MEDICAL STAFF RULES AND REGULATIONS
OF UNIVERSITY HOSPITALS RAINBOW BABIES AND CHILDREN'S HOSPITAL
November 30, 2021

TABLE OF CONTENTS

SECTION — TOPIC — PAGE

1.0 DEFINITIONS 1

2.0 PROFESSIONAL LIABILITY INSURANCE POLICY AND SUSPENSIONS.......... 1

3.0 REPORTING REQUIREMENTS TO THE OHIO STATE MEDICAL BOARD AND NATIONAL PRACTITIONER DATA BANK. 2

4.1 LICENSED INDEPENDENT PRACTITIONER (LIP) HEALTH.......... 4

- **4.2 Definitions 4**
- **4.3 Self-Referral.......... 4**
- **4.4 Report and investigation 6**
- **4.5 Treatment and Monitoring 6**

5.0 TELEMEDICINE.......... 6

6.0 CURRENT DEA REGISTRATION AND CORRECTIVE ACTION. 6

- **6.1 Requirement 6**
- **6.2 Corrective Action.......... 7**

7.0 MEMBER REVIEW AND CORRECTION OF INFORMATION 7

8.0 ASSOCIATIONS WITH HEALTH SYSTEMS NOT AFFILIATED WITH UHHS 7

9.0 COMMUNICABLE DISEASES.......... 8

10.0 GENERAL RESPONSIBILITY 9

11.0 GRADUATE EDUCATION PROGRAMS 10

12.0 REQUIREMENTS FOR ON-CALL ATTENDING COVERAGE.......... 11

13.0 FOCUSED MEDICAL STAFF PEER REVIEW 12

14.0 POLICY FOR VERIFICATION AND MONITORING OF PROFESSIONAL OHIO LICENSURE/REGISTRATION/CERTIFICATION 15

- **14.1 Verification.......... 15**
- **14.2 Monitoring.......... 15**
- **14.3 Responsibilities of the practitioner 15**

15.0 HOSPITAL AND UHHS POLICIES AND PROCEDURES.......... 16

16.0 LICENSED INDEPENDENT HEALTH CARE PRACTITIONERS 16

17.0 PROFESSIONAL APPEARANCE AND BEHAVIOR.......... 17

18.0 ADOPTION AND AMENDMENT OF RULES AND REGULATIONS 17

© 2021 University Hospitals Rainbow Babies and Children's Hospital, All Rights Reserved

MEDICAL STAFF RULES AND REGULATIONS
OF UNIVERSITY HOSPITALS RAINBOW BABIES AND CHILDREN'S HOSPITAL

1.0 DEFINITIONS

1.1 The definitions contained in the Medical Staff Bylaws of University Hospitals Rainbow Babies and Children's Hospital apply to the provisions of these Rules and Regulations for the Medical Staff.

2.0 PROFESSIONAL LIABILITY INSURANCE POLICY AND SUSPENSIONS.

2.1 The Hospital's professional liability insurance does not cover practitioners for their private practice. Medical Staff members and other privileged practitioners must provide evidence of current professional liability insurance coverage, which meets all of the following requirements, specified in the University Hospitals Rainbow Babies and Children's Hospital Policy on Professional Liability Insurance:

2.1.1 professional liability carrier must be rated at least A- or better by A.M. Best Company or equivalent rating by another credible insurance rating organization, or be issued by Western Reserve Assurance Co., Ltd.;

2.1.2 coverage is provided on an individual named basis (blanket coverage does not count toward satisfaction of requirements);

2.1.3 coverage must encompass the entire scope of the practitioner's clinical practice at the Hospital, without limitation;

2.1.4 uninterrupted individual practitioner coverage in the amounts listed below per clinical department and clinical privileges; and

2.1.5 non-compliance with any of the above may result in disciplinary action as stated in the Medical Staff Bylaws or Policy for Privileging Licensed Independent Practitioners (LIAP) or Allied Health Professionals (AHP) and become part of the Medical Staff member's or other privileged practitioner's permanent record.

2.2 Coverage required per clinical department and clinical privileges is $1 million per Occurrence/$3 million per Aggregate

2.3 Those who are covered by the Hospital's professional liability insurance are evaluated on an individual basis and include but are not limited to:

2.3.1 Members of the Medical Staff who admit and/or attend only patients who do not have a designated attending.* Neither these members of the Medical Staff nor their practices bill these patients for their professional services.

2.3.2 Members of the Medical Staff involved in teaching and research only (i.e., no patient care responsibilities).

2.3.3 The General Counsel of UHHS shall be the final arbiter of coverage by the Hospital's professional liability insurance.

* "designated attending" means an independent practitioner who supervises the patient's care as part of his/her independent professional practice.

2.3.4 Practitioners who are classified under Sections 2.3.1-2.3.2 shall submit a written request for a waiver of the required professional liability insurance for membership on the Medical Staff (see Waivers Section 2.8 below).

2.4 Members of the Honorary Staff are not required to provide proof of professional liability insurance.

2.5 A Medical Staff member is required to notify UHCD, the Chief Medical Officer, and Chairman immediately if his/her professional liability insurance will be or has been canceled.

2.6 A Medical Staff member is required to notify UHCD, the Chief Medical Officer, and Chairman when changing professional liability insurance carriers. The Medical Staff member shall be responsible for:

2.6.1 Obtaining adequate tail coverage in the amounts required by Section 2.2 from prior carrier or nose coverage from new carrier;
2.6.2 Assuring that there is no gap in coverage between termination of former professional liability insurance coverage and the retroactive date of the new professional liability insurance coverage.

2.7 A Medical Staff member is required to provide evidence of current, uninterrupted coverage meeting all the requirements stated in Sections 2.1 through 2.6. Admitting and/or clinical privileges shall be suspended for Medical Staff members (and others with clinical privileges) who do not comply with these requirements. The Medical Staff member and Chairman will be notified in writing of the suspension. This suspension shall become part of the Medical Staff member's permanent record. Once professional liability insurance coverage, meeting all requirements stated in Sections 2.1 through 2.6, is secured, the suspension will be removed. In the event that a Medical Staff member has failed to cure the violation within three months, the Medical Staff member shall be automatically terminated from the Medical Staff; this will be considered a voluntary resignation. Special exceptions to these provisions may be made in circumstances deemed necessary by the Chief Medical Officer.

2.8 Requests for waivers of the professional liability insurance requirements (including those practitioners covered by the Hospital's professional liability insurance noted above) shall be submitted in writing to the Chief Medical Officer by the appropriate Chairman; the Chief Medical Officer shall forward such request to the President (or, in the absence of the President, when necessary, his/her designee) with his/her recommendation. Existing waivers of the professional liability insurance requirement shall be reviewed by the Chief Medical Officer, in consultation with the General Counsel, and appropriate Chairman to evaluate the indications for maintaining such waivers. UHCD shall monitor admissions by Medical Staff members with waivers and advise the Chief Medical Officer of those practicing beyond the waiver limits.

3.0 REPORTING REQUIREMENTS TO THE OHIO STATE MEDICAL BOARD AND NATIONAL PRACTITIONER DATA BANK.

3.1 Reporting Requirements.

3.1.1 State Medical Board: Ohio law requires reporting to the Ohio State Medical Board of any formal disciplinary procedure which results in revocation, restriction, reduction or termination of clinical privileges for violations of professional ethics, or for reasons of medical incompetence, medical malpractice, or drug or alcohol abuse, unless referred for treatment in accordance with the Licensed Independent Practitioner (LIP) Health Program. The Hospital shall submit an adverse action report to the appropriate state licensure board within fifteen (15) days of adverse action being considered a final action as determined by the Chief Medical Officer.

3.1.2 National Practitioner Data Bank:

3.1.2.1 The Hospital shall report any professional review action, based on reasons related to professional competence or professional conduct of a physician or dentist that adversely affects or could adversely affect the health or welfare of a patient, adversely affecting clinical privileges for a period longer than thirty (30) days; or acceptance of a physician or dentist's surrender or restriction of clinical privileges while under, or to avoid, investigation for possible professional incompetence or improper professional conduct or in return for not conducting an investigation or reportable professional review action. Adverse actions taken against a physician's or dentist's clinical privileges include reducing, restricting, suspending, revoking, or denying privileges, and also include a health care entity's decision not to renew a physician's or dentist's privileges if that decision was based on the practitioner's professional competence or professional conduct. Health care entities may report such actions taken against the clinical privileges of other health care practitioners.

3.1.2.2 The Hospital shall submit an adverse action report to the National Practitioner Data Bank within fifteen (15) days from the date the adverse action was taken or clinical privileges were voluntarily surrendered. The Hospital may report such actions taken against the clinical privileges of other health care practitioners.

3.1.2.3 The Hospital shall print and send a copy of each report submitted to the National Practitioner Data Bank to the appropriate State of Ohio Licensing Board for its use.

3.1.2.4 Summary suspensions are considered to be final when they become professional review actions through action of Clinical Council, prior to the exhaustion of all internal administrative appeals. The Hospital shall report summary suspension of a Medical Staff member to the National Practitioner Data Bank when it has been imposed for more than 30 days.

3.2 Reporting Formal Disciplinary Procedures to the Ohio State Medical Board and the National Practitioner Data Bank.

© 2021 University Hospitals Rainbow Babies and Children's Hospital, All Rights Reserved

3.2.1 Chief Medical Officer or Chairman reports to UHCD a formal disciplinary action against a Medical Staff member or privileged practitioner according to Section 10 of the Bylaws.

3.2.2 The UHCD shall submit an adverse action report to the National Practitioner Data Bank and/or to the appropriate Ohio state licensure board according to the time frames noted in Sections 3.1.1 and/or 3.1.2, in consultation with Hospital's legal counsel.

4.0 LICENSED INDEPENDENT PRACTITIONER (LIP) HEALTH.

4.1 Definitions.

4.1.1 "Licensed Independent Practitioner (LIP)" refers to members of the Medical Staff, as defined in the Medical Staff Bylaws, and other practitioners privileged by Medical Staff mechanisms.

4.1.2 "Impaired" refers to LIPs whose ability to practice medicine may be compromised by physical, psychological, or cognitive problems; excessive use, or abuse, of drugs or alcohol; and/or LIPs who require assistance in dealing with emotional, health, family, or work-related problems.

4.1.3 "Evaluating Physicians" refers to physicians selected by the Licensed Independent Practitioner Health Committee, or the Chief Medical Officer, to conduct a "fitness for duty" examination on a LIP who may be impaired or may require assistance.

4.1.4 "Licensed Independent Practitioner Health Advisor" refers to a physician who is particularly knowledgeable about impairments and is not on the full-time Medical Staff at University Hospitals Cleveland Medical Center.

4.2 Self-Referral.

4.2.1 LIPs who feel that they have an impairment involving chemical dependence, or a physical, emotional, or psychological problem, may request assistance in selecting a course of action to improve their health. They may contact the Chief Medical Officer, the LIP Health Advisor, or the Hospital's Employee Assistance staff. In all cases, the contact and any referral will be kept confidential.

4.2.2 Resources available to LIPs seeking assistance will vary depending upon their individual condition; such resources include the Employee Assistance Program, Peer Counseling/Critical Incident Stress Management, medical or psychiatric treatment, anger or stress management counseling, and substance abuse treatment.

4.2.3 In the event that information received clearly demonstrates that a LIP's health or impairment poses an unreasonable risk of harm to patients, the LIP shall be reported to the Chief Medical Officer or to an approved treatment provider. [See Ohio Revised Code Section 4731.22(B).]

4.3 Report and investigation.

4.3.1 Any individual working in the hospital who has a reasonable suspicion that a LIP is impaired or requires assistance, shall provide a verbal or, preferably, written report to the Chief Medical Officer. The report must be factual and include a description of the incident(s) that led to the suspicion. The individual making

the report does not need to have proof but must state the facts that led to the suspicion. Confidentiality of the individual reporting the suspicion of impairment or need for assistance shall be maintained at all times, except as limited by law or ethical obligation.

4.3.2 After discussion with the reporting individual, if the Chief Medical Officer believes there is enough information to warrant an investigation, the Chief Medical Officer shall request that an investigation be conducted and a report generated by:

4.3.2.1 the LIP Health Committee; or

4.3.2.2 an appointed individual or individuals appropriate to the circumstances.

The Chief Medical Officer will advise the Chairman of the report.

4.3.3 The Chief Medical Officer shall seek the advice of Hospital Counsel to determine whether the conduct must be reported to law enforcement authorities, or other government agencies, and what further steps must be taken.

4.3.4 If the investigation produces sufficient evidence that a LIP may be impaired or may require assistance, the Chief Medical Officer may suspend the LIP's privileges and/or appoint Evaluating Physicians to conduct a "fitness for duty" examination, or refer the LIP to the LIP Health Advisor for recommendations.

4.3.5 Evaluating Physicians shall make recommendations to the Chief Medical Officer following the "fitness for duty" examination. In the event that a LIP does not follow the recommendation of the Evaluating Physicians, the matter will be referred to the LIP Health Committee for a recommendation. If no reasonable accommodation can be made, or a voluntary agreement cannot be reached with the LIP, or the LIP cannot overcome his/her impairment, the matter will be referred to the Medical Executive Committee, which will submit a report and recommendation to the Rainbow Committee.

4.3.6 The original report, all investigation reports, and descriptions of the actions taken by the Chief Medical Officer shall be placed in a confidential file kept by the Chief Medical Officer.

4.3.7 The Chief Medical Officer shall inform the individual who filed the original report that follow-up action was taken but need not specify the action.

4.3.8 Confidentiality of the LIP seeking referral or referred for assistance shall be maintained at all times, except as limited by law, ethical obligation, or when a patient's safety is threatened. Throughout this process, all parties shall avoid discussing the matter with anyone other than those described in this Rule and Regulation, the LIP's Chairman, and Division Chief.

4.3.9 In the event there is an apparent or actual conflict between this Rule and Regulation or other Policies of the Hospital or Medical

Staff, the provisions of this Rule and Regulation shall supersede such Policies.

4.4 Treatment and Monitoring.

4.4.1 The Evaluating Physicians shall assist the LIP in obtaining appropriate medical or psychiatric treatment. The LIP must authorize release of information from all treating professionals to the Chief Medical Officer.

4.4.2 The Evaluating Physicians shall develop a monitoring program to assure safety of patients, Medical Staff members, other privileged practitioners, and employees until the affected LIP's rehabilitation or any disciplinary process is complete.

4.5 Education.

4.5.1 The Chief Medical Officer shall prepare and distribute to LIPs and other Hospital staff educational material about illness and impairment recognition issues relating to physicians other Medical Staff members, and other privileged practitioners, in collaboration with LIP Health Committee. These materials should also reference the available resources outlined in Section 4.2.2.

5.0 TELEMEDICINE

5.1. Telemedicine Privileges. Any licensed independent practitioner who has either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services) through a telemedicine link is credentialed and privileged according to Section 9.4 of the Bylaws.

5.2 Telemedicine clinical services are limited to those that have been formally recommended by the Medical Staff along with any specific privileging criteria. The process outlined in Section 9.4 of the Bylaws shall be fully completed prior to granting of telemedicine privileges.

5.3 Procedure for Recommending Telemedicine Procedures.

5.3.1 The Chairman forwards to the Chief Medical Officer a written request for Medical Staff recommendation for each specific telemedicine procedure. The request should include for each procedure:

5.3.1.1 name of procedure and specialty where currently performed at the Hospital;

5.3.1.2 rationale for obtaining as the originating site or performing as the distant site these clinical services via telemedicine; and

5.3.1.3 privileging requirements for telemedicine practitioners.

5.3.2 The Chief Medical Officer shall forward approved requests for evaluation and recommendation to the RB&C Medical Executive Committee and Rainbow Committee.

6.0 CURRENT DEA REGISTRATION AND CORRECTIVE ACTION.

6.1 Requirement. Unrestricted DEA registration with all Schedules, valid in the State of Ohio, is required for all Medical Staff members except

members of the Department of Pathology, members of the Associate Medical Staff without prescriptive authority, and Honorary Medical Staff. These Medical Staff members are required to provide a current, valid copy of their DEA registration to UHCD, along with an explanation for any Schedule not maintained.

6.2 Corrective Action. Admitting and clinical privileges shall be automatically suspended for Medical Staff members who do not comply with these requirements. The Medical Staff member and Chairman shall be notified in writing of the suspension. The suspensions shall become part of the Medical Staff member's permanent record. Once DEA registration meeting Hospital requirements is secured, the suspension will be removed. In the event that a Medical Staff member has failed to cure the violation within three (3) months, the Medical Staff member shall be automatically terminated from the Medical Staff; this will be considered a voluntary resignation.

7.0 MEMBER REVIEW AND CORRECTION OF INFORMATION

7.1 It is the practitioner's responsibility to provide UHCD with current information, including but not limited to demographic, professional liability insurance, training, licensure, and board certification.

7.2 If the Medical Staff member believes that data elements maintained by UHCD are incorrect, he/she may request review of the supporting primary source verification of data elements deemed erroneous as permitted by State and Federal law, and Hospital policy. To maintain confidentiality and encourage candid responses, peer review information (including but not limited to evaluations and recommendations) will not be shared with the practitioner.

7.3 The Medical Staff member shall advise UHCD in writing of any additional or alleged discrepant data. UHCD shall obtain initial or reverification of data elements as appropriate, and advise the Medical Staff member of the results of the inquiry into any discrepancy.

8.0 ASSOCIATIONS WITH HEALTH SYSTEMS NOT AFFILIATED WITH UHHS

8.1 Policy. Hospital policy prohibits members of the Medical Staff from having a material financial relationship with or other material conflict of interest as a result of a relationship with a health system (or its controlled entity) not affiliated with University Hospitals Health System.

8.2 A material financial relationship shall include, but is not limited to:

8.2.1 An employment relationship,

8.2.2 An independent contractor relationship whereby the individual receives more than de minimis compensation (it being understood that an individual providing services on an infrequent basis will not be deemed to have such a material financial relationship),

8.2.3 A contractual relationship pursuant to which an individual's professional practice or the professional practice employing the individual is managed by a health system (or an entity controlled by such health system) not affiliated with University Hospitals

Health System.

8.2.4 Material conflicts of interest shall include, but not be limited to, holding a position (paid or unpaid) as an administrator, director, or trustee with any hospital, health care system, and/or health care entity not affiliated with UHHS.

8.2.5 Exceptions. The President of the Hospital may grant individual exceptions to the Hospital policy prohibiting members of the Medical Staff from having a material financial relationship with a health system (or its controlled entity) not affiliated with University Hospitals Health System for appropriate reasons. The reasons for such exceptions will be documented in writing and the benefits accruing to the Hospital must sufficiently outweigh the risks presented by the economic conflict of interest caused by the material financial relationship present between the practitioner and the competing health system. Approved exceptions shall be forwarded to the Chief Medical Officer who will forward to UHCD for processing. This documentation shall become part of the credentialing file.

9.0 COMMUNICABLE DISEASES.

9.1 All Medical Staff members and practitioners privileged by Medical Staff processes shall comply with the UH Communicable Diseases Policy. All Medical Staff members and practitioners privileged by Medical staff processes shall also comply with any and all state and federal laws and regulations with regard to communicable diseases.

9.2 A Medical Staff member who does not comply with the UH Communicable Diseases Policy by failing to be tested or failing to submit results, shall have his/her admitting and clinical privileges suspended until compliance has been met. In the event that a Medical Staff member has failed to cure the violation within three (3) months, such Medical Staff member shall be automatically terminated from the Medical Staff; this will be considered a voluntary resignation.

9.3 Reporting Requirements for Medical Staff Member Infected with HIV or HBV.

9.3.1 The Ohio State Medical Board requires physicians who perform invasive procedures to report to the Ohio Department of Health, the Ohio State Medical Board, and the Chief Medical Officer or the Medical Director of Infection Control, within 48 hours if he or she "believes or has reason to believe that he or she is infected with HIV or HBV" or to "voluntarily refrain from performing invasive procedures until such time as a report has been made in compliance with [State Medical Board Administrative] Rule [4731-19-02]." HBV is defined as Hepatitis B virus with Hepatitis E antigen positive status.

9.3.2 If the individual reports his/her seropositivity internally to the Chief Medical Officer or Medical Director of Infection Control, then the issue will be brought to the Triage Panel and/or the Infection Control Review Panel for analysis and risk assessment.

9.3.3 A Medical Staff member infected with HIV or HBV who is authorized by the Infection Control Panel to perform exposure prone procedures, must disclose his/her seropositivity and obtain

prior informed consent from the patient before performing exposure-prone procedures.

10.0 GENERAL RESPONSIBILITY

10.1 A physician member of the Medical Staff or privileged by Medical Staff processes shall be responsible for the general medical condition including diagnosis and treatment of each patient in the Hospital, for the prompt completion and accuracy of those portions of the medical record for which he/she is responsible, for writing orders, and for supplying information to the patient's family as appropriate.

10.2 Dentists, oral and maxillofacial surgeons, podiatrists, psychologists, optometrists, certified nurse midwives, and other health professionals may treat patients according to the conditions set forth in the University Hospitals Rainbow Babies and Children's Hospital Medical Staff Bylaws and Rules and Regulations, and each is responsible for documenting in the medical record, in a timely fashion, a complete and accurate description of the services provided to the patient.

10.3 A Medical Staff member or practitioner privileged by Medical Staff processes who is granted appropriate privileges shall provide treatment and perform operative and/or invasive procedures within those areas of competence indicated by the scope of his/her delineated clinical privileges.

10.4 In the event that an attending Medical Staff member is unavailable to care for his/her patients, the attending Medical Staff member shall assure timely, adequate professional care for such patients by designating an alternate with whom prior arrangements have been made and who has been granted the requisite clinical privileges at the Hospital. The attending Medical Staff member shall be responsible for communicating such arrangements to the caregivers of the patient. In the absence of such designation, the appropriate Chairman has the authority and responsibility to designate any member of the Medical Staff with the requisite clinical privileges. Failure of a Medical Staff member to meet the requirements of this section may result in a recommendation for such disciplinary action as the RB&C Medical Executive Committee deems appropriate.

10.5 It is the responsibility of the attending Medical Staff member to ensure that his/her patients have the benefits of available and appropriate continuing medical care. Continuing care planning is a coordinated process of activities that involve the patient and health providers working together to facilitate the transition of health care delivery from one environment and/or individual provider to another. This planning includes decisions about self-care, home health care, unit or facility transfer, ambulatory services, and utilization of other community resources.

10.6 Emergency care shall be provided to both inpatient and ambulatory patients as necessary by members of the attending Medical Staff and resident physicians, who are immediately available on the Hospital premises twenty-four (24) hours per day, seven (7) days per week. Provision of emergency care may not be denied because of the payment source for the care to be provided.

© 2021 University Hospitals Rainbow Babies and Children's Hospital, All Rights Reserved…

10.7 Emergency medical screening examination – Qualified Medical Personnel. A medical screening examination of an individual conducted pursuant to the Emergency Medical Treatment and Active Labor Act ("EMTALA") and its accompanying regulations, whether conducted in the Emergency Department or otherwise (including the labor and delivery area), may only be performed by a licensed physician (including residents) or by one of the following categories of non-physician practitioners operating under a valid agreement a physician member of the Hospital's medical staff:

- Certified nurse practitioners;
- Certified nurse midwives (obstetrics only);
- Physician Assistants

For non-resident physicians and non-physician practitioners listed above, the granting of an applicant or re-applicant privileges to perform emergency medical screening examinations shall be further dependent on the processes and approval set forth in the Medical Staff Bylaws.

10.8 A patient may be discharged only on the written order of the attending Medical Staff member or resident physician which order shall be documented in the medical record as soon as the discharge date is determined. The attending Medical Staff member is responsible for discharging his/her patients in a timely fashion.

11.0 GRADUATE EDUCATION PROGAMS

11.1 Graduate education program member ("program member") refers to a resident physician or any other participant registered in a professional graduate education program when the graduate practitioner will be a licensed independent practitioner (LIP).

11.2 Program Member Supervision

11.2.1 Program members are assigned patient care responsibilities commensurate with the individual's level of training, experience and capability. In all matters of an individual patient's care, program members are supervised by the attending physician or an appropriate LIP with appropriate clinical privileges who maintains responsibility for the care of the patient.

11.2.2 Attending physicians and LIPs will supervise program members in a manner consistent with the mandates of the program member's Program Requirements for the specialty in which the program members are training, and in a manner consistent with all Federal and State laws, rules and regulations.

11.2.3 Program directors are responsible for written descriptions of the roles, responsibilities, and patient care activities of program members in graduate educational programs and providing them to the Medical Staff and Hospital staff, including identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each program member's progressive involvement and independence in specific patient care activities.

11.2.4 Resident physicians may write patient care orders if they have a training certificate or full and unrestricted license issued by the

© 2021 University Hospitals Rainbow Babies and Children's Hospital, All Rights Reserved

Ohio State Medical Board. Orders need not be countersigned by the supervising attending physician. Additional order writing delineations are described in these Rules and Regulations and Policies and Procedures.

11.2.5 The Chair of the UH Rainbow Graduate Medical Education Committee (RB&C GMEC) is responsible for effective communication between the RB&C GMEC, the UHCMC GMEC chaired by the Accreditation Council for Graduate Medical Education Designated Institutional Official ("DIO"), the RB&C Medical Executive Committee, and the Rainbow Committee about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs.

11.2.6 The Chair of the RB&C GMEC, through the individual program directors, receives information from hospitals or non-hospital sites where graduate medical education takes place about the quality of care, treatment, and services and educational needs of resident physicians.

11.2.7 Medical Staff demonstrates compliance with residency review committee's program requirement and citations.

11.2.8 Reference UHHS Policy F-16 on Resident, Fellow, and Rotator Tracking.

12.0 REQUIREMENTS FOR ON-CALL ATTENDING COVERAGE

12.1 Clinical Departments/Divisions are required to provide on-call attending physician coverage for all patients, in accordance with the Medical Staff Bylaws, the policies established by the Transfer Referral Center, and the requirements of COBRA, EMTALA, The Joint Commission, and Centers for Medicare and Medicaid Services.

12.2 Chairman/Division Chiefs are responsible to ensure that physicians in their Department and Divisions are assigned to provide on-call coverage, and are aware of, and fulfill, this expectation.

12.3 Electronic On-Call Schedule Management.

12.3.1 Chairman/Division Chiefs are responsible for providing on-call attending physician schedules.

12.3.2 On-call schedules are maintained and managed electronically, and the electronic schedule is considered the only official on-call record. Hard copy on-call schedules are not acceptable.

12.3.3 Data management groups, established in each clinical area, are responsible for entering, maintaining, and reporting accurate and reliable information.

12.3.4 The on-call application is available through the UH Intranet. The application is accessible only through UH network connected devices.

12.4 Chairman is responsible for Division Chiefs fulfilling this responsibility.

© 2021 University Hospitals Rainbow Babies and Children's Hospital, All Rights Reserved

12.5 Such coverage shall include:

12.5.1 For patients off-service:

12.5.1.1 Attending physician consultation services:

12.5.1.1.1 Direct supervision of, and responsibility for, care rendered by the trainees (resident/fellows) assigned to consultative services

12.5.1.1.2 Accessibility, via telephone or pager, to appropriate Hospital personnel, and willingness to meet required time frames for response.

12.5.1.1.3 Availability, within one hour, to provide in-house attending evaluation 24 hours per day, as appropriate for proper patient care. More stringent requirements (e.g. trauma coverage) may be dictated by specific regulatory standards

12.5.1.1.4 Willingness to admit appropriate patients to the specialty service

12.5.2 For patients on-service:

12.5.2.1 All patients must have an attending medical staff member who is responsible for the patient's care

12.5.2.2 The attending medical staff member shall document an assessment of the patient in the medical record within 24 hours following admission

12.5.2.3 The attending medical staff member must provide:

12.5.2.3.1 Direct supervision of, and responsibility for care rendered by trainees (residents/follows) assigned to inpatient service

12.5.2.3.2 Accessibility, via telephone or pager, to appropriate Hospital personnel

12.5.2.3.3 Availability, within one hour, to provide in-house attending evaluation 24 hours per day, as appropriate for proper patient care.

13.0 FOCUSED PEER REVIEW FOR MEDICAL STAFF AND OTHER PRACTITIONERS WITH CLINICAL PRIVILEGES

13.1 Definitions.

13.1.1 A peer is an individual practicing in the same or related profession.

13.1.1.1 Subject matter expertise is required to provide a meaningful evaluation of care. Therefore, the facts of each review will determine what "practicing in the same profession" means. For example, any competent practicing physician may review quality issues arising out of general medical care. For specialty-specific clinical issues, such as the technique employed to perform a specialized surgical procedure, and whether or not the provider is a specialist, a peer must be an individual trained and/or sufficiently experienced in the care, or related care, under review.

13.1.2 Focused peer review refers to a process of evaluating the quality of care provided and identifying opportunities to improve by peers

of the person or persons whose care is under review.

13.1.2.1 Focused peer review differs from pure quality improvement in that it evaluates the strengths and weaknesses of an individual practitioner's performance rather than appraising the quality of care rendered by a group of professionals or a system. Focused review of individual performance and outcomes frequently unveils performance improvement opportunities. In focused peer review, individual performance is evaluated against the applicable standard of care. An outcome of the focused review offers constructive criticism of the performance observed. Through this framework, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

13.2 Circumstances Requiring Internal Focused Peer Review.

13.2.1 Adverse events causing serious outcomes or potential serious outcomes;

13.2.1 The recognition of an unusual clinical pattern of care; or

13.2.2 Cases screened by the Rainbow High Reliability Committee or Rainbow Quality Council, using Medical Staff criteria, to identify those cases that require further review (all other cases/events are trended).

13.3 Circumstances Requiring External Focused Peer Review.

13.3.1 Lack of internal expertise.

13.3.1.1 No member of the Medical Staff possesses adequate expertise to review the care in question.

13.3.1.2 The only practitioners on the Medical Staff with appropriate expertise to conduct the focused review are partners or associates of the practitioner who is being reviewed and the Medical Staff cannot appropriately resolve this potential conflict of interest.

13.3.1.3 The only practitioners on the Medical Staff with appropriate expertise to conduct the focused review are direct competitors or the practitioner under review and the Medical Staff cannot appropriately resolve this potential conflict of interest.

13.3.1.4 The Medical Staff member requests permission to utilize new technology or perform a procedure new to the Hospital and the Medical Staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved. "Necessary subject matter expertise" may be assumed if the requesting staff member's training in the new technology or procedure is deemed to be appropriate by the use of customary tools for evaluating privilege requests.

13.3.1.5 The Medical Staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring

© 2021 University Hospitals Rainbow Babies and Children's Hospital, All Rights Reserved

13.3.1.6 The palpable potential for litigation exists.

13.4 Policy.

13.4.1 Chairman is responsible for proper implementation of the focused peer review process.

13.4.1.1 Internal focused peer review. Chairman shall select at least three peers, as defined in Section 13.1.1.1, to serve on the internal focused peer review panel.

13.4.1.2 External focused peer review.

13.4.1.2.1 The Chairman and Chief Medical Officer or designee shall collaborate in selecting an external focused peer review panel.

13.4.1.2.2 All members of an external focused peer review panel shall be processed for and granted peer review consulting privileges, as described in Section 9.5 of the Medical Staff Bylaws, prior to participating on any external focused peer review panel.

13.4.1.3 Focused peer review panels shall:

13.4.1.3.1 be convened as soon as possible, but no longer than 90 days from identification of the need for focused peer review, unless special circumstances dictate;

13.4.1.3.2 evaluate the standard of care;

13.4.1.3.3 present findings; and

13.4.1.3.4 provide recommendation for action or for information to the Chairman

13.4.1.4 The Chairman, in collaboration with the Chief Medical Officer or designee, shall monitor the effectiveness of any intervention made resulting from the focused peer review process.

13.4.2 The Chief Medical Officer or designee shall be invited to participate or may, at his or her discretion, convene a focused peer review when circumstances warrant.

13.4.3 If the focused peer review process involves the Chairman, the Chief Medical Officer is responsible for the proper implementation of the focused peer review process.

13.4.4 All peer review information is privileged and confidential in accordance with state and federal laws and related rules and regulations governing peer review protection. In Ohio, the specific state citation is currently: O.R.C. § 2305.251.

13.4.5 Rights and Responsibilities of the Involved Practitioner.

13.4.5.1 The chairperson of the focused peer review panel shall provide practitioner-specific feedback to the involved practitioner on an ongoing basis.

13.4.5.2 The practitioner will be given an opportunity to respond to the results of the focused peer review, either in person or by letter.

13.4.5.3 Input from the practitioner will be considered in the final deliberations of the focused peer review panel.

13.4.5.4 Minority opinions and views of the practitioner are considered and recorded in the minutes.

13.4.5.5 The practitioner shall be informed by the Chairman of the final outcome of the focused peer review.

13.4.5.6 If the practitioner is requested to discuss the focused review, the practitioner will be so notified. The practitioner's failure to respond to this request shall be considered acceptance of the panel's focused review.

13.4.6 Individual and aggregate, practitioner-specific peer review results shall be considered in credentialing and privileging recommendations for Medical Staff and other practitioners with clinical privileges and, as appropriate, in the Hospital's performance improvement activities.

13.4.7 The name of any practitioner and the content of every focused peer review will remain confidential within the Department and the Hospital. Minutes from focused peer review activities will refer to the reviewed practitioner by an anonymous identifying number. Focused peer review results reported outside committee will not contain practitioner names or the content of the discussion, absent a specific need for additional processes as described in these Medical Staff Rules and Regulations.

13.4.8 Any peer review or quality file containing provider specific peer review information shall be archived in a secure, locked cabinet separate from the practitioner's credentialing file. Examples of provider specific peer review information are:

13.4.8.1 Quality and utilization review data
13.4.8.2 Incidents or near misses
13.4.8.3 Sentinel events
13.4.8.4 Peer review correspondence to the practitioner, whether commendation or corrective action

13.4.9 Peer review information will be available to authorized staff members who have a legitimate need to know. Examples include:

13.4.9.1 Center for Clinical Excellence
13.4.9.2 Chief Medical Officer
13.4.9.3 Designated RB&C Medical Executive Committee members
13.4.9.4 Individuals surveying for accrediting bodies with appropriate jurisdiction and peer review protection (e.g. The Joint Commission, NCQA, or state/federal regulatory bodies)
13.4.9.5 Individuals whose need for access is determined to be legitimate by Hospital's legal counsel and/or the Rainbow Committee.

13.4.10 No copies of peer review documents will be created or distributed unless authorized by the Hospital's legal counsel.

13.4.11 If a real or apparent conflict of interest suggests a focused peer review may be biased, the Chairman or the Chief Medical Officer or designee will replace, appoint, or determine who will participate in the process.

14.0 POLICY FOR VERIFICATION AND MONITORING OF PROFESSIONAL OHIO LICENSURE/REGISTRATION/CERTIFICATION

14.1 Verification. All members of the Medical Staff and other practitioners privileged by Medical Staff processes must maintain professional Ohio licensure/registration/certification as a condition of Medical Staff

© 2021 University Hospitals Rainbow Babies and Children's Hospital, All Rights Reserved

membership or privileges. UHCD shall obtain primary source verification of each practitioner's current, professional Ohio licensure/registration/certification at minimum at the following times:

14.1.1 Within 180 days prior to initial Medical Staff appointment;

14.1.2 Within 180 days prior to Medical Staff reappointment in each clinical department;

14.1.3 Prior to any change (addition or deletion) of clinical privileges and/or status;

14.1.4 Renewal prior to expiration of the Medical Staff member's professional licensure/registration/certification

14.2 Monitoring. UHCD queries each practitioner name found on monthly disciplinary action reports from Ohio licensure boards to determine if the practitioner is now or has previously been a member of the Hospital Medical Staff, House Staff, or privileged by Medical Staff processes. Affirmative responses are forwarded to the Chief Medical Officer, General Counsel and the Director, Graduate Medical Education.

14.3 Responsibilities of the practitioner

14.3.1 Exercise privileges only with a current and unrestricted licensure. While the Hospital monitors licensure compliance, it is ultimately the practitioner's sole responsibility to assure that his or her licensure/registration/certification is in full force. Practice with licensure/registration/certification that is expired or restricted may result in corrective action as stated in Section 10.0 of the Medical Staff Bylaws.

14.3.2 Inform the Chief Medical Officer and Chairman of the revocation, suspension, or limitation of professional licensure/ registration/certification according to Section 4.2.4.7.1 of the Medical Staff Bylaws. Failure to do so advise may result in corrective action as stated in Section 10.0 of the Medical Staff Bylaws.

14.3.3 Identify himself/herself with the same legal name as set forth on the member's application for membership, as maintained by the applicable State of Ohio licensure board.

15.0 HOSPITAL AND UH POLICIES AND PROCEDURES

15.1 All members of the Medical Staff must abide by the UH RB&C and UH policies and procedures available on the UH Intranet.

16.0 PRIVILEGING POLICY FOR LICENSED INDEPENDENT AFFILIATE HEALTH CARE PRACTITIONERS (LIAPs) AND ALLIED HEALTH PROFESSIONALS (AHPs)

16.1 Licensed Independent Affiliate Health Care Practitioner (LIAP) refers to clinical nurse specialists, nurse practitioners, and others as approved by the Board of Directors, authorized to independently practice or provide clinical services in the Hospital who may or may not be Hospital employees, who are not members of the Medical Staff, but who are employed by and/or in collaboration with an active member of the same specialty, in good standing, of the Hospital Medical Staff.

© 2021 University Hospitals Rainbow Babies and Children's Hospital, All Rights Reserved

16.2 Allied Health Professional (AHP) refers to certified registered nurse anesthetists, physician assistants, and others as approved by the Board of Directors, privileged by Medical Staff process to provide clinical services in the Hospital who may or may not be Hospital employees, who are not members of the Medical Staff, but who are employed by and/or supervised by an active member of the same specialty, in good standing, of the Medical Staff.

16.3 Licensed Independent Affiliate Health Care Practitioners (LIAP) and Allied Health Professionals (AHP) are permitted to practice or provide services in the Hospital, and are credentialed and privileged by UHCD through Medical Staff mechanisms, but are not members of the Medical Staff. Only those types of LIAPs and AHPs that have been approved by the Rainbow Committee shall be permitted to practice at the Hospital.

16.4 Permission to practice or provide services in the Hospital as a LIAP or AHP is a privilege which shall be extended only to those individuals who have successfully completed the application process, been approved for specific clinical privileges, continually meet the qualifications, standards, requirements, and competencies set forth in the Privileging Policy for Licensed Independent Affiliate Health Care Practitioners (LIAPs) and Allied Health Professionals (AHPs) and shall be limited to the needs of the patient population served by the Hospital as determined by the Rainbow Committee.

16.5 All members of the Medical Staff shall abide by the Medical Staff, Departmental, Hospital, and UHHS policies and procedures, including the Privileging Policy for Licensed Independent Affiliate Health Care Practitioners (LIAPs) and Allied Health Professionals (AHPs) as approved by the RB&C Medical Executive Committee and Rainbow Committee and distributed with the Medical Staff Bylaws and Rules and Regulations.

17.0 PROFESSIONAL APPEARANCE AND BEHAVIOR

17.1 Professional appearance and behavior are important in a health care environment. Patients and visitors form opinions and have expectations of standards of care based on Medical Staff members' professional dress and demeanor. Medical Staff members must comply with all UH policies addressing professional conduct and demeanor, including but not limited to HR-63 (Professional Behavior) and HR-66 (Professional Appearance).

17.2 Failure to comply with these policies or department-specific policies may subject the Medical Staff member to corrective action under the Medical Staff Bylaws.

18.0 ADOPTION AND AMENDMENT OF RULES AND REGULATIONS

18.1 The Medical Staff through RB&C Medical Executive Committee shall have the initial responsibility and delegated authority to formulate and submit recommendations to the Rainbow Committee regarding the Medical Staff Rules and Regulations and Amendments thereto. All Amendments and revisions shall be effective when approved by the RB&C Committee.

18.2 A standing or special committee shall review the Medical Staff Rules and Regulations at least every two (2) years.

18.3 Following a nine (9) day written notice accompanied by the proposed

© 2021 University Hospitals Rainbow Babies and Children's Hospital, All Rights Reserved

Rules and Regulations and/or alterations, the Rules and Regulations may be approved by an affirmative vote of a majority of the RB&C Medical Executive Committee acting on behalf of the Medical Staff. An affirmative vote of a majority of the Rainbow Committee is then required for adoption.

Approved by RB&C Medical Executive Committee on July 19, 2021.

Approved and Adopted by the Rainbow Committee on November 30, 2021.

____

Ethan Leonard, M.D.
Chairman, RB&C Medical Executive Committee

____

Janet Miller
Secretary of the Rainbow Committee