granted new or initial privileges are subject to FPPE, which is a six-month period of focused monitoring and evaluation of practitioners' professional performance. Following FPPE medical staff members with clinical privileges are subject to ongoing professional practice evaluation (OPPE), which information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. FPPE and OPPE are fully detailed in medical staff policies that were approved by the medical staff administrative committee and the Wexner medical center board.
  - (g) Upon resignation, termination or expiration of the medical staff member's faculty appointment or employment with the university for any reason, such medical staff appointment and clinical privileges of the medical staff member shall automatically expire.
  - (h) Medical staff members authorize the Ohio state university hospitals and clinics to share credentialing, quality and peer review information pertaining to the medical staff member's clinical competence and/or professional conduct. Such information may be shared at initial appointment and/or reappointment and at any time during the medical staff member's medical staff appointment to the medical staff of the Ohio state university hospitals.
  - (i) Medical staff members authorize the Ohio state university hospitals to release information, in good faith and without malice, to managed care organizations, regulating agencies, accreditation bodies and other health care entities for the purposes of evaluating the medical staff member's qualifications pursuant to a request for appointment, clinical privileges, participation or other credentialing or quality matters.
- (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. All temporary privileges are granted by the chief executive officer or authorized designee. 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.

- (b) Temporary privileges may be extended to visiting medical faculty or for special



activity as provided by the Ohio state medical or dental board.

- (c) Temporary privileges granted for locum tenens may be exercised for a maximum of ninety days, consecutive or not, any time during the thirty-six month period following the date they are granted.
- (d) Practitioners granted temporary privileges will be restricted to the specific delineations for which the temporary privileges are granted. The practitioner will be under the supervision of the chair of the clinical department while exercising any temporary privileges granted.
- (e) Special privileges. Upon receipt of a written request for specific temporary privileges and the approval of the clinical department chief and the chief medical officer, an appropriately licensed practitioner of documented competence, who is not an applicant for medical staff membership, may be granted special privileges for the care of one or more specific patients. Such privileges shall be exercised in accordance with the conditions specified in these bylaws.
- (f) Practitioners exercising temporary privileges shall abide by these medical staff bylaws, rules and regulations, and hospital and medical staff policies.
- (g) The temporary and special privileges must be in conformity with accrediting bodies' standards and the rules and regulations of the professional boards of Ohio.

(3) Expedited privileges.

If the Wexner medical center board is not scheduled to convene in a timeframe that permits the timely consideration of the recommendation of a complete application by the medical staff administrative committee, applicants may be granted expedited privileges by the quality and professional affairs committee of the Wexner medical center board. Certain restrictions apply to the appointment and granting of clinical privileges via the expedited process. These include but are not limited to: an involuntary termination of medical staff membership at another hospital, involuntary termination of medical staff membership at another hospital, involuntary limitation, or reduction, denial or loss of clinical privileges, a history of professional liability actions resulting in a final judgement against the applicant or a challenge by a state licensing board.

(4) Podiatric privileges.

- (a) Practitioners of podiatry may admit patients to the Ohio state university hospitals if such patients are being admitted solely to receive care that a podiatrist may provide without medical assistance, pursuant to the scope of the professional license of the podiatrist. Practitioners of podiatry must, in all other circumstances, co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine. A member of the medical staff who is a doctor of medicine or osteopathy shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals.
- (b) A member of the medical staff who is a doctor of medicine or osteopathy:
  - (i) Shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals; and
  - (ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnosis or therapeutic interventions defined by the medical staff.

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- (c) Practitioners of podiatry shall be responsible for the podiatric care of the patient including the podiatric history and physical examination and all appropriate elements of the patient's record.
  - (d) The podiatrist shall be responsible to the chief of the department of orthopaedics.
- (5) Psychology privileges.
- (a) Psychologists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license to practice. Psychologists shall not prescribe drugs, or perform surgical procedures, or in any other way practice outside the area of their approved clinical privileges or expertise, unless otherwise authorized by law.
  - (b) Psychologists may not admit patients to the Ohio state university hospitals, but may diagnose and treat a patient's psychological illness as part of the patient's comprehensive care while hospitalized. All patients admitted for psychological care shall receive the same medical appraisal as all other hospitalized patients. A member of the medical staff who is a doctor of medicine or osteopathic medicine shall admit the patient and shall be responsible for the history and physical and any medical care that may be required during the hospitalization, and shall determine the appropriateness of any psychological therapy based on the total health status of the patient. Psychologists may provide consultation within their area of expertise on the care of patients within the Ohio state university hospitals.  
  
In outpatient settings, psychologists shall diagnose and treat their patients' psychological illness. Psychologists shall ensure that their patients receive referral for appropriate medical care.
  - (c) Psychologists shall be responsible to the chief of the clinical department in which they are appointed.
- (6) Dental privileges.
- (a) Practitioners of dentistry, who have not been granted clinical privileges as oral and maxillofacial surgeons, may admit patients to the Ohio state university hospitals if such patients are being admitted solely to receive care which a dentist may provide without medical assistance, pursuant to the scope of the professional license of the dentist. Practitioners of dentistry must, in all other circumstances co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine. A member of the medical staff who is a doctor of medicine or osteopathy shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals.
  - (b) A member of the medical staff who is a doctor of medicine or osteopathy:
    - (i) Shall be responsible for any medical problems that the patient has while an inpatient of the Ohio state university hospitals; and
    - (ii) Shall confirm the findings, conclusions and assessment of risk prior to high-risk diagnosis or therapeutic interventions defined by the medical staff.
  - (c) Practitioners of dentistry shall be responsible for the dental care of the patient including the dental history and physical examination and all appropriate elements of the patient's record.

(7) Oral and maxillofacial surgical privileges.

All patients admitted to the Ohio state university hospitals for oral and maxillofacial surgical care shall receive the same medical appraisal as all other hospitalized patients. Qualified oral and maxillofacial surgeons shall admit patients, shall be responsible for the plan of care for the patients, shall perform the medical history and physical examination, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s), and shall be responsible for the medical care that may be required at the time of admission or that may arise during hospitalization.

(8) Other licensed health care professionals.

(a) Clinical privileges may be exercised by licensed health care professionals who are duly licensed in the state of Ohio, and who are either:

(i) Members of the faculty of the Ohio state university, or

(ii) Employees of the Ohio state university whose employment involves the exercise of clinical privileges, or

(iii) Employees or members of the medical staff.

(b) A licensed health care professional as used herein, shall not be eligible for medical staff membership but shall be eligible to exercise those clinical privileges granted pursuant to these bylaws and in accordance with applicable Ohio state law. If granted such privileges under this rule and in accordance with applicable Ohio state law, other licensed health care professionals may perform all or part of the medical history and physical examination of a patient. Licensed health care professionals with privileges are subject to FPPE and OPPE.

(c) Licensed health care professionals shall apply and re-apply for clinical privileges on forms prescribed by the medical staff administrative committee and shall be processed in the same manner as provided in rule 3335-43-04 of the Administrative Code subject to the provisions of paragraph (G)(8) of this rule.

(d) Licensed health care professionals are not members of the medical staff, but may write admitting orders for patients of the Ohio state university hospitals when granted such privileges under this rule and in accordance with applicable Ohio state law. If such privileges are granted, the patient will be admitted under the medical supervision of the responsible medical staff member. Licensed health care professionals and shall not be eligible to hold office, to vote on medical staff affairs, or serve on standing committees of the medical staff unless specifically authorized by the medical staff administrative committee.

(e) Each licensed health care professional shall be individually assigned to a clinical department and shall be sponsored by one or more members of the medical staff. The licensed health care professional's clinical privileges are contingent upon the sponsoring medical staff member's privileges. In the event that the sponsoring medical staff member loses privileges or resigns, the licensed health care professionals whom he or she has sponsored shall be placed on administrative hold until another sponsoring medical staff member is assigned. The new sponsoring medical staff member must be assigned in less than thirty days.

(f) Licensed health care professionals must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials as required by Ohio law, and may only exercise those clinical privileges granted in accordance

with provisions relating to their respective professions.

- (g) Only applicants who can document the following shall be qualified for clinical privileges as a licensed health care professional:
  - (i) Current license, certification, or other legal credential required by Ohio law.
  - (ii) Certificate of authority, standard care agreement, or utilization plan.
  - (iii) Education, training, professional background and experience, and professional competence.
  - (iv) Patient care quality indicators definition for initial appointment. This data will be in a format determined by the licensed health care professional subcommittee and the quality management department.
  - (v) Adherence to the ethics of the profession for which an individual holds a license, certification, or other legal credential required by Ohio law.
  - (vi) Evidence of required immunization.
  - (vii) Evidence of good personal and professional reputation as established by peer recommendations.
  - (viii) Satisfactory physical and mental health to perform requested clinical privileges.
  - (xi) Ability to work with members of the medical staff and the Ohio state university hospitals employees.
- (h) The applicant shall have the burden to produce documentation with sufficient adequacy to assure the medical staff and the Ohio state university hospitals that any patient cared for by the licensed health care professional seeking clinical privileges shall be given quality care, and that the efficient operation of the Ohio state university hospitals will not be disrupted by the applicant's care of patients in the Ohio state university hospitals.
- (i) By applying for clinical privileges as a licensed health care professional, the applicant agrees to the following terms and conditions:
  - (i) The applicant has read the bylaws and rules and regulations of the medical staff of the Ohio state university hospitals and agrees to abide by all applicable terms of such bylaws and any applicable rules and regulations, including any subsequent amendments thereto, and any applicable Ohio state university hospitals policies that the Ohio state university hospitals may from time to time put into effect.
  - (ii) The applicant releases from liability all individuals and organizations who provide information to the Ohio state university hospitals regarding the applicant and all members of the medical staff, the Ohio state university hospitals staff, the Ohio state university Wexner medical center board and the Ohio state university board of trustees for all acts in connection with investigating and evaluating the applicant.
  - (iii) The applicant shall not deceive a patient as to the identity of any practitioner providing treatment or service in the Ohio state university hospitals.

- (iv) The applicant shall not make any statement or take any action that might cause a patient to believe that the licensed health care professional is a member of the medical staff.
  - (v) The applicant shall not perform any patient care in the Ohio state university hospitals that is not permitted under the applicant's license, certification, or other legal credential required under Ohio law.
  - (vi) The applicant shall obtain and continue to maintain professional liability insurance in such amounts required by the medical staff.
- (j) Licensed health care professionals shall be subject to quality review and corrective action as outlined in this paragraph for violation of these bylaws, their certificate of authority, standard of care agreement, utilization plan, or the provisions of their licensure, including professional ethics. Review may be requested by any member of the medical staff, a chief of the clinical department, or by the chief quality officer or his or her designee. All requests shall be in writing and shall be submitted to the chief quality officer. The chief quality officer shall appoint a three-person committee to review and make recommendations concerning appropriate action. The committee shall consist of at least one licensed health care professional and one medical staff member. The committee shall make a written recommendation to the chief quality officer, who may accept, reject, or modify the recommendation. The chief quality officer forwards his or her recommendation to the chief medical officer for final determination.
- (k) Appeal process.
- (i) A licensed health care professional may submit a notice of appeal to the chairperson of the quality and professional affairs committee within thirty days of receipt of written notice of any adverse corrective action pursuant to these bylaws.
  - (ii) If an appeal is not so requested within the thirty-day period, the licensed health care professional shall be deemed to have waived the right to appeal and to have conclusively accepted the decision of the chief medical officer.
  - (iii) The appellate review shall be conducted by the chief of staff, the chair of the licensed health care professionals subcommittee and one medical staff member from the same discipline as the licensed health care professional under review. The licensed health care professional under review shall have the opportunity to present any additional information deemed relevant to the review and appeal of the decision.
  - (iv) The affected licensed health care professional shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the chief quality officer. The licensed health care professional shall submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the review committee no later than seven days following the date of the licensed health care professional's notice of appeal.

- (v) New or additional matters shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.
- (vi) Within thirty days following submission of the written statement by the licensed health care professional, the chief of staff shall make a final recommendation to the chair of the quality and professional affairs committee of the Wexner medical center board. The quality and professional affairs committee of the Wexner medical center board shall determine whether the adverse decision will stand or be modified and shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the review committee for further review and recommendation. Such referral to the review committee may include a request for further investigation.
- (vii) Any final decision by the Wexner medical center board shall be communicated by the chief quality officer and by certified return receipt mail to the last known address of the licensed health care professional as determined by university records. The chief quality officer shall also notify in writing the executive vice president for health sciences, the dean of the college of medicine, the chief executive officer of the Ohio state university hospitals and the vice president for health services and the chief of the applicable clinical department or departments. The chief medical officer shall take immediate steps to implement the final decision.

(9) Emergency privileges.

In case of an emergency, any member of the medical staff to the degree permitted by the member's license or certification and regardless of department or medical staff status shall be permitted to do everything possible to save the life of a patient using every facility of the Ohio state university hospitals necessary, including the calling for any consultation necessary or desirable. After the emergency situation resolves, the patient shall be assigned to an appropriate member of the medical staff. For the purposes of this paragraph, an "emergency" is defined as a condition which would result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

(10) Disaster privileges.

Disaster privileges may be granted in order to provide voluntary services during a local, state, or national disaster in accordance with hospital/medical staff policy and only when the following two conditions are present: the emergency management plan has been activated and the hospital is unable to meet immediate patient needs. Such privileges may be granted by the chief medical officer or his or her designee to fully licensed or certified, qualified individuals who at the time of the disaster are not members of the medical staff. These privileges will be limited in scope and will terminate once the disaster situation subsides or at the discretion of the chief medical officer.

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**3335-43-08 Organization of the medical staff.**

- (A) Each member of the attending, community affiliate A, ~~community affiliate B~~, community affiliate C,

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community affiliate D, limited, and physician scholar medical staff shall be assigned to a clinical department and division, if applicable, upon the recommendation of the applicable chief of the clinical department.

(B) Names of clinical departments.

- (1) Anesthesiology.
- (2) Dermatology
- (3) Emergency medicine.
- (4) Family and community medicine.
- (5) Internal medicine.
- (6) Neurological surgery.
- (7) Neurology.
- (8) Obstetrics and gynecology.
- (9) Ophthalmology and visual science.
- (10) Orthopaedics.
- (11) Otolaryngology – head and neck surgery.
- (12) Pathology.
- (13) Pediatrics.
- (14) Physical medicine and rehabilitation.
- (15) Plastic and reconstructive surgery.
- (16) Psychiatry and behavioral health.
- (17) Radiation oncology.
- (18) Radiology.
- (19) Surgery.
- (20) Urology.
- (21) Dentistry.

(C) The directors of the divisions in the Ohio state university hospitals shall be appointed by the chiefs of the clinical departments in the Ohio state university hospitals in which the divisions are included.

(D) Qualifications and responsibilities of the chief of the clinical department.

The academic department chairperson shall ordinarily serve also as the chief of the clinical department. Each chief of the clinical department shall be qualified by education and experience appropriate to the discharge of the responsibilities of the position. Each chief of the clinical

department must be board certified by an appropriate specialty board or must establish comparable competence. The chief of the clinical department must be a medical staff member at the Ohio state university hospitals. Such qualifications shall be judged by the respective dean of the college of medicine or dentistry. Qualifications for chief of the clinical department generally shall include: recognized clinical competence, sound judgment and well-developed administrative skills.

- (1) Procedure for appointment and reappointment of the chief of the clinical department.

Appointment or reappointment of chief of the clinical department shall be made by the dean of the respective college of medicine or dentistry in consultation with elected representatives of the medical staff and the chief medical officer.

- (2) Term of appointment of the chief of the clinical department.

The term of appointment of the chief of the clinical department shall be concurrent with the chief's academic appointment but shall be no longer than four years. Prior to the end of said four-year term, a review shall be conducted by the dean of the college of medicine and such review shall serve as the basis for the recommendation for reappointment pursuant to paragraph (D)(1) of this rule.

- (3) Duties of the chief of the clinical department.

Each chief of the clinical department is responsible for the following:

- (a) Clinically related activities of the department;
- (b) Administratively related activities of the department, unless otherwise provided by the hospital;
- (c) Continuing surveillance of the professional performance of all practitioners in the department who have delineated clinical privileges;
- (d) Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
- (e) Recommending clinical privileges for each practitioner of the department based on relevant training and experience, current appraised competence, health status that does not present a risk to patients, and evidence of satisfactory performance with existing privileges;
- (f) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;
- (g) The integration of the department or service into the primary functions of the hospital, developing services that complement the medical center's mission and plan for clinical program development;
- (h) The coordination and integration of interdepartment and intradepartmental services;
- (i) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services. This includes the development, implementation, enforcement and updating of departmental policies and procedures that are consistent with the hospital's mission. The clinical department chief shall make such policies and procedures available to the medical staff;



- (j) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services, including ensuring that call coverage provides for continuous high quality and safe care;
- (k) The determination of the qualifications and competence of department or service personnel who are not licensed practitioners and who provide patient care, treatment, and services;
- (l) The continuous assessment and improvement of the quality of care, treatment, and services;
- (m) The maintenance of quality control programs, as appropriate;
- (n) The orientation and continuing education of all persons in the department or service;
- (o) Hold regular clinical department meetings and ensure open lines of communication are maintained in the clinical department. The agenda for the meetings shall include, but not be limited to, a discussion of the clinical activities of the department and communication of the decisions of the medical staff administrative committee. Minutes of departmental meetings, including a record of attendance, shall be electronically available and/or distributed to all medical staff members in the clinical department, and such minutes shall be kept in the clinical department.

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

(A) Chief of staff.

The chief of staff shall:

- (1) Serve on those committees of the Ohio state university Wexner medical center board as appointed by the chairperson of that board.
- (2) Serve as vice chairperson of the medical staff administrative committee.
- (3) Provide for communication between the medical staff and the Ohio state university Wexner medical center board or its committees in matters of quality of care, education, and research.
- (4) Serve as liaison between the Ohio state university hospitals administration, medical administration, and the medical staff in all matters of mutual concern within the Ohio state university hospitals.
- (5) In consultation with the medical directors and the chief medical officer, seek to ensure that the medical staff is represented and participates as appropriate in any Ohio state university hospitals deliberation which affects the discharge of medical staff responsibilities.
- (6) Call, preside, and be responsible for the agenda of all general medical staff meetings.
- (7) Make medical staff committee appointments in accordance with paragraph (D)(1) of rule 3335-43-10 of the Administrative Code jointly with the medical directors and chief of staff-elect in consultation with the chief executive officer of the Ohio state health system and the Wexner medical center board.

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- (8) Be spokesperson for the medical staff in its external professional and public relations.
- (9) Serve as chairperson of the nominating committee of the medical staff.

(B) Chief of staff-elect.

The chief of staff-elect shall:

- (1) Serve on those committees of the Ohio state university Wexner medical center board as appointed by the chairperson of the Wexner medical center board.
- (2) Carry out all the duties of the chief of staff when the chief of staff is unable to do so.
- (3) Oversee the inclusion of changes in the bylaws, rules and regulations of the medical staff.
- (4) Assist the Chief of Staff with duties outlined above in paragraph (A)(1) to (A)(9).

(C) Representatives of the medical staff elected at-large.

There shall be ~~three~~ ~~five~~ ~~six~~ medical staff representatives elected at-large. Each representative shall be a member of the medical staff administrative committee and shall serve on those committees of the Ohio state university Wexner medical center board as appointed by the chairperson of the Wexner medical center board.

(D) Qualifications of officers.

- (1) Officers must be members of the attending staff at the time of their nomination and election and must remain members in good standing during the term of their office. Failure to maintain such status shall immediately create a vacancy in the office involved.
- (2) Chiefs of the clinical departments shall not be eligible to serve as chief of staff or chief of staff-elect unless they are replaced in their Ohio state university hospitals administrative role during the period of their term of office.

(E) Election of officers.

- (1) All officers (other than at-large officers) shall be elected by a majority of those voting by electronic ballot of the attending staff.
- (2) The nominating committee shall be composed of five members. The chief of staff shall serve on the committee and shall select four other members for the committee. The chief of staff shall be its chairperson.
- (3) Nominations for officers shall be accepted from any member of the medical staff and shall be submitted either electronically or in writing to the nominating committee.
- (4) The committee's nominees shall be submitted to all voting members of the attending staff no later than May first of the election year.
- (5) Candidates for the office of chief of staff-elect shall be listed and each attending staff member shall be entitled to cast one vote. Candidates for the at-large positions shall be voted upon as a group. Each voting member of the attending staff shall be entitled to vote for three at-large candidates. The three candidates with the highest number of votes shall be elected. A majority of the votes shall not be necessary.

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- (6) Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with medical staff rules and regulations, policies and procedures of the medical staff, for conduct or statements that damage the reputation of the Ohio state university Wexner medical center, its goals and missions, or programs, or an automatic termination or suspension of clinical privileges that lasts more than thirty days.
- (F) Term of office.
- (1) The chief of staff and chief of staff-elect shall each serve two years in office beginning on July first. The chief of staff-elect shall be elected in the odd numbered years. A former chief of staff may not succeed the immediately preceding chief of staff-elect.
- (2) The at-large representatives shall each serve two years, beginning July first. The at-large representatives may succeed themselves for three successive terms (six years total), if so elected. Upon completion of the three successive terms, the representative may not serve again without a period of two years out of office as an at-large representative. The representative may be elected chief of staff-elect at any time.
- (G) Vacancies in office.
- (1) A vacancy in the office of chief of staff shall be filled by the chief of staff-elect. If the unexpired term is one year or less, the new chief of staff shall serve out the remaining term in office and shall then serve as chief of staff for the term for which elected. If the unexpired term is more than one year, the new chief of staff shall serve out the remaining term only.
- (2) Vacancies in the office of chief of staff-elect shall be filled by a special election held within sixty days of the vacancy by the nominating and election process set forth in paragraph (F) of this rule. The new chief of staff-elect shall become chief of staff at the end of the term of the incumbent.
- (3) Vacancies in the at-large representatives medical staff positions shall be filled by appointment by the chief of staff.

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**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 officer.

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. 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

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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) Medical directors.

The medical directors of the hospitals of the Ohio state university report to the chief executive officer or the executive director of the respective hospital and chief medical officer. Each medical director will collaborate with the chief quality officer, the chief medical officer and the clinical department chiefs to develop, execute and monitor the quality and safety programs of the hospital. The appointment, scope of authority, and responsibilities of the medical directors for the Ohio state university hospitals shall be further outlined in the Ohio state university Wexner medical center board bylaws.

(D) Medical staff committees.

(1) Appointments:

Appointments to all medical staff committees except the medical staff administrative committee, nominating committee and all health system committees, shall be made jointly by the chief of staff, chief of staff-elect, and the hospital medical directors with medical staff administrative committee ratification. Representatives from the Ohio state university hospitals to health system committees shall be appointed jointly by the chief medical officer of the health system and the medical director. Unless otherwise provided by these bylaws, all appointments to medical staff committees shall be for two years and may be renewed. The chief of staff, chief medical officer, medical director, and the chief executive officer of the Ohio state university hospitals may serve on any medical staff committee as an ex-officio member without vote.

(2) Meetings:

Each medical staff committee shall meet at the call of its chairperson and at least quarterly. Committees shall maintain records of proceedings and minutes of meetings and shall forward all recommendations and actions taken to the chief medical officer who shall promptly communicate them to the medical staff administrative committee. The chairperson shall control the committee agenda, attendance of staff and guests, and conduct of the proceedings. A simple majority of appointed voting members shall constitute a quorum.

(3) Peer review committees:

The medical staff as a whole and each committee provided for by these medical staff bylaws is hereby designated as a peer review committee in accordance with the laws of the state of Ohio. The medical staff through its committees shall be responsible for evaluating, maintaining and/or monitoring the quality and utilization of patient care services provided by the Ohio state university hospitals.

(E) Medical staff administrative committee.

(1) Composition.

- (a) This committee shall consist of the following voting members: chief of staff, chief of staff-elect, chiefs of the clinical departments, [chief physician for the affiliated entity employing community affiliate B medical staff](#), ~~three~~ ~~five~~ ~~six~~ medical staff representatives elected at large, the chief medical officer, and the chief executive officer of the Ohio state university hospitals [or designee](#). Additional members may be appointed to the medical staff administrative committee at the recommendation of the dean or the chief medical officer of the medical center subject to the approval of the medical staff administrative committee and subject to review/renewal on a biennial basis. Any members may be

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removed from the medical staff administrative committee at the recommendation of the dean, the executive vice president for health sciences or the chief medical officer of the medical center and subject to the review and approval of the medical staff administrative committee. A replacement will be appointed as outlined above to maintain the medical staff administrative committee's constituency. The chief medical officer shall be the chairperson and the chief of staff shall be vice-chairperson.

- (b) Any member of the committee who anticipates absence from a meeting of the committee may appoint as a temporary substitute another member of the same category of the medical staff to represent him or her at the meeting. The temporary substitute shall have all the rights of the absent member. ~~The chief executive officer of the Ohio state university hospitals may invite any member of the chief executive officer's staff to represent him or her at a meeting or to attend any meeting.~~
- (c) All members of the committee shall attend, either in person, virtual, or by proxy, a minimum of two-thirds of all committee meetings.

(2) Duties.

- (a) To represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws, by the bylaws of the Ohio state university Wexner medical center board, the bylaws or rules of the board of trustees of the Ohio state university.
- (b) To have primary authority for activities related to self-governance of the medical staff. Action approved by the medical staff administrative committee can be reviewed by the quality and professional affairs committee pursuant to section 3335-43-13 of these bylaws.
- (c) To receive and act upon committee reports.
- (d) To delegate appropriate staff business to committees while retaining the right of executive responsibility and authority over all medical staff committees. This shall include but is not limited to review of and action upon medical staff appointments and reappointments whenever timely action is necessary.
- (e) To approve and implement policies of the medical staff.
- (f) To provide a liaison between the medical staff, medical director, chief executive officer, and the Wexner medical center board.
- (g) To recommend action to the medical directors and chief executive officer of the Ohio state university hospitals on matters of medical-administrative nature.
- (h) To fulfill the medical staff's accountability to the Wexner medical center board and the board of trustees of the Ohio state university for medical care rendered to patients in the Ohio state university hospitals, and for the professional conduct and activities of the medical staff, including recommendations concerning:
  - (i) Medical staff structure;
  - (ii) The mechanism to review credentials and to delineate clinical privileges;
  - (iii) The mechanism by which medical staff membership may be terminated;

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- (iv) Participation in the Ohio state university hospitals' performance improvement activities; and
    - (v) Corrective action and hearing procedures applicable to medical staff members and other licensed health care professionals granted clinical privileges.
    - (vi) To ensure the medical staff is kept abreast of the accreditation process and informed of the accreditation status of the Ohio state university hospitals.
  - (i) To review and act on medical staff appointments, reappointments, and requests for delineation of clinical privileges. Whenever there is doubt of an applicant's ability to perform the privileges requested, the medical staff administrative committee shall have the authority to request an evaluation of the applicant's clinical activities relevant to requested privileges.
  - (j) To report to the medical staff all actions affecting the medical staff.
  - (k) To inform the medical staff of all changes in committees, and the elimination of such committees as circumstances shall require.
  - (l) To create committees (for which membership is subsequently appointed pursuant to rule 3335-43-09 of the Administrative Code) to meet the needs of the medical staff and comply with the requirements of accrediting agencies.
  - (m) To establish and maintain rules and regulations governing the medical staff.
  - (n) To perform other functions as are appropriate.
- (3) Executive session.
- (a) Upon the recommendation of the credentialing committee, the medical staff administrative committee may vote to hold a portion of a regular, special or emergency meeting in executive session with participation limited to voting members of the medical staff administrative committee. Other individuals may be invited to attend any or all portions of an executive session as deemed necessary by the committee chair.
- (4) Meetings. The committee shall meet monthly and shall keep detailed minutes which shall be distributed to each committee member and to the Wexner medical center board through the quality and professional affairs committee.
- (5) Voting. At a properly constituted meeting, voting shall be by a simple majority of members present except in the case of termination or non-reappointment of medical staff membership or permanent suspension of clinical privileges, wherein a two-thirds vote of members present shall be required.
- (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 of the health system. The chief of staff, director of medical affairs and medical directors of each 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) To review all applications for medical staff and licensed health care professional appointment and reappointment, as well as all requests for delineation, renewal, or amendment of clinical privileges in the manner provided in these medical staff bylaws, including applicable time limits. During its evaluation, the credentialing committee of the hospitals of the Ohio state university will take into consideration the appropriateness of the setting where the requested privileges are to be conducted;
- (b) To review triennially all applications for reappointment or renewal of clinical privileges;
- (c) To review all requests for changes in medical staff membership;
- (d) To assure, through the chairperson of the committee, that all records of formal peer review activity taken by the committee, including committee minutes, are maintained in the strictest of confidence in accordance with the laws of the state of Ohio. The committee may conduct investigations and interview applicants as needed to discharge its duties. The committee may refer issues and receive issues as appropriate from other medical staff committees;
- (e) To make recommendations to the medical staff administrative committee through the 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) To recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session;
- (g) The committee, after review and investigation, may make recommendations to the chief medical officer, chief of staff or the chief of a clinical department, regarding the restriction or limitation of a member's clinical privileges for noncompliance or any other matter related to its responsibilities;
- (h) To review all grants of special or temporary privileges; and
- (i) To review requests made for clinical privileges by other licensed health care professionals as set forth in these bylaws.
- (j) To recommend eligibility criteria for the granting of medical staff membership and privileges.
- (k) To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities.

- (l) To review, and where appropriate take action on, reports that are referred to it from other medical staff committees and medical staff members.
  - (m) To perform such other functions as requested by the medical staff administrative committee, the quality and professional affairs committee or Wexner medical center board.
- (3) Licensed health care professionals subcommittee.
- (a) Composition.

This subcommittee shall consist of other licensed health care professionals who have been appointed in accordance with paragraph ~~(D)(1) of rule 3335-43-10(A)(6) of rule 3335-43-09~~ of the Administrative Code. The subcommittee shall be chaired by a director of nursing who shall serve as chair of the subcommittee.
  - (b) Duties.
    - (i) To review, within thirty days of receipt, all completed applications as may be referred by the credentialing committee of the hospitals of the Ohio state university.
    - (ii) To review and investigate the character, qualifications and professional competence of the applicant.
    - (iii) To review the applicant's patient care quality indicator definitions on initial granting of clinical privileges and the performance based profile at the time of renewal.
    - (iv) To verify the accuracy of the information contained in the application.
    - (v) To request a personal interview with the applicant if deemed appropriate.
    - (vi) To forward, following review of the application, a written recommendation for clinical privileges to the credentialing committee of the hospitals of the Ohio state university for review at its next regularly scheduled meeting.
    - (vii) To develop relevant policies and procedures regarding the scope of service and scope of practice to be granted to each licensed health care professional specialty. These policies and procedures shall be ratified by the credentialing committee and medical staff administrative committee, and be approved by the Wexner medical center board.
- (G) Committee for practitioner health.
- (1) Composition.

The committee shall consist of medical staff members appointed in accordance with paragraph ~~(D)(1) of rule 3335-43-10 (A)(6) of rule 3335-43-09~~ of the Administrative Code.
  - (2) Duties.
    - (a) To consider issues of licensed practitioner health or impairment whenever a self-referral or referral is requested by an affected member or another member or committee of the medical staff, the Ohio state university hospitals staff, or any other



individual.

- (b) To educate the medical staff and the Ohio state university hospitals staff about illness and impairment recognition issues, including at-risk criteria, specific to licensed practitioners.
- (c) To provide appropriate counsel, referral and monitoring until the rehabilitation is complete and periodically thereafter, if required, to enable the medical staff member to obtain appropriate diagnosis and treatment, and to provide appropriate standards of care.
- (d) To consult regularly with the chief of staff, chief medical officer and medical director of the Ohio state university hospitals.
- (e) To advise credentials or other appropriate medical staff committees on the credibility of any complaint, allegation or concern, including those affecting the quality and safety of patient care.
- (f) To assure, through the chairperson of the committee, that all proceedings and records, including the identity of the person referring the case, are handled and maintained in the strictest confidence in accordance with the laws of the state of Ohio.
- (g) To initiate appropriate actions when a licensed practitioner fails to complete the required rehabilitation program.

(H) Medical staff bylaws committee.

(1) Composition.

The committee shall consist of those members appointed in accordance with paragraph (D)(1) of rule 3335-43-10 (A)(6) of rule 3335-43-09 of the Administrative Code. The chairperson shall always be the chief of staff-elect.

(2) Duties.

- (a) To review and recommend amendments, as appropriate, to these medical staff bylaws to the medical staff administrative committee at least every two years.
- (b) To receive from members of the medical staff or the medical staff administrative committee any suggestions that may necessitate amendment of these bylaws.

(I) Infection prevention committee.

(1) Composition.

The medical staff members of the committee shall consist of those members appointed in accordance with paragraph (D)(1) of rule 3335-43-10 (A)(6) of rule 3335-43-09 of the Administrative Code. The committee shall also include representatives of nursing, environmental services, and hospital administration as may be invited from time to time by the chief of staff. The chairperson shall be a physician member of the medical staff with experience or training in infectious diseases.

(2) Duties.

- (a) To oversee surveillance and institute any recommendations necessary for the investigation, prevention, containment of nosocomial and clinical infectious diseases

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of both patients and staff at all facilities owned, operated, or controlled by the Ohio state university hospitals and subject to JCAHO standards.

- (b) To take necessary action through the chairperson of the committee, and the Ohio state university hospitals' epidemiologist, in consultation with the medical director of the Ohio state university hospitals, to prevent and control emerging spread or outbreaks of infections; isolate communicable and infectious patients as indicated; and obtain all necessary cultures in emergent situations when the responsible medical staff member is unavailable.

(J) Ethics committee.

(1) Composition.

The committee shall consist of members of the medical staff, nursing, hospital administration, and other persons who by reason of training, vocation, or interest may make a contribution. Members shall be appointed as provided in these bylaws. The chairperson shall be a medical staff member who is a clinically active physician.

(2) Duties.

- (a) To make recommendations for the review and development of guidelines or policies regarding ethical issues.
- (b) To provide ethical guidelines and information in response to requests from members of the medical staff, patients, patient's family or other representative, and staff members of the Ohio state university hospitals.
- (c) To provide a support mechanism for primary decision makers at the Ohio state university hospitals.
- (d) To provide educational resources on ethics to all health care providers at the Ohio state university hospitals.
- (e) To provide and enhance interaction between hospitals administration and staff, departmental ethics committees, pastoral care services, and members of the medical staff.

(K) Practitioner evaluation committee.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners. If additional expertise is needed, the practitioner evaluation committee may request the assistance from any medical staff member or recommend to the chief medical officer an external review.

(2) Duties.

- (a) To meet and keep minutes, which describe issues, opportunities to improve patient care, recommendations and actions to the chief quality officer and chair of the clinical department, responsible parties, and expected completion dates. The minutes are maintained in the quality and operations improvement office.
- (b) To ensure that ongoing and systematic monitoring, evaluation, and process improvement is performed in each clinical department.

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- (c) To develop and utilize objective criteria in practitioner peer review activities.
- (d) To ensure that the medical staff peer review process is effective.
- (e) To maintain confidentiality of its proceedings. These issues are not to be handled outside of PEC by any individual, clinical department, division, or committee.

(L) Quality Leadership Council.

(1) Composition.

The quality leadership council shall consist of members appointed in accordance with paragraph ~~(D)(1) of rule 3335-43-10 (A)(6) of rule 3335-43-09~~ of the Administrative Code, and shall include the executive vice president for health sciences, the dean of the college of medicine and the chairperson of the quality and professional affairs committee of the Wexner medical center board as ex-officio members without a vote. The chief quality officer shall be the chairperson of the quality leadership council.

- (a) To design and implement systems and initiatives to enhance clinical care and outcomes throughout the integrated health care delivery system.
- (b) To serve as the oversight council for the clinical quality management and patient safety plan.
- (c) To establish goals and priorities for clinical quality, safety and service on an annual basis.

(M) Clinical quality and patient safety committee.

(1) Composition.

The members of this group shall be appointed pursuant to these bylaws and shall include medical staff members from various clinical departments and support services, and shall include the director of the clinical quality management policy group, and representatives of nursing and hospitals administration. The chairperson of the policy group shall be a physician member of the medical staff.

(2) Duties.

- (a) To coordinate the quality management related activities of the clinical departments, the medical information management department, utilization review, infection control, pharmacy and therapeutics and drug utilization committee, transfusion and isoimmunization, and other medical staff and the Ohio state university hospitals committees.
- (b) To implement clinical improvement programs to achieve the goals of the Ohio state university hospitals quality management plan, as well as assure optimal compliance with accreditation standards and governmental regulations concerning performance improvement.
- (c) To review, analyze, and evaluate on a continuing basis the performance of the medical staff and other health care providers; and advise the clinical department clinical quality sub-committees in defining, monitoring, and evaluating quality indicators of patient care and services.

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- (d) To serve as liaison between the Ohio state university and the Ohio peer review organizations through the chairperson of the policy group and the director of clinical quality.
- (e) To make recommendations to the medical staff administrative committee on the establishment of and the adherence to standards of care designed to improve the quality of patient care delivered in the Ohio state university hospitals.
- (f) To hear and determine issues concerning the quality of patient care rendered by members of the medical staff and the Ohio state university hospitals staff and make appropriate recommendations and evaluate action plans when appropriate to the chief medical officer, the medical director, the chief of a clinical department, or the Ohio state university hospitals administration.
- (g) To appoint ad-hoc interdisciplinary teams to address the Ohio state university hospitals-wide quality management plan.
- (h) To annually review and revise as necessary the Ohio state university hospitals-wide clinical quality management plan.
- (i) To report and coordinate with the quality leadership council all quality improvement initiatives.

(N) Clinical resource utilization policy group.

(1) Composition.

The members shall be appointed in accordance with paragraph [\(D\)\(1\) of rule 3335-43-10](#) ~~(A)(6) of rule 3335-43-09~~ of the Administrative Code and shall include medical staff members from various clinical departments and support services the directors of clinical quality and case management, and representatives of nursing and hospitals administration. The chairperson of the policy group shall be a physician member of the medical staff.

(2) Duties.

- (a) To promote the most efficient and effective use of the hospitals of the Ohio state university health system facilities and services by participating in the review process and continued stay reviews on all hospitalized patients.
- (b) To formulate and maintain a written resource management review plan for the hospitals of the Ohio state university health system consistent with applicable governmental regulations and accreditation requirements.
- (c) To conduct resource management studies by clinical department or divisions, or by disease entity as requested or in response to variation from benchmark data would indicate.
- (d) To report and recommend to the quality leadership council changes in clinical practice patterns in compliance with applicable governmental regulations and accreditation requirements, and when the opportunity exists to improve the resource management.
- (e) To oversee evaluation and cost effective utilization of clinical technology.
- (f) To oversee the activities of the utilization management committee of the hospitals of the Ohio state university health system. This oversight will include the annual review

and approval of the utilization management plan.

(O) Clinical practice guideline committee.

(1) Composition.

The members shall be appointed in accordance with paragraph (D)(1) of rule 3335-43-10 ~~(A)(6) of rule 3335-43-09~~ of the Administrative Code, and shall include medical staff members from various clinical departments and support services, representatives of nursing, pharmacy, information systems, hospitals administration, and the chair of the clinical quality and management policy group. The chairperson of the policy group shall be a physician member of the medical staff.

(2) Duties.

- (a) To oversee the planning, development, approval, implementation and periodic review of evidence-based medicine resources (i.e., clinical practice guidelines, quick reference guides, clinical pathways, and clinical algorithms) for use within the Ohio state university hospitals and its affiliated institutions. Planning should be based on the prioritization criteria approved by the quality leadership council and review should focus on incorporating recent medical practice, literature or developments. Annual review should be done in cooperation with members of the medical staff with specialized knowledge in the field of medicine related to the guideline.
- (b) To report and recommend to quality leadership council specific process and outcomes measures for each evidence-based medicine resource.
- (c) To oversee ongoing education of medical staff (including specifically limited staff) and other appropriate Ohio state university hospitals staff regarding the fundamental concepts and value of evidence-based practice and outcomes measurement and its relation to quality improvement.
- (d) To initiate and support research projects when appropriate in support of the objectives of the quality leadership council.
- (e) To oversee the development, approval and periodic review of the clinical elements of computerized ordersets and clinical rules to be used within the information system of the Ohio state university hospitals and its affiliated institutions. Computerized ordersets and clinical rules related to specific practice guidelines should be forwarded to quality leadership council for approval. All other computerized ordersets and clinical rules should be forwarded to the quality leadership council for information.
- (f) To regularly report a summary of all actions to the quality leadership council.

(P) Professionalism consultation committee.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners and other individuals with expertise in professionalism.

(2) Duties.

- (a) Receive and review validity of complaints regarding concerns about professionalism of credentialed practitioners;

- (b) Treat, counsel and coach practitioners in a firm, fair and equitable manner;
- (c) Maintain confidentiality of the individual who files a report unless the person who submitted the report authorizes disclosure or disclosure is necessary to fulfill the institution's legal responsibility;
- (d) Ensure that all activities be treated as confidential and protected under applicable peer review and quality improvement standards in the Ohio Revised Code;
- (e) Forward all recommendations to the clinical department chief, the chief medical officer or his/her designee and, if applicable, to the chief nursing officer.

(Board approval dates: 4/7/2000, 10/5/2001, 6/7/2002, 5/30/2003, 6/4/2004, 5/6/2005, 11/4/2005, 2/2/2007, 2/1/2008, 9/19/2008, 9/18/2009, 10/29/2009, 4/8/2011, 8/31/2012, 2/01/2013, 1/31/2014, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018, 5/18/2021, 8/15/2023)

### **3335-43-11 History and physical**

(A) History and physical examination.

- (1) A history and physical appropriate to the patient and/or the procedure to be completed shall be documented in the medical record of all patients either:
  - (a) Admitted to the hospital
  - (b) Undergoing outpatient/ambulatory procedures [requiring anesthesia services or sedation](#)
  - (c) Undergoing outpatient/ambulatory surgery
  - (d) In a hospital-based ambulatory clinic
- (2) For patients admitted to the hospital, the history and physical examination shall include at a minimum:
  - (a) Date of admission
  - (b) History of present illness, including chief complaint
  - (c) Past medical and surgical history
  - (d) Relevant past social and family history
  - (e) Medications and allergies
  - (f) Review of systems
  - (g) Physical examination
  - (h) Test results
  - (i) Assessment or impression
  - (j) Plan of care
- (3) For patients undergoing outpatient/ambulatory procedures [requiring anesthesia services or sedation](#) or outpatient/ambulatory surgery,

the history and physical examination shall include at a minimum:

- (a) Indications for procedure or surgery
  - (b) Relevant medical and surgical history
  - (c) Medications and allergies or reference to current listing in the chart or electronic medical record
  - (d) Focused review of systems, as appropriate for the procedure or surgery
  - (e) Pre-procedure assessment and physical examination
  - (f) Assessment/impression and treatment plan
- (4) For patients seen in a hospital-based ambulatory clinic, the history and physical shall include at a minimum:
- (a) Chief complaint
  - (b) History of present illness
  - (c) Medications and allergies
  - (d) Problem-focused physical examination
  - (e) Assessment or impression
  - (f) Plan of care
- (5) Deadlines and sanctions.
- (a) A history and physical examination must be performed by a member of the medical staff, his/her designee or other licensed health care professional, who is appropriately credentialed by the hospital, and be signed, timed and dated.
  - (b) Patients admitted to the hospital: If the history and physical is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, the history and physical must be countersigned by the responsible medical staff member.
  - (c) The complete history and physical examination shall be dictated, written or updated no later than twenty-four hours after admission for all inpatients.
  - (d) Admitted patients or patients undergoing a procedure [requiring anesthesia services or sedation](#) or surgery, the history and physical examination may be performed or updated up to thirty days prior to admission or the procedure/surgery. If completed before admission or the procedure/surgery, there must be a notation documenting an examination for any changes in the patient's condition since the history and physical was completed. The updated examination must be completed and documented in the patient's medical record within twenty-four hours after admission or before the procedure/surgery, whichever occurs first. It must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and be signed, timed and dated. In the event the history and physical update is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital,

it shall be countersigned, timed and dated by the responsible medical staff member.

- (i) For patients undergoing an outpatient procedure requiring anesthesia services or sedation or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.
  - (ii) If a licensed health care professional is appropriately credentialed by the hospital to perform a procedure or surgery independently, a history and physical performed by the licensed health care professional prior to the procedure or surgery is not required to be countersigned.
- (e) Hospital-based ambulatory clinic: If a history and physical examination is performed by a licensed health care professional who is appropriately credentialed by the hospital to see patients independently, the history and physical is not required to be countersigned.
- (f) When the history and physical examination, including the results of indicated laboratory studies and x-rays, is not recorded in the medical record before the time stated for a procedure or surgery, the procedure or surgery cannot proceed until the history, and physical is signed or countersigned when required, by the responsible medical staff member, and indicated test results are entered into the medical record. In cases where such a delay would likely cause harm to the patient, this condition shall be entered into the medical record by the responsible medical staff member, his/her designee or other licensed health care professional, who is appropriately credentialed by the hospital, and the procedure or surgery may begin. When there is a disagreement concerning the urgency of the procedure, it shall be adjudicated by the medical director or the medical director's designee. (B/T 10, 29/2009, 8/31/12)
- (g) Ambulatory patients must have a history and physical at the initial visit as outlined in paragraph (A)(4) of this rule.
- (h) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:
- i. within the past six months prior to the initial visit,
  - ii. at the initial visit, or
  - iii. within 30 days following the initial visit.

(Board approval dates: 10/29/2009, 8/31/2012, 1/31/2014, 11/7/2014, 11/6/2015)

**3335-43-12 Meetings and dues.**

(A) Meetings.

The medical staff of the Ohio state university hospitals shall conduct scheduled meetings at least annually. 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.



(B) Dues.

The medical staff, by two-thirds vote of those in attendance at a regularly scheduled meeting, may establish dues. Payment of dues is a requirement for continued staff membership.

(Board approval date: 10/29/2009, 4/6/2018, 8/15/2023)

**3335-43-13 Amendments and adoption.**

(A) Medical staff responsibility.

The medical staff bylaws committee shall have the initial responsibility to formulate, review at least biennially, and recommend to the quality and professional affairs committee of the Wexner medical center board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws shall be effective when approved by the university board of trustees. Amendments to the rules and regulations shall be effective when approved by the Wexner medical center board.

Such responsibility shall be exercised in good faith, in a timely manner and in accordance with applicable laws and regulatory standards. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

The organized medical staff shall also have the ability to propose amendments to the medical staff bylaws, rules and regulations, and policies and procedures and propose them directly to the quality and professional affairs committee of the Wexner medical center board.

If the voting members of the organized medical staff propose to adopt amendments to the bylaws, rules and regulations or policies, they must first communicate the proposal to the medical staff administrative committee. When the medical staff administrative committee proposes to adopt amendments to the bylaws, rules and regulations or policies, it communicates the proposal to the organized medical staff.

Conflict between the organized medical staff and the medical staff administrative committee will be managed by allowing communication directly from the medical staff to the quality and professional affairs committee of the Wexner medical center board on issues including, but not limited to amendments to the bylaws and the adoption of new rules and regulations or policies. Medical staff members may communicate with the quality and professional affairs committee of the Wexner medical center board by submitting their communication in writing to the chief of staff, who shall then communicate on their behalf to the quality and professional affairs committee of the Wexner medical center board at its next regularly scheduled meeting for final determination.

In cases of urgent need to update the medical staff bylaws or rules and regulations in order to comply with law, statute, federal regulation, or accreditation standard, the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board may provisionally approve an urgent amendment without prior notification to the medical staff. The medical staff shall be immediately notified by the medical staff administrative committee. The medical staff shall have the opportunity for review of and vote on the provisional amendment. If the medical staff votes in favor of the provisional amendment, it shall stand. If there is conflict over the provisional amendment, process for resolving conflict between the organized medical staff and the medical staff administrative committee shall be implemented.

(B) Methods of adoption and amendment to these bylaws.

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Proposed amendments to these bylaws may be originated by the medical staff bylaws committee, medical staff administrative committee or by a petition signed by twenty-five per cent of attending medical staff members.

Each attending medical staff member will be eligible to vote on the proposed amendment via secure ballot in a manner determined by the medical staff administrative committee. All attending medical staff members shall receive at least fourteen days advance notice of the changes to be adopted:

- (1) The medical staff receives a simple majority of the votes cast by those members eligible to vote.
- (2) Amendments so adopted shall be effective when approved by the university board of trustees.

(C) **Methods of adoption and amendment to medical staff rules, regulations and policies.**

The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws.

Proposed amendments to the rules, regulations and policies may be originated by the medical staff bylaws committee or the medical staff administrative committee.

The medical staff administrative committee shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the medical staff administrative committee, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the organized medical staff, and the Wexner medical center board. Policies and procedures will become effective upon approval of the medical staff administrative committee.

In addition to the process described above, the organized medical staff itself may recommend directly to the quality and professional affairs committee of the Wexner medical center board an amendment to any rule, regulation, or policy by submitting a petition signed by twenty-five percent of the members of the attending medical staff category. Upon presentation of such petition, the adoption process outlined above will be followed.

(D) **The medical staff administrative committee may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, administrative, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Wexner medical center board but must be approved by the vice president of health services. Neither the organized medical staff nor the Wexner medical center board may unilaterally amend the medical staff bylaws or rules and regulations.**

The medical staff bylaws, rules and regulations, Wexner medical center board bylaws, and relevant policies shall not conflict. The medical staff bylaws committee shall assure that there is no conflict.

(Board approval date: 4/8/2011, 11/7/2014, 8/15/2023)

### **3335-43-14 Rules of construction.**

- (A) "Shall" as used herein is to be construed as mandatory.
- (B) These bylaws should be construed to be gender neutral.

(Effective 6/14/2011 no board date given; was not 4/8/2011)

APPENDICES

APPENDIX I. COAT OF ARMS OF  
THE OHIO STATE UNIVERSITY HOSPITALS

The official coat of arms of The Ohio State University Hospitals shall be as follows:

The blazon of the arms of University Hospitals is a shield, 16th century style, on a field of gray surrounded by an "O" in scarlet with the words, "The Ohio State University Hospitals" in black.

The shield is embattled above the chief, with three azure towers. The shield is divided "fesse cotised," through the "fesse point" by three bars, "gemels of or" (gold), separated each by bars, "gemels of argent" (silver). The chief is "gules" (scarlet), impaled by a charge, "The Ohio State University Crest." The "O" is argent, the center is gules, impaled by a charge with the "or" book of knowledge, and the base of the "O" is impaled by a charge of a "buckeye leaf vert" (green).

The base is quartered per pale.

The dexter base is vertical with a charge, the staff of Aesculapius.

The sinistra base is azure with a charge, the Hospitalier's cross, gules.

The scroll contains the Latin motto: "Hospitale-Academia-Investigatus."

The use of the coat of arms of The Ohio State University Hospitals will be by all who are connected with University Hospitals.

APPENDIX II.

COAT OF ARMS OF THE MEDICAL STAFF  
OF THE OHIO STATE UNIVERSITY HOSPITALS

The official coat of arms of the medical staff of The Ohio State University Hospitals shall be as follows: The shield on vertical narrow stripes, alternating silver and white, is square, parted per green (medicine) chevron. The dexter chief contains the golden oak leaf surmounted by the silver acorn representing the practice of medicine; the sinistra chief contains the multiple atomis circles representing research; the center base contains the golden book of knowledge encircled by the gray "O" from the crest of The Ohio State University and represents the teaching obligation of our staff. The scroll is gold, with the black lettering of the motto, "Eruditio A Scientia Exornata Miliorem Valetudinem Mortalibus Praestat" (knowledge enhanced by science assures better health for mankind).

Encircling the achievement are the words, "The Medical Staff" joined by a green buckeye leaf (symbol of the State of Ohio) to the words, "The Ohio State University Hospitals." Impaled in this "coat of arms" are the heritage of the State of Ohio and The Ohio State University with the obligation of teaching and research to provide and improve medical care. The use of this coat of arms of the medical staff shall be limited to duly appointed members of the medical staff and the staff organization.

**AMENDMENTS TO THE BYLAWS OF THE MEDICAL STAFF**

THE OHIO STATE UNIVERSITY COMPREHENSIVE CANCER CENTER  
ARTHUR G. JAMES CANCER HOSPITAL AND RICHARD J. SOLOVE RESEARCH INSTITUTE

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

WHEREAS a summary of the proposed amendments to the Bylaws of the Medical Staff of the James Cancer Hospital is attached; and

WHEREAS the proposed amendments are also attached; and

WHEREAS the proposed amendments to the Bylaws of the Medical Staff of the James Cancer Hospital were approved by the James Medical Staff Bylaws Committee on July 8, 2024; and

WHEREAS the proposed amendments to the Bylaws of the Medical Staff of the James Cancer Hospital were approved by the James Cancer Hospital Medical Staff Administrative Committee on June 21, 2024:

WHEREAS on July 23, 2024, the Quality and Professional Affairs Committee recommended that the Wexner Medical Center Board approve the amendments to the Bylaws of the Medical Staff of the James Cancer Hospital:

NOW THEREFORE

BE IT RESOLVED, That the Wexner Medical Center Board hereby approves the amendments to the Bylaws of the Medical Staff of the James Cancer Hospital for The James.

## **James Medical Staff Bylaws Changes**

June 11, 2024

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

#### **(A) Chief of staff**

(4) Updates medical staff committee appointment language to follow process outlined in paragraph (A) of rule 3335-111-10

### **3335-111-10 Administration of the medical staff of the CHRI**

#### **(C) Medical staff administrative committee.**

(1) Composition.

(c) removes language allowing the CEO of Ohio state university hospitals to invite any member of their staff to represent him/her at a meeting or to attend any meeting

(d) change to: All members of the committee shall attend, either in person, **virtual**, or by proxy, a minimum of two-thirds of all committee meetings.

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

(3) Licensed health care professionals subcommittee

(a) Composition

- Replaces outdated cross reference with (A) of rule 3335-111-10

#### **(E) Medical staff bylaws committee.**

(1) Composition

- Replaces outdated cross reference (A) of rule 3335-111-10

#### **(F) Committee for practitioner health.**

(1) Composition

- Replaces outdated cross reference with (A) of rule 3335-111-10

### **3335-111-11 History and physical**

#### **(A) History and physical examination.**

(1) A history and physical appropriate to the patient and/or the procedure to be completed shall be documented in the medical record of all patients either:

- (b) Updates language to “Undergoing outpatient/ambulatory procedures **requiring anesthesia or sedation.**”

(3) Updates language to “For patients undergoing outpatient/ambulatory procedures **requiring anesthesia or sedation** or outpatient/ambulatory surgery, the history and physical examination shall include at a minimum:”

**(B) Deadlines and sanctions.**

(4) Updates language in first sentence to: “(4) Admitted patients or patients undergoing a procedure **requiring anesthesia or sedation** or surgery, the history and physical examination may be performed or updated up to thirty days prior to admission or the procedure/surgery.”

(4) (a) Updates language to: “For patients undergoing an outpatient procedure **requiring anesthesia or sedation** or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.



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**3335-111-01 Medical staff name.**

The board of trustees of the Ohio state university, by official action, established "the Arthur G. James cancer hospital and Richard J. Solove research institute (CHRI)." Hereinafter, the abbreviation "CHRI" shall mean the Arthur G. James cancer hospital and Richard J. Solove research institute; the term "medical staff" shall refer to the medical staff of the cancer hospital and research institute. "The medical staff of the Arthur G. James cancer hospital and Richard J. Solove research institute" shall be the name of the hospital's medical staff organization. In accordance with rules 3335-109-01 to 3335-109-20 and 3335-104-07 of the Administrative Code, the Ohio state university Wexner medical center board (herein called "Wexner medical center board") has delegated to the medical staff of the CHRI the responsibility to prepare and recommend adoption of these bylaws.

(Board approval dates: 9/1/1993, 2/5/1999, 9/6/2002, 2/6/2004, 11/4/2005, 2/11/2011, 11/7/2014)

**3335-111-02 Purpose.**

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

- (A) To maintain exemplary standards of medical care for all patients at the CHRI. To assure continuity of care and treatment for the individual patient throughout the course of his or her illness, and to assure ongoing support and care for cancer survivors. To commit to being responsive to the needs of all CHRI patients and to communicate compassionately and effectively concerning matters of patient care.
- (B) To support and encourage research, with an emphasis on the prevention and treatment of cancer; to actively encourage patients to participate in clinical trials and other research, and to foster research programs to enhance and advance the educational and patient care programs.
- (C) To support educational programs for health care and other professionals, patients and families, and the community, with an emphasis on cancer-related education; to elevate and advance the educational standards of our professions, including pre and post medical or osteopathic students, nursing students, students of the allied medical professions, and students of other health professional colleges.
- (D) To provide a means to identify and review medical problems, assure adherence to regulatory and accreditation standards, review and revise policies and procedures; and to provide a means for establishing and maintaining standards of professional, medical and educational performance, evaluation and discipline within the medical staff, and harmonious cooperation and understanding among the units comprising the CHRI.
- (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



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and financial relationships between the Ohio state university Wexner medical center and such practitioners.

(Board approval dates: 9/1/1993, 12/6/1996, 9/1/1999, 12/3/1999, 6/2/2000, 11/4/2005, 9/18/2009, 10/29/2011, 4/8/2011, 4/6/2018)

**3335-111-03 Patients.**

- (A) The continuous care and treatment of individual patients is the medical responsibility of the member of the attending, associate attending, clinical attending or community associate attending medical staff to whose care the patient is treated at or transferred to the CHRI, and to an allied health professional being granted clinical privileges under these bylaws.
- (B) There shall be only one category or classification of patients in the CHRI, and those patients are the patients of the medical staff under whose care they are treated. Patients treated at the CHRI who, prior to treatment, have not requested or selected a member of the medical staff to attend them shall be assigned for their care and treatment to a member of the medical staff for their care and treatment.
- (C) All patients treated at the CHRI should cooperate in, and, whenever applicable, participate in an approved cancer related protocol and knowingly participate in the teaching program of the college of medicine. Should a patient, or on the behalf of the patient, the patient's representative, refuse to participate or cooperate in the teaching program of the CHRI or the college of medicine, the medical staff member responsible for the care and treatment of the patient will encourage participation in the Ohio state university's teaching programs, but will simultaneously inform patients, or when appropriate, the patients representative, of their right to refuse participation.
- (D) Students, including pre and post medical or osteopathic, but not limited thereto, shall be under the direction and control of the members of the medical staff to whom the patient is assigned for treatment within the CHRI. The CHRI respects the patient's right to participate in decisions about his or her care, treatment and services, and further respects the patient's rights to refuse care, treatment and services, in accordance with law and regulation.

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

**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.

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- (2) All members of the medical staff of the CHRI, except 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. 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 approved by the medical staff administrative committee or as required by the CHRI to meet accreditation standards, federal regulations, or quality and safety goals is required for medical staff members with clinical privileges in addition to conflict of interest disclosures. Medical staff members and licensed health care professionals 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.

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- (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 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.
  - (c) If the medical staff member's or credentialed provider's participation in all governmental programs is fully reinstated, the affected medical staff member or credentialed provider shall be eligible to apply for membership and clinical privileges at that time.

- (5) Board certification.

An applicant for membership shall at the time of appointment or reappointment, be board certified in his or her specialty. This board certification must be approved by the American board of medical specialties, or other applicable certifying boards for doctors of osteopathy, podiatry, psychology, and dentistry. All applicants must be certified within the specific areas for which they have requested clinical privileges. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for medical staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training. Applicants must maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirement. Recertification will be assessed at reappointment. Failure to meet or maintain board certification shall result in termination of membership on the medical staff of the CHRI.

- (6) All applicants must demonstrate recent clinical activity in their primary area of practice during the last two years to satisfy minimum threshold criteria for privileges within their clinical departments.
- (7) Waiver requests for the threshold eligibility requirements listed in paragraphs (A)(4) to (A)(6) of this rule may be requested and considered as follows:
  - (a) A request for a waiver will only be considered if the applicant provides information sufficient to satisfy his or her burden to demonstrate that his or her qualifications are

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equivalent to or exceed the criterion in question and that there are exceptional circumstances that warrant a waiver. The clinical department chief must endorse the request for waiver in writing to the credentialing committee.

- (b) The credentialing committee may consider supporting documentation submitted by the prospective applicant, any relevant information from third parties, input from the relevant clinical department chiefs, and the best interests of the hospital and the communities it serves. The credentialing committee will forward its recommendation, including the basis for such, to the medical staff administrative committee.
  - (c) The medical staff administrative committee will review the recommendation of the credentialing committee and make a recommendation to the Wexner medical center board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.
  - (d) The Wexner medical center board determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a denial of appointment or clinical privileges and does not give rise to a right to a hearing. The prospective applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent for any other applicant. A determination to grant a waiver does not mean that an appointment will be granted.
  - (e) Waivers of threshold eligibility criteria will not be granted routinely. No applicant is entitled to a waiver or to a hearing if a waiver is not granted.
  - (f) Waivers to requirements prescribed by regulatory, accrediting, or other external agencies will not be granted.
- (8) Resignation, termination or non-reappointment to the faculty of the Ohio state university shall result in immediate termination of membership on the medical staff of the CHRI for attending, associate attending and clinical attending staff members.
- (9) Any staff member whose membership has been terminated pursuant to paragraph (A)(4) or (A)(5) of this rule shall not be entitled to request a hearing and appeal in accordance with rule 3335-111-06 of the Administrative Code. Any allied health professional whose clinical privileges have been terminated pursuant to paragraph (A)(4) of this rule may not request an appeal in accordance with paragraph (J)(8)(i) of rule 3335-111-07 of the Administrative Code.
- (10) No applicant shall be entitled to medical staff membership and or clinical privileges merely by the virtue of fulfilling the above qualifications or holding a previous appointment to the medical staff.
- (B) Application for membership.

Initial application for all categories of medical staff membership shall be made by the applicant to the clinical department chief or designee on forms prescribed by the medical staff administrative committee, stating the qualifications and references of the applicant and giving an account of the applicant's current licensure, relevant professional training and experience, current competence and ability to perform the clinical privileges requested. All applications for appointment must specify the clinical privileges requested. Applications may be made only if the qualifications are fulfilled as outlined in paragraph (A) of this rule. See paragraph (E)(1) of rule 3335-111-07 of the Administrative Code for exceptions to signature requirements. The application shall include written statements by

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the applicant that commit the applicant to abide by the bylaws, rules and regulations and policies and procedures of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university. The applicant shall produce a government issued photo identification to verify his/her identity pursuant to hospital/medical staff policy. The applicant for medical staff membership shall agree that membership requires participation in and cooperation with the peer review processes of evaluating credentials, medical staff membership and clinical privileges, and that a condition for membership requires mutual covenants between all members of the medical staff to release one another from civil liability in these review processes as long as the peer review is not conducted in bad faith, with malice, or without reasonable effort to ascertain the accuracy of information being disclosed or relied upon. A separate record shall be maintained for each applicant requesting appointment to the medical staff.

(C) Terms of appointment.

Initial appointment to the medical staff, except for the honorary category, shall be for a period not to exceed thirty-six 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.

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.

The code of ethics as adopted, or as may be amended, by the American medical association, the American dental association, the American osteopathic association, the American psychological association, the American college of surgeons, or the American podiatric medical association shall usually govern the professional ethical conduct of the respective members of the medical staff.

(E) Procedure for appointment.

- (1) The completed and signed application for membership of all categories of the medical staff as defined in rule 3335-111-07 of the Administrative Code, shall be presented to the clinical

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department chief or designee. The applicant shall include in the application a signed statement indicating the following:

- (a) If the applicant should be appointed to a category of the CHRI medical staff, the applicant agrees to be governed by the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of the trustees of the Ohio state university.
- (b) The applicant consents to be interviewed in regard to the application.
- (c) The applicant authorizes the CHRI to consult with members of the medical staffs of other hospitals with which the applicant has been or has attempted to be associated, and with others who may have information bearing on the applicant's competence, character and ethical qualifications.
- (d) The applicant consents to the CHRI's inspection of all records and documents that may be material to the evaluation of the applicant's professional qualifications and competence to carry out the clinical and educational privileges which the applicant is seeking as well as the applicant's professional and ethical qualifications for medical staff membership.
- (e) The applicant releases from any liability:
  - (i) All representatives of the CHRI for acts performed in connections with evaluating the applicant's credentials or releasing information to other institutions for the purpose of evaluating the applicant's credentials in compliance with these bylaws performed in good faith and without malice; and
  - (ii) All third parties who provide information, including otherwise privileged and confidential information, to members of the medical staff, the CHRI staff, the medical center board members, and members of the Ohio state university board of trustees concerning the applicant's credentials performed in good faith and without malice.
- (f) The applicant has an affirmative duty to disclose any prior termination, voluntary or involuntary, current loss, restriction, denial, or the voluntary or involuntary relinquishment of any of the following: professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.
- (g) The applicant further agrees to disclose to the director of medical affairs or the medical director of credentialing the initiation of any process which could lead to such loss or restriction of the applicant's professional licensure, board certification, DEA registration, membership in any professional organization or medical staff membership or privileges at any other hospital or health care facility.
- (h) The applicant agrees that acceptance of an appointment to any category of the CHRI medical staff authorizes the CHRI to conduct any appropriate health assessment including, but not limited to, drug or alcohol screens on a practitioner before granting of privileges and at any time during the normal pursuit of medical staff duties, based upon reasonable cause as determined by the chief of the practitioner's clinical

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department or the director of medical affairs of the CHRI or their authorized designees.

- (2) The purpose of the health assessment shall be to ensure that the applicant or appointee to the CHRI medical staff is able to fully perform and discharge the clinical, educational, administrative and research responsibilities which the applicant or appointee would or is permitted to exercise by reason of medical staff appointment. If, at the time of the initial request for a health assessment, and at any time an appointee refuses to participate as needed in a health assessment, including, but not limited to, a drug or alcohol screening, this shall result in automatic lapse of membership, privileges, and prerogatives until remedied by compliance with the requested health assessment. Upon request of the medical staff administrative committee or the Wexner medical center board, the applicant or appointee will provide documentation of their physical/mental status with sufficient adequacy to demonstrate that any patient treated by the applicant or appointee will receive efficient and quality care at a professionally recognized level of quality and efficiency. The conditions of this paragraph shall be deemed continuing and may be applicable to issues of continued good standing as an appointee to the medical staff.
  
- (3) An application for membership on the medical staff shall be considered complete when all the information requested on the application form is provided, the applicant signs the application and the information is verified. A completed application must contain:
  - (a) Peer recommendations from at least three individuals with first hand knowledge about the applicant's clinical and professional skills within the last year;
  - (b) Evidence of required immunizations;
  - (c) Evidence of current professional medical malpractice liability coverage required for the exercise of clinical privileges;
  - (d) Satisfaction of ECFMG requirements, if applicable. If an individual receives a conceded eminence certificate or a clinical research faculty certificate from the state medical board of Ohio, the requirement for ECFMG certification may be waived at the discretion of the Wexner medical center board.
  - (e) Verification by primary source documentation of:
    - (i) Current and previous state licensure, and
    - (ii) Faculty appointment, when applicable.
    - (iii) DEA registrations, when required for the exercise of requested clinical privileges;
    - (iv) Graduation from an accredited professional school, when applicable;
    - (v) Successful completion or record of post professional graduate medical education;
    - (vi) Board certification or, active candidacy for board certification or applicant qualifies for a waiver pursuant to paragraph (A)(5) of this rule.

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- (f) Information from the national practitioner data bank and other JCAHO approved sources;
  - (g) Verification that the applicant has not been excluded from any federally funded health care program; and
  - (h) Complete disclosure by the applicant of all past and current claims, suits, verdicts, and settlements, if any.
  - (i) Completion of a criminal background investigation that meets the requirements of the Wexner medical center.
  - (j) Completion of drug testing for substances required for individuals applying for clinical privileges and in accordance with Wexner medical center approved testing protocols.
  - (k) Verification of completion of specific competencies required for clinical privileges, as approved by the Medical Staff Administrative Committee and maintained in the provider's credentials files. All other required annual online learnings must be completed within sixty days of employment.
  - (l) Demonstration of recent active clinical practice during the last two years required for exercise of clinical privileges.
  - (m) Attestation of current Ohio automated Rx reporting system ("OARRS") account for all applicants who have a DEA registration.
- (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. 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 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) The applicants shall have the burden of producing information for an adequate evaluation of his/her qualifications for membership and for the clinical privileges requested. If the applicant fails to complete the prescribed forms or fails to provide the information requested within sixty days of receipt of the signed application, processing of the application shall cease and the application shall be deemed to have been voluntarily withdrawn, action which is not subject to hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.



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- (7) If the clinical department chief does not submit a report and recommendation on a timely basis, the completed application shall be forwarded to the medical director of credentialing for presentation to the credentials committee on the same basis as other applicants.
- (8) Completed applications shall be acted upon as follows:
  - (a) By the credentials committee within thirty days after receipt of a completed application from the medical director of credentialing;
  - (b) By the medical staff administrative committee within thirty days after receipt of a completed application and the report of the recommendation of the credentials committee;
  - (c) By the quality and professional affairs committee of the Wexner medical center board;
  - (d) By the Wexner medical center board within one hundred twenty days after receipt of a completed application and the report and recommendation of the medical staff administrative committee; and
  - (e) By the Wexner medical center board, or a subcommittee of the Wexner medical center board if eligible for expedited credentialing, within one hundred twenty days after receipt of a completed application and the report and recommendation of the medical staff administrative committee.
- (9) These time periods are deemed guidelines only and do not periods. These periods may be stayed or altered pending receipt and verification of further information requested from the applicant, or if the application is deemed incomplete at any time. If the procedural rights create any right to have an application processed within these precise specified in rule 3335111-06 of the Administrative Code are activated, the time requirements provided therein govern the continued processing of the application.
- (10) The credentials committee shall review the application, evaluate and verify the supporting documentation, references, licensure, the clinical department chief's report and recommendation, and other relevant information. The credentials committee shall examine the character, professional competence, professional conduct, qualifications, and ethical standing of the applicant and shall determine, through information contained in the personal references and from other sources available, whether the applicant established and met all of the necessary qualifications for the category of the medical staff and clinical privileges requested.
- (11) The credentials committee shall, within thirty days from receipt of a completed application, make a recommendation to the medical director of credentialing that the application be accepted, rejected or modified. The medical director of credentialing shall forward the recommendation of the credentials committee to the medical staff administrative committee. The credentials committee or the medical director of credentialing may recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session.
- (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

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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.

- (13) At any time, the medical staff administrative committee first recommends non-appointment of an initial applicant for any category of the medical staff or recommends denial of any clinical privileges requested by the applicant, the medical staff administrative committee shall require the medical director of credentialing to notify the applicant by certified return receipt mail that applicant may request an evidentiary hearing as provided in paragraph (D) of rule 3335-111-06 of the Administrative Code. The applicant shall be notified of the requirement to request a hearing as provided by paragraph (B) of rule 3335-111-06 of the Administrative Code. If a hearing is properly requested, the applicant shall be subject to the rights and responsibilities of rule 3335-111-06 of the Administrative Code. If an applicant fails to properly request a hearing, the medical staff administrative committee shall accept, reject, or modify the application for appointment to membership and clinical privileges.
- (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, and the Ohio state university board of trustees.

(F) Procedure for reappointment.

- (1) Reappointment for all categories of the medical staff shall be for a period not to exceed ~~thirtysix~~thirty-six months. An appointment or grant of privileges for a period of less than thirty-six months shall not be deemed an adverse action. At least ninety days prior to the end of the medical staff member' or licensed allied health professional's appointment period, the clinical department chief shall provide each individual with an application for reappointment to the medical staff on forms prescribed by the medical staff administrative committee.
- (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 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) An application for reappointment is complete when all the information requested on the reappointment application is provided, the reappointment form is signed by the applicant, and the information is verified, and no need for additional or clarifying information is identified. A completed reappointment application must contain:

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- (a) Evidence of current professional medical malpractice liability insurance required for the exercise of clinical privileges;
  - (b) Verification by primary source documentation of state licensure;
  - (c) DEA registration when required for clinical privileges as requested;
  - (d) Successful completion or record of any additional post graduate medical or professional education not submitted since initial or last appointment;
  - (e) Board certification, recertification, or continued active candidacy for certification or applicant qualifies for a waiver pursuant to paragraph (A)(5) of this rule.
  - (f) Information from the national practitioner data bank;
  - (g) Verification that the applicant has not been excluded from any federally funded health care program;
  - (h) Specific requests for any changes in clinical privileges sought at reappointment with supporting documentation as required by credentialing guidelines;
  - (i) Specific requests for any changes in medical staff category;
  - (j) A summary of the member's clinical activity during the previous appointment period;
  - (k) Verification of completion of any annual education requirements approved by the medical staff administrative committee and maintained in the chief medical officer's office;
  - (l) Complete disclosure by individuals of claims, suits, verdicts and settlements, if any since last appointment; and
  - (m) Continuing medical education and applicable continuing professional education activities: documentation of category one CME that, at least in part, relates to the individual medical staff member's specialty or subspecialty area and is consistent with the licensing requirements of the applicable Ohio state licensing board shall be required.
  - (n) Attending physicians only: submit information summarizing clinical research activities with each application.
  - (o) Attestation of current OARRS account for all applicants who have a DEA registration.
- (4) The applicant for reappointment shall be required to submit any reasonable evidence of current ability to perform the clinical privileges requested. The clinical department chief shall review and evaluate the reappointment application and the supporting documentation. The clinical department chief shall evaluate all matters relevant to recommendation, including: the applicant's professional competence; clinical judgment; clinical or technical skills; ethical conduct; participation in medical staff affairs, if applicable; compliance with the bylaws, rules and regulations of the medical staff, the Wexner medical center board, and the board of trustees of the Ohio state university; cooperation with the CHRI hospitals personnel and the use of the CHRI hospital's facilities for patients; relations with other physicians other health

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professionals or other staff; maintenance of a professional attitude toward patients; and the responsibility to the CHRI and the public.

- (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. 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 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 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) The credentials committee shall forward its recommendations to the medical director of credentialing at least thirty days prior to the end of the period of appointment for the individual. The medical director of credentialing shall transmit the completed reappointment application and recommendation of the credentials committee to the medical staff administrative committee.
- (7) Failure of the member to submit a reappointment application shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership and all clinical privileges at the end of the medical staff member's current appointment period, action which shall not be subject to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code. A request for reappointment subsequently received from a member who has been automatically terminated shall be processed as a new appointment.
- (8) Failure of the clinical department chief to act in a timely manner on an application for reappointment shall be the same as provided in paragraph (E)(7) of this rule.
- (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.
- (10) When the decision of the medical staff administrative committee results in a decision of non reappointment or reduction, suspension, or revocation of clinical privileges, the medical staff

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administrative committee shall instruct the medical director of credentialing to give written notice to the affected member of the decision, the stated reason for the decision, and the member's right to a hearing pursuant to rule 3335-111-06 of the Administrative Code. This notification and an opportunity to exhaust the appeal process shall occur prior to an adverse decision unless the provisions outlined in paragraph (C) of rule 3335-111-06 of the Administrative Code apply. The notice by the medical director of credentialing shall be sent certified return receipt mail to the affected member's last known address as determined by the Ohio state university records.

- (11) If the affected member of the medical staff does not make a written request for a hearing to the director of medical affairs within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any hearing or appeal as provided in rule 3335-11106 of the Administrative Code to which the staff member might otherwise have been entitled on the matter. If a timely, written request for hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.
- (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

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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, 4/6/2018, 8/15/2023)

**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 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.
- (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:
  - (a) The matter warrants no further action;
  - (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

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- (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) Formal peer review may be requested in more serious situations or where informal review has not resolved an issue or whenever the activities or professional conduct of a member of the medical staff of the CHRI:
  - (a) Violates the standards or aims of the medical staff or standards of professional conduct;
  - (b) Is considered to be disruptive to the operation of the CHRI;
  - (c) Violates the bylaws, rules and regulations of the medical staff, the Wexner medical center board, or the board of trustees of the Ohio state university;
  - (d) Violates state or federal law; or
  - (e) Is detrimental to patient safety or to the delivery of patient care within the CHRI.
- (2) Formal peer review may be initiated by the clinical department chief, the department chairperson and/or division director, 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 Wexner 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) The director of medical affairs shall promptly notify the affected member of the medical staff, in a confidential manner, that a request for formal peer review has been made, and inform the member of the specific activities or conduct which constitute grounds for the requested action. The director of medical affairs shall verify the facts related to the request for formal peer review, and within thirty days, make a written determination. If the director of medical affairs decides that no further action is warranted, the director of medical affairs shall notify the person(s) who filed the request for formal peer review and the member accused, in writing, that no further action would be taken.
- (4) Whenever the director of medical affairs determines that formal peer review is warranted and that a reduction, suspension or revocation of clinical privileges could result, the director of medical affairs shall refer the request for formal peer review to the formal peer review committee. The affected member of the medical staff shall be notified of the referral to the formal peer review committee, and be informed that these medical staff bylaws shall govern all further proceedings. The executive vice president for health sciences or designee shall exercise any or all duties or responsibilities assigned to the director of medical affairs under these rules for implementing corrective action and appellate procedure only if:
  - (a) The director of medical affairs is the medical staff member charged;

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- (b) The director of medical affairs is responsible for having the charges brought against another medical staff member; or
  - (c) There is an obvious conflict of interest.
- (5) The formal peer review committee shall investigate every request and shall report in writing its findings and recommendations for action to the appropriate clinical department chief and notice given to the 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 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 approve or 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; 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



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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) If the affected member of the medical staff does not make a written request for a hearing to the director of medical affairs within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the right to any review by the medical staff administrative committee to which the staff member might otherwise have been entitled on the matter.
  - (9) If a timely, written request for hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.
- (C) Composition of the formal peer review committee.
- (1) When the determination that formal peer review is warranted is made, the clinical department chief shall select three members of the medical staff to serve on a formal peer review committee.
  - (2) Whenever the questions raised concern the clinical competence of the member under review, the clinical department chief shall select members of the medical staff to serve on the formal peer review committee who shall have similar levels of training and qualifications as the member who is subject to formal peer review.
  - (3) An external review consultant may serve as a member of the formal peer review whenever:
    - (a) A determination is made by the clinical department chief and the director of medical affairs that the clinical expertise needed to conduct the review is not available on the medical staff;
    - (b) The objectivity of the review may be compromised due to economic considerations;  
or
    - (c) Whenever the director of medical affairs determines that an external review is otherwise advisable.

If an external reviewer is recommended, the clinical department chief shall make a written recommendation to the director of medical affairs for selection of an external reviewer. The director of medical affairs shall make the final selection of an external reviewer.
- (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 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.

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- (2) A medical staff member whose privileges have been summarily suspended or whose appointment has been terminated shall be entitled to appeal the suspension pursuant to rule 3335-111-06 of the Administrative Code. If the affected member of the medical staff does not make a written request for a hearing to the chief executive officer within thirty-one days after receipt of the adverse decision, it shall be deemed a waiver of the affected member's right to any review by the medical staff administrative committee of which the member might otherwise been entitled. If a timely, written request for a hearing is made, the procedures set forth in rule 3335-111-06 of the Administrative Code shall apply.
  - (3) Immediately upon the imposition of a summary suspension, the chief executive officer in consultation with the appropriate 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) Notwithstanding the provisions of this rule, a temporary lapse of a medical staff member's admitting privileges, effective until medical records are completed, may be imposed automatically by the chief executive officer after a warning, in writing, of delinquency for failure to complete medical records as defined by the rules and regulations of the medical staff.
  - (2) Action by the state boards of licensure revoking or suspending a medical staff member's licensure or placing the member on probation shall automatically impose the same restrictions to that member's CHRI medical staff privileges.
  - (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 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 immediately and automatically terminate, unless resignation in lieu of automatic termination is permitted pursuant to rule 3335-43-04(A)(4).
  - (5) If a medical staff member pleads guilty to or is found guilty of a felony which involves violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; fraud, bribery, evidence tampering, or perjury; or a drug offense, the medical staff member's appointment and privileges shall be immediately and automatically terminated.
  - (6) Whenever a medical staff member's drug enforcement administration (DEA) or other controlled substances number is revoked, he or she shall be immediately and automatically divested of his or her right to prescribe medications covered by the number.

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- (7) When a medical staff member's DEA or other controlled substances number is suspended or restricted in any manner, his or her right to prescribe medications covered by the number is similarly automatically suspended or restricted during the term of the suspension or restriction.
- (8) No medical staff member shall be entitled to the procedural rights set forth in rule 3335-11106 of the Administrative Code as a result of an automatic suspension or termination. As soon as practicable after the imposition of an automatic suspension, the medical staff administrative committee shall convene to determine if further corrective action is necessary. Any further action with respect to an automatic suspension must be taken in accordance with this rule.

(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, 4/6/2018)

**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, 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.

(3) 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.

- (1) The request for a hearing shall be submitted in writing by the affected medical staff member to the chief executive officer within thirty days of notifications by the chief executive officer of

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the intended action. The chief executive officer shall forward the request to the medical staff administrative committee along with instructions to convene a hearing.

- (2) The failure of a medical staff member to request a hearing to which the member is entitled by these bylaws within the time and in the manner herein provided, shall be deemed a waiver of the member's right to any review by the medical staff administrative committee to which the member might otherwise been entitled. The chief executive officer shall then implement the decision and that action shall become and remain effective against the medical staff member in the same manner as a final decision of the Wexner medical center board as provided for in paragraph (E) of this rule. The chief executive officer shall promptly inform the affected medical staff member that the proposed decision, which had entitled the medical staff member to a hearing, has now become final.

(C) Notice of hearing.

- (1) After receipt of a timely request for hearing by the chief executive officer from a medical staff member entitled to such hearing, the medical staff administrative committee shall be notified of the request for hearing by the chief executive officer, and shall at the next scheduled meeting take the following action:

- (a) Instruct the director of medical affairs and chief of staff to jointly appoint within seven days a hearing committee, consisting of three to five members of the medical staff who are not members of the medical staff administrative committee, are not direct competitors, do not have a conflict of interest, and who have not previously participated in the peer review of the matter under consideration.
- (b) Instruct the hearing committee to schedule and arrange for a hearing which hearing shall be conducted not less than thirty nor more than sixty days from the date of the receipt of the request for a hearing by the chief executive officer. However, an initial hearing or meeting for a medical staff member who is under summary suspension, which is then in effect, shall be held as soon as arrangements may be reasonably made.

- (2) The medical staff member shall be given at least ten days prior notice of the scheduled hearing, provided that the medical staff member may waive this notice in writing. Notice shall be by certified return receipt mail to the staff member at the staff member's last known address as reflected by university records. The notice of hearing shall state in concise language the acts or omissions with which the medical staff member is charged; a list of representative medical records or documents being used; names of potential witnesses to be called; and any other reason or evidence that may be considered by the hearing committee during the hearing.

(D) Conduct of hearing.

- (1) The hearing committee shall select a chairperson from the committee to preside over the hearing. The chairperson may require a representative for the individual and for the medical staff administrative committee (or the Wexner medical center board) to participate in a prehearing conference. At the pre-hearing conference, the chairperson shall resolve all procedural questions, including any objections to exhibits or witnesses, the role of legal counsel, and determine the time to be allotted to each witness's testimony and cross-examination. The hearing committee shall have benefit of Ohio state university legal counsel. The hearing committee may grant continuances, recesses, and the chairperson may

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excuse a member of the hearing committee from attendance temporarily for good cause, provided that there shall be at no time less than two members of the hearing committee present unless the affected staff member waives this requirement.

All members of the hearing committee must be present to deliberate and vote. No member may vote by proxy. The person who has taken the action from which the affected staff member has requested the hearing shall not participate in the deliberation or voting of the hearing committee. The hearing shall be a de novo hearing, although evidence of the prior recommendations and decisions may be presented.

- (2) An accurate record of the hearing shall be kept. The record shall be done by the use of a professional stenographer. This record shall be available to the affected member of the medical staff upon request at the affected member's expense.
- (3) The personal presence of the medical staff member for whom the hearing has been scheduled shall be required. A medical staff member who fails without good cause to appear and proceed at such hearing shall be deemed to have waived the right to appear and to have a hearing before the medical staff administrative committee in the same manner as provided in paragraph (B) of this rule, and to have accepted the adverse recommendation or decision involved and the same shall therein become and remain in effect as provided in paragraph (B) of this rule. The hearing committee may, at its own discretion, proceed with the hearing without the medical staff member and impose a sanction.
- (4) Postponements of hearings beyond the time set forth in this chapter shall be made only with the approval of the medical staff administrative committee. Granting of such postponement shall be only for good cause shown.
- (5) The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or presentation of evidence. Any relevant matters upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The member of the medical staff for whom the hearing is being held shall, prior to, or during the hearing, be entitled to submit memoranda concerning any issues of procedure or of fact and such memoranda shall become a part of the hearing record.
- (6) The affected medical staff member shall have the following rights: to be represented by an attorney at law and to call and examine witnesses; to introduce evidence; to cross-examine any witnesses on any matter relevant to the issue of the hearing; and to challenge any witness and to rebut any evidence. If the medical staff member does not testify in his/her own behalf, the member may be called and examined as if under cross-examination.
- (7) The hearing committee shall request the person who has taken the action from which the affected medical staff member has requested the hearing to present evidence to the hearing committee in support of the adverse recommendation. The hearing committee may proceed to hear evidence and testimony from either party in whatever order the hearing committee deems appropriate. The hearing committee may call its own witnesses, may recall any party's witnesses, and may question witnesses as it deems appropriate. All parties shall be responsible to secure the attendance of their own witnesses. All witnesses and evidence received by the hearing committee shall be open to challenge and cross-examination by the parties. Witnesses shall not be placed under oath. At the close of the evidence the hearing committee may request each party to make summary statements, either oral or written.

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- (8) The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. The hearing committee shall make its best effort to expeditiously determine the issues presented. The hearing committee may limit its proceedings when sufficient material has been received. The parties may be required to provide evidence in oral or written form. Upon conclusion of the presentation of evidence the hearing shall be closed. The hearing committee may there upon, at a time convenient to itself, conduct its deliberations outside the presence of the medical staff member for whom the hearing was convened.
  - (9) Within sixty days after its appointment, unless otherwise extended by the medical staff administrative committee, the hearing committee shall forward its written report and recommendation together with the transcript of the hearing and all other documentation presented by the parties to the medical staff administrative committee. The affected member shall be notified of the recommendation of the hearing committee including a statement of the basis for the recommendation. The medical staff administrative committee shall accept, reject, or modify the recommendation of the hearing committee. The medical staff administrative committee may conduct further hearings as it deems necessary or may remand the matter back to the hearing committee for further action as directed. The medical staff administrative committee may impose a greater or lesser sanction than that recommended by the hearing committee.
  - (10) Within fourteen days after the conclusion of the taking of all evidence and of all hearings, the medical staff administrative committee shall make a written report of its findings and its recommendation and shall forward the same together with the hearings record and all other documentation to the chairperson of the Wexner medical center board. Notice of that decision shall be sent certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records by the director.
  - (11) The decision and record of the medical staff administrative committee shall be transmitted to the quality and professional affairs committee of the Wexner medical center board, which shall, subject to the affected member's right to appeal and implementation of paragraph (E) of this rule, consider the matter at its next scheduled meeting, or at a special meeting to be held no less than thirty days following receipt of the transmittal. The quality and professional affairs committee of the Wexner medical center board may accept, reject, or modify the decision of the medical staff administrative committee.
  - (12) The recommendation of the quality and professional affairs committee of the Wexner medical center board shall be promptly considered by the Wexner medical center board at its next scheduled meeting. The Wexner medical center board may accept, reject, or modify the recommendation of the quality and professional affairs committee of the Wexner medical center board.
  - (13) A copy of the Wexner medical center board decision shall be sent by certified return receipt mail to the affected medical staff member at the member's last known address as determined by university records.
- (E) Appeal process.
- (1) Within thirty days after receipt of a notice by an affected medical staff member of the action of the medical staff administrative committee the staff member may, by written notice to the

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chairperson of the Wexner medical center board, request an appeal. Such appeal shall only be held on the record before the medical staff administrative committee.

- (2) If an appeal is not requested within the thirty-day period, the affected medical staff member shall be deemed to have waived the right to an appeal, and to have accepted such adverse decision.
- (3) The appeal shall be conducted by the quality and professional affairs committee of the Wexner medical center board.
- (4) The affected medical staff member shall have access to the reports and records, including transcripts, if any, of the medical staff administrative committee and all other material, favorable or unfavorable, that have been considered by that committee. The member shall then submit a written factual statement specifying those factual and procedural matters with which the member disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the quality and professional affairs committee of the Wexner medical center board no later than seven days following the date of the affected member's notice of appeal.
- (5) New or additional matters not raised during the hearing procedure or in the medical staff administrative committee hearings shall only be introduced on appeal at the sole discretion of the quality and professional affairs committee of the Wexner medical center board.
- (6) Within fourteen days following submission of the written statement by the affected medical staff member, the quality and professional affairs committee shall recommend to the Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the medical staff administrative committee for further review and recommendation. Such referral to the medical staff administrative committee may include a request for further investigation.
- (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 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, 4/6/2018, 8/15/2023)

**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, 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 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,

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demonstration of recent active clinical practice during the last two years and specific annual education 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, 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 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:**

Attending staff members may:

- (a) Admit patients consistent with the balanced teaching and patient care responsibilities of the CHRI. When, in the judgment of the director of medical affairs, a balanced teaching program is jeopardized, following consultation with the chief executive



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officer, the clinical department chief and with the concurrence of a majority of the medical staff administrative committee, the director of medical affairs may restrict admissions. Imposition of such restrictions shall not entitle the attending staff member to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.

- (b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.
- (c) Vote on all matters presented at general and special meetings of the medical staff and committees of which he or she is a member unless otherwise provided by resolution of the medical staff, clinical department or committee and approved by the medical staff administrative committee.
- (d) Hold office in the medical staff organization, clinical departments and committees of which they are a member, unless otherwise provided by resolution of the medical staff, clinical department or committee and approved by the medical staff administrative committee.

(3) Responsibilities:

An attending staff member 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 the member's area of professional competence for the continuous care and supervision of each patient in the CHRI for whom he or she 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 medical 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 medical 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. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services that the limited staff member is competent to perform under supervision.
- (f) Supervise other licensed allied health professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed allied health professional to perform only those services which the licensed allied health professional is privileged to perform.
- (g) Take call as assigned by the clinical department chief.

(D) Associate attending staff.

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(1) Qualifications:

The associate attending staff shall consist of those regular faculty members of the colleges of medicine and dentistry who do not qualify for attending staff appointment.

(2) Prerogatives:

The associate attending staff may:

- (a) Admit patients consistent with the balanced teaching and patient care responsibilities of the institution. When, in the judgment of the director of medical affairs, a balanced teaching program is jeopardized, following consultation with the chief executive officer, the clinical department chief and with the concurrence of a majority of the medical staff administrative committee, the director of medical affairs may restrict admissions. Imposition of such restrictions shall not entitle the associate attending staff member to a hearing or appeal pursuant to rule 3335-111-06 of the Administrative Code.
- (b) Be free to exercise such clinical privileges as are granted pursuant to the bylaws.
- (c) Vote on all matters presented at general and special meetings of the medical staff and at committees of which he or she is a member unless otherwise prohibited by these bylaws or by resolution approved by the medical staff administrative committee.
- (d) The associate attending staff member may not vote on amendments to the bylaws.

(3) Responsibilities:

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 the member's care area of professional competence for the continuous care and supervision of each patient in the CHRI for whom the member is providing care, or arrange a suitable alternative for such care and supervision including the supervision of interns, residents and fellows assigned to their service.
- (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 medical staff meetings and meetings of those committees of which they are a member.

(E) Clinical attending staff.

(1) Qualifications:

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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 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:

The clinical attending staff may:

- (a) Admit patients which complement the research and clinical teaching program. At times when hospital beds or other resources are in short supply, patient admissions of clinical staff shall be subordinate to those of attending or associate attending staff.
- (b) Be free to exercise such clinical privileges as are granted pursuant to these bylaws.
- (c) Attend meetings as non-voting members of the medical staff and any medical staff or hospital education programs. The clinical attending staff may not hold elected office in the medical staff organization.

(3) Responsibilities:

- (a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.
- (b) Retain responsibility within the member's area of professional competence for the continuous care and supervision of each patient in the CHRI for whom the member is providing care, or arrange a suitable alternative for such care and supervision including the supervision of interns, residents and fellows assigned to their service.
- (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 medical 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. It is the responsibility of the attending physician to authorize each member of the limited staff to perform only those services which the limited staff member is competent to perform under supervision.
- (f) Supervise other licensed allied health professionals as necessary in accordance with accreditation standards and state law. It is the responsibility of the attending physician to authorize each licensed allied health professional to perform only those services which the licensed allied health professional is privileged to perform.

(F) Consulting medical staff.

(1) Qualifications.

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The consulting medical staff shall consist of those faculty members of the colleges of medicine and dentistry who:

- (a) Satisfy the requirements and qualifications for membership set forth in rule 3335111-04 of the Administrative Code.
- (b) Are consultants of recognized professional ability and expertise who provide a service not readily available from the attending medical staff. These practitioners provide services to James patients only at the request of attending or associate attending members of the medical staff.
- (c) Demonstrate participation on the active medical staff at another accredited hospital requiring performance improvement/quality assessment activities similar to those of the hospitals of the Ohio state university. The practitioner shall also hold at such other hospital the same privileges, without restriction, that he/she is requesting at the James cancer hospital. An exception to this qualification may be made by the Wexner medical center board provided the practitioner is otherwise qualified by education, training and experience to provide the requested service.

(2) Prerogatives:

Consulting medical staff members may:

- (a) Exercise the clinical privileges granted for consultation purposes on an occasional basis when requested by an attending or associate attending medical staff member.
- (b) Have access to all medical records and be entitled to utilize the facilities of the Ohio state university hospitals and James cancer hospital incidental to the clinical privileges granted pursuant to these bylaws.
- (c) Not admit patients to the Ohio state university hospitals or James cancer hospital.
- (d) Not vote on medical staff policies, rules and regulations, or bylaws, and may not hold office.
- (e) Must actively participate in such quality evaluation and monitoring activities as required by the medical staff and as outlined in the medical staff policy entitled "consulting medical staff member policy."
- (f) Attend medical staff meetings, but shall not be entitled to vote at such meetings or hold office.
- (g) Attend department meetings, but shall not be entitled to vote at such meetings or serve as clinical department chief.
- (h) Serve as a non-voting member of a medical staff committee; provided, however, that he/she may not serve as a committee chair or as a member of the medical staff administrative committee.

(3) Responsibilities.

Each member of the consulting medical staff shall:

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- (a) Meet the basic responsibilities set forth in rules 3335-111-02 and 3335-111-03 of the Administrative Code.
- (b) Be exempt from all medical staff dues.

(G) 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:

The limited staff shall consist of doctors of medicine, osteopathic physicians, dentists and practitioners of podiatry or psychology who are accepted in good standing by a program director into a postdoctoral graduate medical education program and appointed to the limited staff in accordance with these bylaws. The limited staff shall maintain compliance with the requirements of state law, including regulations adopted by the Ohio state medical board, or the limited staff member's respective licensing board.

Members of the limited staff shall possess a valid training certificate or an unrestricted Ohio license from the applicable state board based on eligibility criteria defined by that state board. All members of the limited staff shall be required to successfully obtain an Ohio training certificate prior to beginning training within a program.

(2) Responsibilities:

The limited staff shall:

- (a) Be responsible to respond to all questions and complete all forms as may be required by the credentials committee.
- (b) Participate fully in the teaching programs, conferences, and seminars of the clinical department in which he or she is appointed in accordance with accreditation standards and policies and procedures of the graduate medical education committee and approved clinical training programs.
- (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 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) Serve as full members of the various medical staff committees in accordance with established committee composition as described in these bylaws and/or rules and

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regulations of the medical staff. The limited staff member shall not be eligible to vote or hold elected office in the medical staff organization, but may vote on committees to which the limited staff member is assigned.

- (e) Be expected to make regular satisfactory professional progress including anticipated certification by the respective specialty or subspecialty program of post-doctoral training in which the limited staff member is enrolled. Evaluation of professional growth and appropriate humanistic qualities shall be made on a regular schedule by the clinical department chief, program director, teaching faculty or evaluation committee in accordance with accreditation standards and policies and procedures of the approved training programs.
- (f) Appeal by a member of the limited staff of probation, lack of 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 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:

Termination of employment from the limited staff member's residency or fellowship training program shall result in automatic termination of the limited staff member's appointment pursuant to these bylaws.

(4) Temporary appointments:

- (a) Limited staff members who are Ohio state university faculty may be granted an early commencement or an extension of appointment upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, when it is necessary for the limited staff member to begin his or her training program prior to or extend his or her training program beyond a regular appointment period. The appointment shall not exceed sixty days.
- (b) Temporary appointments may be granted upon the recommendation of the chief of the clinical department, with prior concurrence of the associate dean for graduate medical education, for limited staff members who are not Ohio state university faculty but who, pursuant to education affiliate agreements approved by the university, need to satisfy approved graduate medical education clinical rotation requirements. These appointments shall not exceed a total of one hundred twenty days in any given postgraduate year. In such cases, the mandatory requirement for a faculty

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appointment may be waived. All other requirements for limited staff member appointment must be satisfied.

(5) Supervision:

Limited staff members shall be under the supervision of an attending, associate attending or clinical 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 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 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 medical staff member or the director of the training program.

- (a) Limited staff members may write admission, discharge or other orders for the care of patients under the supervision of the attending, associate attending or clinical attending medical staff member.
- (b) All records of limited staff member cases must document involvement of the attending, associate attending or clinical 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) Associates to the medical staff.

(1) Qualifications:

Licensed health care professionals are those professionals who possess a license, certificate or other legal credential required by Ohio law to provide direct patient care in a hospital setting, but who are not acting as licensed independent practitioners.

(2) Due process:

Licensed health care professionals are subject to corrective action for violation of these rules, their certificate of authority, standard care agreement, utilization plan or the provisions of their licensure, including professional ethics. Corrective action may be requested by any member of the medical staff, the clinical department chief, the chairperson of an academic department, the section chief, the medical director of credentialing or the director of medical affairs. All requests shall be in writing and be submitted to the director of medical affairs.

The director of medical affairs shall appoint a three-person committee to review the situation and recommend appropriate corrective action, including termination or suspension of clinical privileges. The committee shall consist of at least one licensed health care professional licensed in the same field as the individual being reviewed, if available, and one medical staff member. The committee shall make a written recommendation to the director of medical affairs, who may accept, reject or modify the recommendation. The decision of the director of medical affairs shall be final.

(I) Temporary medical staff appointment.

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- (1) External peer review. When peer review activities are being conducted by someone other than a current member of the medical staff, the chief medical officer or director of medical affairs may admit a practitioner to the medical staff for a limited period of time. Such membership is solely for the purpose of conducting peer review in a particular evaluation and this temporary membership automatically expires upon the member's completion of duties in connection with such peer review. Such appointment does not include clinical privileges, and is for a limited purpose.
  - (2) Proctoring. Temporary privileges may be extended to visiting physician or visiting medical faculty for special clinical or educational activities as permitted by the Ohio state medical or dental board. When medical staff members require proctoring for the purposes of gaining experience to become credentialed to perform a procedure, a visiting medical faculty or visiting physician may apply for temporary privileges pursuant to the medical staff proctoring policy.
- (J) Clinical privileges.
- (1) Delineation of clinical privileges:
    - (a) Every person practicing at the CHRI by virtue of medical staff membership, faculty appointment, contract or under authority granted in these bylaws shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically applied for and granted to the staff member or other licensed allied health professional by the Wexner medical center board after recommendation from the medical staff administrative committee.
    - (b) Each clinical department and CHRI 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) Requests for the exercise and delineation of clinical privileges must be made as part of each application for appointment or reappointment to the medical staff on the forms prescribed by the medical staff administrative committee. Every person in an administrative position who desires clinical privileges shall be subject to the same procedure as all other applicants. Requests for clinical privileges must be submitted to the chief of the clinical department in which the clinical privileges will be exercised. Clinical privileges requested other than during appointment or reappointment to the medical staff shall be submitted to the chief of the clinical department and such request must include documentation of relevant training or experience supportive of the request.
    - (d) The chief of the clinical department shall review each applicant's request for clinical privileges and shall make a recommendation regarding clinical privileges to the medical director of credentialing. Requests for clinical privileges shall be evaluated based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information including the direct observation and review of records of the applicant's performance by the clinical department in which the clinical privileges are exercised. Whenever possible, the review should be of primary source information. The applicant shall have the burden



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of establishing qualifications and competence in the clinical privileges requested and shall have the burden of production of adequate information for the proper evaluation of qualifications.

- (e) The applicant's request for clinical privileges and the recommendation of the clinical department chief shall be forwarded to the credentials committee and shall be processed in the same manner as applications for appointment and reappointment pursuant to rule 3335-111-04 of the Administrative Code.
  - (f) Medical staff members who are granted new or initial privileges are subject to FPPE, which is a six-month period of focused monitoring and evaluation of practitioner's professional performance. Following FPPE medical staff members with clinical privileges are subject to ongoing professional practice evaluation (OPPE), which information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal. FPPE and OPPE are fully detailed in medical staff policies that were approved by the medical staff administrative committee and the Wexner medical center board.
  - (g) Upon resignation, termination or expiration of the medical staff member's faculty appointment or employment with the university for any reason, such medical staff appointment and clinical privileges of the medical staff member shall automatically expire.
  - (h) Medical staff members authorize the CHRI and clinics to share amongst themselves credentialing, quality and peer review information pertaining to the medical staff member's clinical competence and/or professional conduct. Such information may be shared at initial appointment and/or reappointment and at any time during the medical staff member's medical staff appointment to the medical staff of the CHRI.
  - (i) Medical staff members authorize the CHRI to release, in good faith and without malice, information to managed care organizations, regulating agencies, accreditation bodies and other health care entities for the purposes of evaluating the medical staff member's qualifications pursuant to a request for appointment, clinical privileges, participation or other credentialing or quality matters.
- (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. All temporary privileges are granted by the chief executive officer or authorized designee. 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) Temporary privileges may be extended to visiting medical faculty or for special activity as provided by the Ohio state medical or dental boards.

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- (c) Temporary privileges granted for locum tenens may be exercised for a maximum of one hundred twenty days, consecutive or not, any time during the thirty-six month period following the date they are granted.
  - (d) Practitioners granted temporary privileges will be restricted to the specific delineations for which the temporary privileges are granted. The practitioner will be under the supervision of the chair of the clinical department while exercising any temporary privileges granted.
  - (e) Practitioners exercising temporary privileges shall abide by these medical staff bylaws, rules and regulations, and hospital and medical staff policies.
  - (f) Special privileges -- upon receipt of a written request for specific temporary clinical privileges and the approval of the clinical department chief, the chairperson of the academic department and the director of medical affairs, an appropriately licensed or certified practitioner of documented competence, who is not an applicant for medical staff membership, may be granted special clinical privileges for the care of one or more specific patients. Such privileges shall be exercised in accordance with the conditions specified in rule 3335-111-04 of the Administrative Code.
  - (g) The temporary and special privileges must also be in conformity with accrediting bodies' standards and the rules and regulations of professional boards of Ohio.
- (3) Expedited privileges:

If the Wexner medical center board is not scheduled to convene in a timeframe that permits the timely consideration of the recommendation of a complete application by the medical staff administrative committee, eligible applicants may be granted expedited privileges by the quality and professional affairs committee of the Wexner medical center board. Certain restrictions apply to the appointment and granting of clinical privileges via the expedited process. These include but are not limited to: an involuntary termination of medical staff membership at another hospital, involuntary limitation, or reduction, denial or loss of clinical privileges, a history of professional liability actions resulting in a final judgment against the applicant, or a challenge by a state licensing board.

- (4) Podiatric privileges:
- (a) Practitioners of podiatry may admit patients to the CHRI if such patients are being admitted solely to receive care that a podiatrist may provide without medical assistance, pursuant to the scope of the professional license of the podiatrist. Practitioners of podiatry must, in all other circumstances co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine.
  - (b) A member of the medical staff who is a doctor of medicine or osteopathy.
    - (i) Shall be responsible for any medical problems that the patient has while an inpatient of the CHRI; and
    - (ii) Shall confirm the findings, conclusions and assessment of risk prior to highrisk diagnosis or therapeutic interventions defined by the medical staff.

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- (c) Practitioners of podiatry shall be responsible for the podiatric care of the patient including the podiatric history and physical examination and all appropriate elements of the patient's record.
  - (d) The podiatrist shall be responsible to the chief of the department of orthopaedics.
- (5) Psychology privileges:
  - (a) Psychologists shall be granted clinical privileges based upon their training, experience and demonstrated competence and judgment consistent with their license to practice. Psychologists shall not prescribe drugs, or perform surgical procedures, or in any other way practice outside the area of their approved clinical privileges or expertise unless otherwise authorized by law.
  - (b) Psychologists may not admit patients to the CHRI, but may diagnose and treat a patient's psychological illness as part of the patient's comprehensive care while hospitalized. All patients admitted for psychological care shall receive the same medical appraisal as all other hospitalized patients. A member of the medical staff who is a doctor of medicine or osteopathic medicine shall admit the patient and shall be responsible for the history and physical and any medical care that may be required during the hospitalization, and shall determine the appropriateness of any psychological therapy based on the total health status of the patient. Psychologists may provide consultation within their area of expertise on the care of patients within the CHRI. In ambulatory settings, psychologists shall diagnose and treat their patient's psychological illness. Psychologists shall ensure that their patients receive referral for appropriate medical care.
  - (c) Psychologists shall be responsible to the chief of the clinical department in which they are appointed.
- (6) Dental privileges:
  - (a) Practitioners of dentistry, who have not been granted clinical privileges as oral and maxillofacial surgeons, may admit patients to the CHRI if such patients are being admitted solely to receive care which a dentist may provide without medical assistance, pursuant to the scope of the professional license of the dentist. Practitioners of dentistry must, in all other circumstances, co-admit patients with a member of the medical staff who is a doctor of medicine or osteopathic medicine.
  - (b) A member of the medical staff who is a doctor of medicine or osteopathy:
    - (i) Shall be responsible for any medical problems that the patient has while an inpatient of the CHRI; and
    - (ii) Shall confirm the findings, conclusions and assessment of risk prior to highrisk diagnoses or therapeutic interventions defined by the medical staff.
  - (c) Practitioners of dentistry shall be responsible for the dental care of the patient including the dental history and physical examination and all appropriate elements of the patient's record.
- (7) Oral and maxillofacial surgical privileges:

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All patients admitted to the CHRI for oral and maxillofacial surgical care shall receive the same medical appraisal as all other hospitalized patients. Qualified oral and maxillofacial surgeons shall admit patients, shall be responsible for the plan of care for the patients, shall perform the medical history and physical examination, if they have such privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedure(s), and shall be responsible for the medical care that may be required at the time of admission or that may arise during hospitalization.

- (8) Licensed allied health professionals:
- (a) Clinical privileges may be exercised by licensed allied health professionals who are duly licensed in the state of Ohio and who are either:
    - (i) Members of the faculty of the Ohio state university, or
    - (ii) Employees of the Ohio state university whose employment involves the exercise of clinical privileges, or
    - (iii) Employees of members of the medical staff.
  - (b) A licensed allied health professional as used herein, shall not be eligible for medical staff membership but shall be eligible to exercise those clinical privileges granted pursuant to these bylaws and in accordance with applicable Ohio state law. If granted such privileges under this rule and in accordance with applicable Ohio state law, other licensed allied health professionals may perform all or part of the medical history and physical examination of the patient. Licensed health care professionals with privileges are subject to FPPE and OPPE.
  - (c) Licensed allied health professionals shall apply and re-apply for clinical privileges on forms prescribed by the medical staff administrative committee and shall be processed in the same manner as provided in rule 3335-111-04 of the Administrative Code.
  - (d) Licensed allied health professionals are not members of the medical staff, but may write admitting orders for; patients of the CHRI when granted such privileges under this rule and in accordance with applicable Ohio state law. If such privileges are granted, the patient will be admitted under the medical supervision of the responsible medical staff member. Licensed allied health professionals are not members of the medical staff and shall not be eligible to hold office, to vote on medical staff affairs, or to serve on standing committees of the medical staff unless specifically authorized by the medical staff administrative committee.
  - (e) Each licensed allied health professional shall be individually assigned to a clinical department and shall be supervised by or collaborate with one or more members of the medical staff as required by Ohio law. The licensed health care professional's clinical privileges are contingent upon the collaborating/supervising medical staff member's privileges. In the event that the collaborating/supervising medical staff member loses privileges or resigns, the licensed allied health care professionals whom he or she has supervised shall be placed on administrative hold until another collaborating/ supervising medical staff member is assigned. The new

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collaborating/supervising medical staff member shall be assigned in less than thirty days.

- (f) Licensed allied health professionals must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials as required by Ohio law, and may only exercise those clinical privileges granted in accordance with provisions relating to their respective professions.
- (g) Only applicants who can document the following shall be qualified for clinical privileges as a licensed allied health professional:
  - (i) Current license, certification, or other legal credential required by Ohio law;
  - (ii) Certificate of authority, standard care arrangement/agreement, or utilization plan;
  - (iii) Education, training, professional background and experience, and professional competence;
  - (iv) Patient care quality indicators definition for initial appointment. This data will be in a format determined by the licensed allied health professional subcommittee and the quality management department of the Ohio state university medical center;
  - (v) Adherence to the ethics of the profession for which an individual holds a license, certification, or other legal credential required by Ohio law;
  - (vi) Evidence of required immunization;
  - (vii) Evidence of good personal and professional reputation as established by peer recommendations;
  - (viii) Satisfactory physical and mental health to perform requested clinical privileges; and
  - (ix) Ability to work with members of the medical staff and the CHRI employees.
- (h) The applicant shall have the burden to produce documentation with sufficient adequacy to assure the medical staff and the CHRI that any patient cared for by the licensed allied health professional seeking clinical privileges shall be given quality care, and that the efficient operation of the CHRI will not be disrupted by the applicant's care of patients in the CHRI.
- (i) By applying for clinical privileges as a licensed allied health professional, the applicant agrees to the following terms and conditions:
  - (i) The applicant has read the bylaws and rules and regulations of the medical staff of the CHRI and agrees to abide by all applicable terms of such bylaws and any applicable rules and regulations, including any subsequent amendments thereto, and any applicable CHRI policies that the CHRI may from time to time put into effect;

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- (ii) The applicant releases from liability all individuals and organizations who provide information to the CHRI regarding the applicant and all members of the medical staff, the CHRI staff and the Wexner medical center board and the Ohio state university board of trustees for all acts in connection with investigating and evaluating the applicant;
  - (iii) The applicant shall not deceive a patient as to the identity of any practitioner providing treatment or service in the CHRI;
  - (iv) The applicant shall not make any statement or take any action that might cause a patient to believe that the licensed allied health professional is a member of the medical staff; and
  - (v) The applicant shall obtain and continue to maintain professional liability insurance in such amounts required by the medical staff.
- (j) Licensed allied health care professionals shall be subject to quality review and corrective action as outlined in this paragraph for violation of these bylaws, their certificate of authority, standard of care agreement, utilization plan, or the provisions of their licensure, including professional ethics. Review may be requested by any member of the medical staff, a chief of the clinical department, or by the medical director of quality or the chief quality officer. All requests shall be in writing and shall be submitted to the chief quality officer. The chief quality officer, unless delegated to the medical director of quality, shall appoint a three-person committee to review and make recommendations concerning appropriate action. The committee shall consist of at least one licensed allied health care professional and one medical staff member. The committee shall make a written recommendation to the chief quality officer, unless delegated to the medical director of quality, who may accept, reject, or modify the recommendation. The chief quality officer, unless delegated to the medical director of quality shall forward his or her recommendation to the director of medical affairs for final determination.
- (k) Appeal process.
- (i) A licensed allied health care professional may submit a notice of appeal to the chairperson of the quality and professional affairs committee within thirty days of receipt of written notice of any adverse corrective action pursuant to these bylaws.
  - (ii) If an appeal is not so requested within the thirty-day period, the licensed allied health care professional shall be deemed to have waived the right to appeal and to have conclusively accepted the decision of the director of medical affairs.
  - (iii) The appellate review shall be conducted by the chief of staff, the chair of the licensed health care professionals subcommittee and one medical staff member from the same discipline as the licensed allied health care professional under review. The licensed allied health care professional under review shall have the opportunity to present any additional information deemed relevant to the review and appeal of the decision.

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- (iv) The affected licensed allied health care professional shall have access to the reports and records, including transcripts, if any, of the hearing committee and of the medical staff administrative committee and all other material, favorable or unfavorable, that has been considered by the chief quality officer. The licensed allied health care professional shall submit a written statement indicating those factual and procedural matters with which the member disagrees, specifying the reasons for such disagreement. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the review committee no later than seven days following the date of the licensed allied health care professional's notice of appeal.
- (v) New or additional matters shall only be considered on appeal at the sole discretion of the quality and professional affairs committee.
- (vi) Within thirty days following submission of the written statement by the licensed allied health care professional, the chief of staff shall make a final recommendation to the chair of the quality and professional affairs committee of the Wexner medical center board. The quality and professional affairs committee of the Wexner medical center board shall determine whether the adverse decision will stand or be modified and shall recommend to the Ohio state university Wexner medical center board that the adverse decision be affirmed, modified or rejected, or to refer the matter back to the review committee for further review and recommendation. Such referral to the review committee may include a request for further investigation.
- (vii) Any final decision by the Wexner medical center board shall be communicated by the chief quality officer and by certified return receipt mail to the last known address of the licensed allied health care professional as determined by university records. The chief quality officer shall also notify in writing the senior vice president for health sciences, the dean of the college of medicine, the chief executive officer of the CHRI and the vice president for health services and the chief of the applicable clinical department or departments. The chief quality officer, unless delegated to the medical director of quality, shall take immediate steps to implement the final decision.

(9) Emergency privileges:

In the case of an emergency, any member of the medical staff to the degree permitted by the member's license or certification and regardless of department or medical staff status shall be permitted to do everything possible to save the life of a patient using every facility of the CHRI necessary, including the calling for any consultation necessary or desirable. After the emergency situation resolves, the patient shall be assigned to an appropriate member of the medical staff. For the purposes of this paragraph, an "emergency" is defined as a condition that would result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

(10) Disaster privileges:

Disaster privileges may be granted in order to provide voluntary services during a local, state or national disaster in accordance with hospital/medical staff policy and only when the

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following two conditions are present: the emergency management plan has been activated and the hospital is unable to meet immediate patient needs. Such privileges may be granted by the director of medical affairs or the medical director of credentialing to fully licensed or certified, qualified individuals who at the time of the disaster are not members of the medical staff. These privileges will be limited in scope and will terminate once the disaster situation subsides or at the discretion of the director of medical affairs temporary privileges are granted thereafter.

(11) Telemedicine:

Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may now be performed via telemedicine link.

- (a) A member of the medical staff who wishes to utilize electronic technologies (telemedicine) to render care must so indicate on the application for clinical privileges form.
- (b) A member of the medical staff may request to exercise via telemedicine the same clinical privileges he or she has already been granted. The credentials committee, the chief of the clinical service, medical director of credentialing, the director of medical affairs or the medical staff administrative committee, and the Wexner medical center board shall have the prerogative of requiring documentation or making a determination of the appropriateness of the exercise of a particular specialty/subspecialty via telemedicine.

(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, 4/6/2018, 5/18/2021, 2/8/2022, 8/15/2023)

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

(A) The chief executive officer.

(1) Method of appointment:

The chief executive officer shall be appointed by the board of trustees of the Ohio state university upon recommendation of the president, executive vice president for health sciences, and the vice president for health services following consultation with the medical center board in accordance with university bylaws, rules and regulations. The chief executive officer shall be a member of the attending medical staff of the CHRI.

(2) Responsibilities:

The chief executive officer shall be responsible for the conduct of teaching, research, and CHRI service activities of the facility, including continuing compliance with all appropriate quality assurance standards, ethical codes, or other monitoring or regulatory requirements. The chief executive officer shall be a member of all committees of the CHRI.

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



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(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 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 determines initial medical staff category appointments, reappointments and any changes in categories of the medical staff.

(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, 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. 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.

The medical director of credentialing for the James cancer hospital oversees the process for the credentialing of practitioners applying for membership and/or clinical privileges at the James cancer hospital. The medical director of credentialing shall provide guidance on specific practitioner application or privileging concerns as raised pursuant to these bylaws and shall recommend practitioners for membership and/or privileges at the James cancer hospital and facilitate the process for approving such membership and granting of clinical privileges.

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(F) Medical director, James surgical services.

The 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 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 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 medical director, James surgical services reports to the director of medical affairs of the James.

(G) Professional assignments.

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

Appointment to a specific department and/or division is based on the clinical specialty of the applicant for medical staff membership. Each department and/or division is headed by a department chairperson or division director who has the responsibility to oversee all research and clinical activities conducted by members of the department and/or division. Specifically, the 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 department and/or division; the orientation and continuing surveillance of the professional performance of all department and/or division members; recommendation for space and other resources needed.

(H) Clinical department chief.

- (1) Qualifications and responsibilities of the chief of the clinical department. The academic department chair shall ordinarily serve also as the chief of the clinical department. Each clinical department chief shall be qualified by education and experience appropriate to the discharge of the responsibilities of the position. Each clinical department chief must be board certified by an appropriate specialty board or must establish comparable competence. The chief of the clinical department must be a medical staff member at the Ohio state university hospitals. Such qualifications shall be judged by the respective dean of the colleges of medicine or dentistry. Qualifications for chief of the clinical department generally shall include recognized clinical competence, sound judgment and well-developed administrative skills.
- (2) Procedure for appointment. Appointment or reappointment of chief of the clinical department shall be made by the dean of the respective colleges of medicine or dentistry in consultation with elected representatives of the medical staff and the chief medical officer of the Ohio state university medical center.
- (3) Term of appointment of the chief of the clinical department. The term of the appointment of the chief of the clinical department shall be concurrent with the chief's academic appointment but shall be no longer than four years. Prior to the end of said four-year term, a review shall be conducted by the dean of the college of medicine and such review shall serve as the basis for the recommendation for reappointment pursuant to paragraph (D)(2) of this rule.
- (4) Duties of the chief of the clinical department:

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Each clinical department chief is responsible for the following:

- (a) Clinically related activities of the department;
- (b) Administratively related activities of the department, unless otherwise provided by the hospital;
- (c) Continuing surveillance of the professional performance of all practitioners in the department who have delineated clinical privileges;
- (d) Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department;
- (e) Recommending clinical privileges for each practitioner of the department based on relevant training and experience, current appraised competence, health status that does not present a risk to patients, and evidence of satisfactory performance with existing privileges;
- (f) Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;
- (g) The integration of the department or service into the primary functions of the hospital, developing services that complement the medical center's mission and plan for clinical program development;
- (h) The coordination and integration of interdepartmental and intradepartmental services;
- (i) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services. This includes the development, implementation, enforcement and updating of departmental policies and procedures that are consistent with the hospital's mission. The clinical department chief shall make such policies and procedures available to the medical staff;
- (j) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services, including call coverage for continuous high quality and safe care;
- (k) The determination of the qualifications and competence of department or service personnel who are not licensed practitioners and who provide patient care, treatment, and services;
- (l) The continuous assessment and improvement of the quality of care, treatment, and services;
- (m) The maintenance of quality control programs, as appropriate;
- (n) The orientation and continuing education of all persons in the department or service;

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- (o) Recommending space and other resources needed by the department or service; and
- (p) Hold regular clinical department meetings and ensure open lines of communication are maintained in the clinical department. The agenda for the meetings shall include, but not be limited to, a discussion of the clinical activities of the department and communication of the decisions of the medical staff administrative committee. Minutes of the departmental meetings, including a record of attendance, shall be kept in the clinical department.

(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, 4/6/2018, 8/15/2023)

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

(A) Chief of staff.

The chief of staff shall:

- (1) Serve on those committees of the Ohio state medical center board as appointed by the chairperson of the medical center board.
- (2) Be a vice chairperson of the medical staff administrative committee and serve as liaison between university administration, CHRI administration, and the medical staff in all matters of mutual concern within the CHRI.
- (3) Call, preside, and be responsible for the agenda of all general staff meetings.
- (4) Make medical staff committee appointments ~~jointly with the director of medical affairs and chief of staff elect for approval by the CHRI medical staff administrative committee in accordance with paragraph (A) of rule 3335-111-10 of the Administrative Code.~~
- (5) Be a spokesperson for the medical staff in its external professional and public relations.
- (6) Serve as chairperson of the nominating committee of the medical staff.

(B) Chief of staff-elect.

The chief of staff-elect shall:

- (1) Serve on those committees of the Ohio state medical center board as appointed by the chairperson of the medical center board.
- (2) Serve as the chairperson of the bylaws committee of the CHRI.
- (3) Carry out all the duties of the chief of staff when the chief of staff is unable to do so.
- (4) Oversee the inclusion of changes in the bylaws, rules and regulations of the medical staff.

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(5) Assist the Chief of Staff with duties outlined above in section (A) 1-6.

(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 every two years.

(D) Qualifications of officers.

(1) Officers must be members of the 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, and division 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) All officers (other than at-large officers) will be elected by a majority of those voting by electronic ballot after the April meeting of the medical staff. If one candidate does not achieve a majority vote, there will be an election on a second ballot between the two receiving the greatest number of votes.

(2) The nominating committee will be composed of five members. The chief of staff and the chief of staff-elect will serve on the committee and the chief of staff will be its chairperson. The chief of staff will appoint the three other members of the committee.

(3) Nominations for officers will be accepted from the floor at the March meeting.

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

(5) Candidates for the office of chief of staff-elect will be listed and each attending staff member may vote for one.

(6) Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with medical staff rules and regulations, policies and procedures of the medical staff, for conduct or statements that damage the reputation of the CHRI, its goal and missions, or programs, or an automatic termination or suspension of clinical privileges that lasts more than thirty days.

(F) Term of office.

(1) The chief of staff and chief of staff-elect will each serve two years in office beginning on the first of July. The chief of staff-elect will be elected in the odd years. The chief of staff may not be elected chief of staff-elect within one year of the end of the chief of staff's term in office.

(2) The at-large representatives shall serve two years, beginning on the first of July. The delegate at large may succeed themselves for three successive terms (six years, total), if so elected. They may not serve again without a period of two years out of office as a delegate at large.

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The delegate at large may be elected chief of staff-elect at any time if they are members of the attending staff.

(G) Vacancies in office.

- (1) Vacancies in the office of chief of staff during the chief's term will be automatically succeeded and performed by the chief of staff-elect. When the unexpired term is one year or less, the new chief of staff will continue in office until the completion of the expected term in that office. When the unexpired term is more than one year, the new chief of staff will serve out the remaining term only.
- (2) Vacancies in the office of chief of staff-elect shall be filled by a special election held within sixty days of establishing the vacancy by the nominating and election process set forth in paragraph (F) of this rule. The nominating committee will make nominations and a special meeting of the voting members of the medical staff will be called to add nominations and elect the replacement. The new chief of staff-elect will become chief of staff at the end of the term of the incumbent.
- (3) Vacancies in the at-large representatives' positions will be filled by appointment by the 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, 4/6/2018, 5/18/2021, 8/15/2023)

**3335-111-10 Administration of the medical staff of the CHRI.**

Medical staff committees.

- (A) Appointments: Appointments to all medical staff committees except the medical staff administrative committee (MSAC) and the nominating committee will be made jointly by the chief of staff, chief of staff-elect, and the director of medical affairs with medical staff administrative committee ratification. Unless otherwise provided by the bylaws, all appointments to medical staff committees are for two years and may be renewed. The chairperson shall control the committee agenda, attendance of staff and guests and conduct the proceedings. A simple majority of appointed voting members shall constitute a quorum. All committee members appointed or elected to serve on a medical staff committee are expected to participate fully in the activities of those committees. The chief of staff, director of medical affairs and the chief executive officer of the CHRI may serve on any medical staff committee as an ex-officio member without vote.
- (B) The medical staff as a whole and each committee provided for by these medical staff bylaws is hereby designated as a peer review committee in accordance with the laws of the state of Ohio. The medical staff through its committees shall be responsible for evaluating, maintaining and monitoring the quality and utilization of patient care services provided by CHRI.
- (C) Medical staff administrative committee:
  - (1) Composition:
    - (a) Voting membership includes: chief of staff, chief of staff-elect, immediate past chief of staff, clinical department chief or division director of medical oncology, radiation oncology, anatomic pathology and molecular pathology; department chairperson or division director of hematology, gynecologic oncology, otolaryngology/head and

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neck, hospital medicine, human genetics, infectious diseases, surgical oncology, thoracic surgery, neurological oncology, orthopaedic oncology/sarcoma pulmonary, critical care, sleep medicine, and urology; medical director of James emergency services; clinical department chiefs of anesthesia, dermatology, 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, CCC director for cancer control, and medical director of the 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 director is a member by leadership position, he or she will also fulfill the role of division 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 chief nursing officer, the 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.
- (c) Any member of the committee who anticipates absence from a meeting of the committee may appoint a temporary substitute as a representative at the meeting. The temporary substitute will have all the rights of the absent member. ~~The chief executive officer may invite any member of staff as the chief executive officer's representative at a meeting or to attend any meeting with the chief executive officer.~~
- (d) All members of the committee shall attend, either in person, virtual, or by proxy, a minimum of two-thirds of all committee meetings.
- (e) Any members may be removed from the medical staff administrative committee at the recommendation of the dean of the college of medicine, the director of medical affairs or the executive vice president for health sciences and subject to the review and approval of the medical staff administrative committee. A replacement will be appointed as outlined above to maintain the medical staff administrative committee's composition as stated in this paragraph.

(2) Duties:

- (a) To represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by this chapter, and the bylaws or rules of the Ohio state university.
- (b) To have primary authority for activities related to self-governance of the medical staff. Action approved by the medical staff administrative committee can be reviewed by the quality and professional affairs committee pursuant to rule 3335-43-13 of the Administrative Code.
- (c) To receive and act upon commission and committee reports. To delegate appropriate staff business to committees while retaining the right of executive responsibility and authority over all medical staff committees. This shall include but is not limited to

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review of and action upon medical staff appointments and reappointments whenever timely action is necessary.

- (d) To approve and implement policies of the medical staff.
  - (e) To recommend action to the chief executive officer on matters of medicoadministrative nature.
  - (f) To fulfill the medical staff's accountability to the Wexner medical center board for medical care rendered to patients in the CHRI, and for professional conduct and activities of the medical staff, including recommendations concerning;
    - (i) Medical staff structure;
    - (ii) The mechanism to review credentials and to delineate clinical privileges;
    - (iii) The mechanism by which medical staff membership may be terminated or suspended;
    - (iv) Participation in the CHRI's performance improvement, quality and patient safety activities; and
    - (v) Corrective action and hearing procedures applicable to medical staff members and other licensed allied health professionals granted clinical privileges.
  - (g) To ensure the medical staff is kept abreast of the accreditation process and informed of the accreditation status of the CHRI.
  - (h) To review and act on medical staff appointments and reappointments.
  - (i) To report to the medical staff all actions affecting the medical staff.
  - (j) To inform the medical staff of all changes in committees, and the creation or elimination of such committees as circumstances shall require.
  - (k) To create committees (for which membership is subsequently appointed pursuant to rule 3335-111-10 of the Administrative Code) to meet the needs of the medical staff and comply with the requirements of accrediting agencies.
  - (l) To establish and maintain rules and regulations governing the medical staff.
  - (m) To oversee functions related to performance improvement of professional services provided by individuals with clinical privileges.
  - (n) To perform other functions as are appropriate.
- (3) Executive session.

Upon the recommendation of the credentialing committee, the medical staff administrative committee may vote to hold a portion of a regular, special or emergency meeting in executive session with participation limited to voting members of the medical staff administrative



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committee. Other individuals may be invited to attend any or all portions of an executive session as deemed necessary by the committee chair.

(4) Meetings:

The committee shall meet monthly and keep detailed minutes, which shall be distributed to each committee member before or at the next meeting of the committee.

(5) Voting:

At a properly constituted meeting, voting shall be by a simple majority of members present except in the case of termination or non-reappointment of medical staff membership or permanent suspension of clinical privileges, wherein two-thirds of members present shall be required.

(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 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:

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- (a) To review all applications for medical staff and licensed allied health professional appointment and reappointment, as well as all requests for delineation, renewal, or amendment of clinical privileges in the manner provided in these medical staff bylaws, including applicable time limits. During its evaluation, the credentialing committee of the hospitals of the Ohio state university will take into consideration the appropriateness of the setting where the requested privileges are to be conducted;
- (b) To review triennially all applications for reappointment or renewal of clinical privileges;
- (c) To review all requests for changes in medical staff membership;
- (d) To assure, through the chairperson of the committee, that all records of peer review activity taken by the committee, including committee minutes, are maintained in the strictest of confidence in accordance with the laws of the state of Ohio. The committee may conduct investigations and interview applicants as needed to discharge its duties. The committee may refer issues and receive issues as appropriate from other medical staff committees;
- (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), 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) To recommend to the medical staff administrative committee that certain applications for appointment be reviewed in executive session;
- (g) The committee, after review and investigation, may make recommendations to the director of medical affairs, chief of staff, or the chief of a clinical department, regarding the restriction or limitation of any medical staff member's clinical privileges, noncompliance with the credentialing process, or any other matter related to its responsibilities;
- (h) To review requests made for clinical privileges by other licensed allied health professionals as set forth in this chapter.
- (i) To recommend eligibility criteria for the granting of medical staff membership and privileges.
- (j) To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities.
- (k) To review, and where appropriate take action on, reports that are referred to it from other medical staff committees and medical staff members.

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- (a)
  - (l) To perform such other functions as requested by the medical staff administrative committee, quality and professional affairs committee or Wexner medical center board.
  
- (3) Licensed health care professionals subcommittee:

This subcommittee shall consist of other licensed health care professionals who have been appointed in accordance with paragraph ~~(A) of rule 3335-111-10(A)(3) of rule 3335-111-09~~ of the Administrative Code. This subcommittee shall be chaired by a director of nursing.
  
- (b) Duties:
  - (i) To review, within thirty days of receipt, all completed applications as may be referred by the credentialing committee of the hospitals of the Ohio state university;
  - (ii) To review and investigate the character, qualifications and professional competence of the applicant;
  - (iii) To review the applicant's patient care quality indicator definitions on initial granting of clinical privileges and the performance based profile at the time of renewal;
  - (iv) To verify the accuracy of the information contained in the application; and
  - (v) To forward, following review of the application, a written recommendation for clinical privileges to the credentialing committee of the hospitals of the Ohio state university for review at its next regularly scheduled meeting.
  - (vi) To develop relevant policies and procedures regarding the scope of service and scope of practice to be granted to each licensed allied health care professional specialty. These policies and procedures shall be ratified by the credentialing committee, and medical staff administrative committee and be approved by the Wexner medical center board.
  
- (E) Medical staff bylaws committee:
  - (1) Composition.

The committee shall be composed of at least four members of the attending staff pursuant to paragraph ~~(A)(3) of rule 3335-111-09(A) of rule 3335-111-10~~ of the Administrative Code. The chairperson shall always be the chief of staff-elect.
  
  - (2) Duties.

To review and recommend amendments to the medical staff administrative committee as necessary to maintain bylaws that reflect the structure and functions of the medical staff but not less than every two years. This committee will recommend changes to the medical staff administrative committee.

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(a)

(F) Committee for practitioner health.

(1) Composition:

The committee shall consist of medical staff members appointed in accordance with paragraph ~~(A)(3) of rule 3335-111-09~~ (A) of rule 3335-111-10 of the Administrative Code.

(2) Duties:

To consider issues of licensed practitioner health or impairment whenever a selfreferral or referral is requested by an affected member or another member or committee of the medical staff, CHRI hospital staff, or any other individual.

- (b) To provide appropriate counsel, referral, and monitoring until the rehabilitation is complete and periodically thereafter, if required, to enable the medical staff member to obtain appropriate diagnosis and treatment, and to provide appropriate standards of care.
- (c) To consult regularly with the chief of staff, medical director of credentialing and director of medical affairs of the CHRI.
- (d) To advise credentials and/or other appropriate medical staff committees on the credibility of a complaint, allegation or concern, including those affecting the quality and safety of patient care.
- (e) It will be the responsibility of the chairperson of the committee to assure that all proceedings and records, including the identity of the person referring the case, are handled and maintained in the strictest of confidence in accordance with the laws of the state of Ohio.
- (f) To educate CHRI hospital and the medical staff about illness and impairment recognition issues, including at risk criteria specific to licensed practitioners.

(G) Cancer subcommittee:

(1) Composition:

Required to be included as members of the cancer subcommittee are physician representatives from surgery, medical oncology, 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 non-physician 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.

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- (a)
- (2) Duties:
  - (a) Develop and evaluate the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer.
  - (b) Promote a coordinated, multidisciplinary approach to patient management.
  - (c) Ensure that educational and consultative cancer conferences cover all major site and related issues.
  - (d) Ensure that an active supportive care system is in place for patients, families, and staff.
  - (e) Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.

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- (f) Promote clinical research.
- (g) Supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up reporting.
- (h) Perform quality control of registry data.
- (i) Encourage data usage and regular reporting.
- (j) Ensure content of the annual report meets requirements.
- (k) Publishes the annual report by November first of the following year.
- (l) Upholds medical ethical standards.
- (m) Serve as cancer committee for commission on cancer program of the American college of surgeons.

(3) Meetings:

- (a) The subcommittee shall meet in collaboration with the medical staff administrative committee as a policy-advisory and administrative body with documentation of activities and specialties in attendance.
- (b) Any member anticipating an absence from the meeting should designate a representative to attend in their place.

(H) Ethics committee.

(1) Composition.

The committee is a joint committee and shall consist of members of the medical staff, nursing, hospital administration, and other persons representing both the CHRI and UH who, by reason of training, vocation, or interest, may make a contribution. Appointments will be made as provided by in this chapter. The chairperson shall be a physician who is a clinically active member of the medical staff of UH or the CHRI.

(2) Duties

- (a) To make recommendations for the review and development of guidelines or policies regarding ethical issues.
- (b) To provide ethical guidelines and information in response to requests from members of the medical staff, patients, patient's family or other representative, and staff members of the CHRI.
- (c) To provide a support mechanism for primary decision makers at the CHRI.
- (d) To provide educational resources on ethics to all health care providers at the CHRI.

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- (e) To provide and enhance interaction between CHRI administration and staff, departmental ethics committees, pastoral care services, and members of the medical staff.

(I) Practitioner evaluation committee.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners. If additional expertise is needed, the practitioner evaluation committee may request the assistance from any medical staff member or recommend to the director of medical affairs an external review.

(2) Duties:

- (a) To meet regularly and keep minutes, which describe issues, opportunities to improve patient care, recommendations and actions to the chief quality officer, unless delegated to the medical director of quality and the chair of the clinical department, responsible parties, and expected completion dates. The minutes are maintained in the quality and patient safety office.
- (b) To ensure that ongoing and systematic monitoring, evaluation and process improvement is performed in each clinical department.
- (c) To develop and utilize objective criteria in practitioner peer review activities.
- (d) To ensure that the medical staff peer review process is effective.
- (e) To maintain confidentiality of its proceedings. These issues are not to be handled outside of the practitioner evaluation committee by any individual, clinical department, division, or committee.

(J) Professionalism consultation committee.

(1) Composition.

This multi-disciplinary peer review committee is composed of clinically-active practitioners and other individuals with expertise in professionalism.

(2) Duties.

- (a) Receive and review validity of complaints regarding concerns about professionalism of credentialed practitioners;
- (b) Treat, counsel and coach practitioners in a firm, fair and equitable manner;
- (c) Maintain confidentiality of the individual who files a report unless the person who submitted the report authorizes disclosure or disclosure is necessary to fulfill the institution's legal responsibility;

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- (d) Ensure that all activities be treated as confidential and protected under applicable peer review and quality improvement standards in the Ohio Revised Code;
- (e) Forward all recommendations to the clinical department chief, director of medical affairs or his/her designee and, if applicable, to the chief nursing officer.

(Board approval dates: 9/1/1993, 3/3/1995, 12/6/1996, 9/1/1999, 10/1/1999, 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, 2/1/2013, 11/7/2014, 11/6/2015, 9/2/2016, 4/6/2018, 5/18/2021, 8/15/2023)

**3335-111-11 History and physical.**

(A) History and physical examination.

- (1) A history and physical appropriate to the patient and/or the procedure to be completed shall be documented in the medical record of all patients either:
  - (a) Admitted to the hospital
  - (b) Undergoing outpatient/ambulatory procedures requiring anesthesia or sedation
  - (b) Undergoing outpatient/ambulatory surgery
  - (d) In a hospital-based ambulatory clinic
- (2) For patients admitted to the hospital, the history and physical examination shall include at a minimum:
  - (a) Date of admission
  - (b) Chief complaint and/or indication for procedure
  - (c) History of present illness
  - (d) Past medical and surgical history
  - (e) Relevant past social and family history
  - (f) Medications and allergies
  - (g) Review of systems
  - (h) Physical examinations
  - (i) Test results
  - (j) Assessment or impression
  - (k) Plan of care



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- (3) For patients undergoing outpatient/ambulatory procedures requiring anesthesia or sedation or outpatients/ambulatory surgery, the history and physical examination shall include at a minimum:
    - (a) Indication for procedure/surgery
    - (b) Relevant medical or surgical history
    - (c) Medications and allergies or reference to current listing in the electronic medical record
    - (d) Focused review of systems, as appropriate
    - (e) Pre-procedure assessment and physical examination
    - (f) Assessment/impression and treatment plan
  - (4) For patients seen in a hospital-based ambulatory clinic, the history and physical shall include at a minimum:
    - (a) Chief complaint
    - (b) History of present illness
    - (c) Medications and allergies
    - (d) Problem-focused physical examination
    - (e) Assessment or impression
    - (f) Plan of care
- (B) Deadlines and sanctions
- (1) A history and physical examination must be performed by a member of the medical staff, his/her designee or other licensed healthcare professional, who is appropriately credentialed by the hospital, and be signed, dated and timed.
  - (2) Patients admitted to the hospital: If the history and physical is performed by the medical staff member's designee or other licensed healthcare professional who is appropriately credentialed by the hospital, the history and physical must be countersigned by the responsible medical staff member.
  - (3) The complete history and physical examination shall be dictated, written or updated no later than twenty-four hours after admission for all inpatients.
  - (4) Admitted patients or patients undergoing a procedure requiring anesthesia or sedation or surgery, the history and physical examination may be performed or updated up to thirty days prior to admission, or the procedure/surgery. If completed before admission or the procedure, there must be a notation documenting an examination for any changes in the patient's condition since the history and physical was completed. The updated examination must be

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completed and documented in the patient's medical record within twenty-four hours after admission, or before the procedure/surgery, whichever occurs first. It must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and be signed, dated and timed. In the event the history and physical update is performed by the medical staff member's designee or other licensed health care professional who is appropriately credentialed by the hospital, it shall be countersigned, dated and timed by the responsible medical staff member.

- (a) For patients undergoing an outpatient procedure requiring anesthesia or sedation or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.
  - (b) If a licensed health care professional is appropriately credentialed by the hospital to perform a procedure or surgery independently, a history and physical performed by the licensed health care professional prior to the procedure or surgery is not required to be countersigned.
- (5) Hospital-based ambulatory clinic: If a history and physical examination is performed by a licensed health care professional who is appropriately credentialed by the hospital to see patients independently, the history and physical is not required to be countersigned.
- (6) When the history and physical examination including the results of indicated laboratory studies and x-rays is not recorded in the medical record before the times stated for a procedure or surgery, the procedure or surgery cannot proceed until the history and physical is signed or countersigned, when required, by the responsible medical staff member, and indicated test results are entered into the medical record. In cases where such a delay would likely cause harm to the patient, this condition shall be entered into the medical record by the responsible medical staff member, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and the procedure or surgery may begin. When there is disagreement concerning the urgency of the procedure, it shall be adjudicated by the medical director or the medical director's designee.
- (7) Ambulatory patients must have a history and physical at the initial visit.
- (8) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:
- (a) Within the past six months prior to the initial visit,
  - (b) At the initial visit, or
  - (c) Within thirty days following the initial visit.

(Board approval dates: 5/14/2010, 6/6/2014, 11/7/2014, 11/6/2015)

**3335-111-12 Amendments and adoption.**

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(A) Medical staff responsibility.

The medical staff bylaws committee shall have the initial responsibility to formulate, review at least biennially, and recommend to the quality and professional affairs committee of the Wexner medical center board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws shall be effective when approved by the university board of trustees. Amendments to the rules and regulations shall be effective when approved by the Wexner medical center board.

Such responsibility shall be exercised in good faith, in a timely manner and in accordance with applicable laws and regulatory standards. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

The organized medical staff shall also have the ability to propose amendments to the medical staff bylaws, rules and regulations and policies and procedures and propose them directly to the quality and professional affairs committee of the Wexner medical center board.

If the voting members of the organized medical staff propose to adopt amendments to the bylaws, rules and regulations or policies, they must first communicate the proposal to the medical staff administrative committee. When the medical staff administrative committee proposes to adopt amendments to the bylaws, rules and regulations or policies, it communicates the proposal to the organized medical staff.

Conflict between the organized medical staff and the medical staff administrative committee will be managed by allowing communication directly from the medical staff to the quality and professional affairs committee of the Wexner medical center board on issues including, but not limited to: amendments to the bylaws and the adoption of new rules and regulations or policies. Medical staff members may communicate with the quality and professional affairs committee of the Wexner medical center board by submitting their communication in writing to the chief of staff, who shall then communicate on their behalf to the quality and professional affairs committee of the Wexner medical center board at its next regularly scheduled meeting for final determination.

In cases of urgent need to update the medical staff bylaws or rules and regulations in order to comply with law, statute, federal regulation, or accreditation standard, the medical staff administrative committee and the quality and professional affairs committee of the Wexner medical center board may provisionally approve an urgent amendment without prior notification to the medical staff. The medical staff shall be immediately notified by the medical staff administrative committee. The medical staff shall have the opportunity for review of and vote on the provisional amendment. If the medical staff votes in favor of the provisional amendment it shall stand. If there is conflict over the provisional amendment, process for resolving conflict between the organized medical staff and the medical staff administrative committee shall be implemented.

(B) Methods of adoption and amendment to these bylaws.

Proposed amendments to these bylaws may be originated by the medical staff bylaws committee, medical staff administrative committee or by a petition signed by twenty-five percent (25%) of attending medical staff members.

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Each attending medical staff member will be eligible to vote on the proposed amendment via secure ballot in a manner determined by the medical staff administrative committee. All attending medical staff members shall receive at least fourteen days advance notice of the changes to be adopted:

- (1) The medical staff receives a simple majority of the votes cast by those members eligible to vote.
- (2) Amendments so adopted shall be effective when approved by the university board of trustees.

(C) Methods of adoption and amendment to medical staff rules, regulations and policies.

The medical staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these bylaws.

Proposed amendments to the rules, regulations and policies may be originated by the medical staff bylaws committee or the medical staff administrative committee.

The medical staff administrative committee shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the medical staff administrative committee, rules and regulations may be adopted, amended or repealed, in whole or in part and such changes shall be effective when approved by the organized medical staff, and the Wexner medical center board. Policies and procedures will become effective upon approval of the medical staff administrative committee.

In addition to the process described above, the organized medical staff itself may recommend directly to the quality and professional affairs committee of the Wexner medical center board an amendment to any rules, regulation, or policy by submitting a petition signed by twenty-five per cent of the members of the attending medical staff category. Upon presentation of such petition, the adoption process outlined above will be followed.

(D) The medical staff administrative committee may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, administrative, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Wexner medical center board but must be approved by the vice president of health services. Neither the organized medical staff nor the Wexner medical center board may unilaterally amend the medical staff bylaws or rules and regulations.

The medical staff bylaws, rules and regulations, Wexner medical center board bylaws, and relevant policies shall not conflict. The medical staff bylaws committee shall assure that there is no conflict.

(Board approval dates: 9/1/1993, 3/3/1995, 12/3/1999, 9/6/2002, 2/6/2004, 9/18/2009, 5/14/2010, 2/11/2011, 4/8/2011, 11/7/2014, 8/15/2023)

**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

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encouraged, but shall not be a requirement for continued medical staff membership and clinical privileges. Special or electronic meetings may be called at the option of the medical staff administrative committee.

- (B) Dues. The medical staff, by two-thirds vote of those in attendance at a regularly scheduled meeting, may establish dues. Payment of dues is a requirement for continued medical staff membership except honorary, clinical, and limited staff.

(Board approval date: 4/8/2011)

**3335-111-14 Rules of construction.**

- (A) "Shall" as used herein is to be construed as mandatory.
- (B) These bylaws should be construed to be gender neutral.

(Board approval dates: 9/1/1993, 12/6/1996, 9/1/1999, 9/6/2002, 5/14/2010, 4/8/2011)