RULES AND REGULATIONS

OF THE MEDICAL STAFF

OF

UPPER VALLEY MEDICAL CENTER

TROY, OHIO

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1.1 DUTIES AND RESPONSIBILITIES OF MEDICAL STAFF PRACTITIONERS IN THE ADMISSION, CONTINUED CARE, AND DISCHARGE OF PATIENTS

1.1-1 OVERVIEW RESPONSIBILITIES

- The Medical Staff practitioner who admits and attends patients at Upper Valley Medical Center is responsible for the direction and oversight of his/her patients' care.
- The Medical Staff practitioner is also responsible for the preparation of a timely, complete, accurate and legible medical record. **(*Refer to Section 1.2 Medical Records-Inpatient/Ambulatory*)**
- Medical Staff practitioners shall provide information to assure safety of the patient and Upper Valley Medical Center caregivers and provide alternatives to restraint whenever possible. ***(Refer to Restraints Policy)***
- He/she will obtain appropriate consent as required, sharing risks, benefits and alternatives of operative/invasive procedures and other treatments, including administration of blood/blood products, with the patient and/or appropriate others. ***(Refer to Consent Policy)***
- Medical Staff practitioners shall assure DNR/Advanced Directive statuses are observed and honored. (***Refer to DNR and Advanced Directive Policies)***
- Medical Staff practitioners are responsible for working collaboratively with the entire team of caregivers, including care management, discharge planning and compliance for the best outcome and utilization of services in the care of patients **(Refer to Disruptive Practitioner Policy)**.
- Medical Staff practitioner is responsible for and is responsible and free to provide appropriate medical care to his/her patients without regard for payor status or financial incentive/disincentives.
- Medical Staff practitioner shall participate in Emergency Preparedness Plans. ***(refer to policy and procedures)***
- Medical Staff practitioner is responsible for communicating treatment outcomes to patients/ families, as appropriate, whether expected or unanticipated. ***(refer to policy on Disclosure of Unanticipated Outcomes)***

1.1-2 ADMITTING PRIVILEGE

Medical Staff Practitioners in good standing may admit and care for patients at Upper Valley Medical Center.

1.1-3 TRANSFER OF CARE

Whenever the responsibility for attending Medical Staff practitioner is transferred to another Medical Staff practitioner, the attending Medical Staff practitioner is responsible for physician-to-physician contact assuring acceptance of this transfer and documentation of this transfer responsibility on the order sheet of the medical record.

1.1-4 MEDICAL STAFF AVAILABILITY AND COVERAGE

Each Medical Staff practitioner must assure timely and adequate care for their patients who are inpatients or who present to Upper Valley Medical Center by being available or having available an eligible alternative staff member with whom prior arrangements have been made. This individual must also have appropriate clinical privileges at Upper Valley Medical Center. Specific time requirements must be followed for services of Trauma, Women's Services, and Cardiac Cath Lab. ***(Refer to these specific policies).*** A Medical Staff practitioner who will be out of town or unavailable to care for his/her patients shall indicate on the order sheet of the chart of each inpatient the name of the Medical Staff practitioner who has accepted and will be assuming responsibility for the care of the patient during his/her absence. The Medical Staff practitioner must also notify the Telecommunications Department of his/her impending absence and indicate who has accepted and will assume responsibility for care of the practitioner's patients in his/her absence.

If the attending Medical Staff practitioner, or consultant, or coverage practitioner(s) cannot be reached and the patient's condition warrants immediate medical decisions, then the Section Chief, Department Chair, Vice President/Chief Medical Officer, or Officer of the Medical Staff (President of the Medical Staff, First Vice-President, or Second Vice-President) shall be contacted and a practitioner assigned to the patient.

1.1-5 PATIENTS WITHOUT MEDICAL STAFF PRACTITIONERS

Patients who present to the Emergency Department for care and require admission or follow up for management of an acute condition or acute exacerbation of chronic condition requiring an outpatient follow-up visit shall be referred to the Medical Staff practitioner on the appropriate Emergency Service On-call list. The patient shall be seen by the practitioner at least one time, regardless of ability of the patient to pay. The follow-up visit shall be conducted by the practitioner in a timely fashion as determined by the practitioner and the referring practitioner according to the patient's condition. After the initial follow-up visit, there is no obligation that the practitioner otherwise accept the patient into the practitioner's practice for further treatment.

1.1-6 ADMISSION STATUS AND CONTINUED HOSPITALIZATION

The attending Medical Staff practitioner is required to admit each patient to the most appropriate admission status. In addition, the attending Medical Staff practitioner shall document in the medical record appropriate need for continued stay. Such decision-making should be guided by accepted best practice and by the use of clinical paths as available.

1.1-7 ORDERS FOR TREATMENT

Orders for treatment will be given in writing. In the event of an urgent or emergent situation, orders may be given by telephone or verbally and authenticated by the individual giving the order as soon as reasonably possible. ***(Refer to Policy on***

Procedure for Recording Therapeutic and Diagnostic Orders). In order to assure accurate transcription of verbal or telephone orders, Medical Staff practitioners are urged to repeat orders, and ask for verbal repetition of such orders from the individuals to whom the order was given.

1.1-8 GENERAL CONSENT FORM

A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer should notify the attending Medical Staff practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the Medical Staff practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

1.1-9 PROTECTION FROM HARM

The attending Medical Staff practitioner shall provide any and all patient information that might be necessary to assure protection of the patient from self-harm and protection of all caregivers. The attending Medical Staff practitioner shall actively participate with the care team in evaluating alternatives to the use of restraint and seclusion, and shall follow policies and procedures relative to restraint. ***(Refer to Policy on "Restraints")***

1.1-10 CONSULTATIONS

To the extent that a Medical Staff Practitioner seeks to provide care outside the scope of his/her clinical privileges, consultation must be obtained. Consultations must be ordered by the Medical Staff Practitioner attending the patient or designee with clinical privileges to order consultation. The consult should be called physician to physician whenever possible and especially in emergency situations. Consultations shall be performed within 24 hours of receipt of request, unless otherwise agreed upon by physician-to-physician communication or as communicated via physician order.

1.1-11 PSYCHIATRIC CONSULTATIONS/TRANSFERS

The attending Medical Staff practitioner may request consultation of psychiatric services to assess need for transfer to Behavioral Health Unit or plan for outpatient treatment. Such consultations shall be answered by the Crisis Center within 24 hours, or sooner, upon verbal agreement between attending Medical Staff practitioner/ Crisis Center/psychiatrist. Crisis Center evaluations are performed under direction of on-call or attending psychiatrist. Attending Medical Staff practitioner requesting care/management/consultation by a psychiatrist shall request same with physician-to-physician communication.

1.1-12 ADMIT TO INTENSIVE CARE UNIT (ICU)

Daily review of all patients in ICU is to be performed by Medical Director. In the event that there is a question of necessity/intensity or admission/continued stay, the decision shall be made by communication between attending Medical Staff practitioner, Medical Director and/or Department Chair as needed. ***(Refer to policies addressing Intensive***

Care Unit)

1.1-13 INPATIENT MEDICAL STAFF PRACTITIONERS

A Medical Staff practitioner who is a patient in-house must have an attending Medical Staff practitioner who provides for his/her care, including orders for care and treatment.

1.1-14 PATIENT DISCHARGE

The Medical Staff practitioner shall discharge patients with written order. The attending Medical Staff practitioner is responsible for providing complete discharge instructions to assure patient safety, provide timely follow-up and continuity of care. In the event that a patient demands discharge against medical advice, ***refer to policy on Leave Against Medical Advice.***

1.1-15 DEATH IN THE HOSPITAL

Attending Medical Staff practitioner shall be notified immediately upon the death of his/her patient in the hospital. Pronouncement of death shall be performed by the attending Medical Staff practitioner or his/her designee.

1.1-16 AUTOPSY PROCUREMENT

It is incumbent upon Medical Staff practitioners to be actively interested in securing meaningful autopsies. To be performed, the autopsy request must be performed with written consent in accordance with Ohio state law. Cases which meet the criteria for Coroner's Cases shall be discussed with the Miami County Coroner. ***(Refer to Autopsy Policy)***

1.1-17 ORIENTATION OF MEDICAL STAFF PRACTITIONERS

New members of the Medical and Allied Health Professional Staff shall participate in An orientation designed for their areas of clinical practice. This process shall be coordinated by the Medical Staff Services Department. This orientation shall include a face-to-face meeting for the purposes of identity verification with the credentialing documents. This verification of identity shall occur prior to the exercising of clinical privileges.

1.2-1 MEDICAL RECORD STANDARDS

All Medical Staff and Allied Health Practitioners who provide care for patients at Upper Valley Medical Center shall be responsible for complete and timely entries in the medical record. All entries shall be legible, accurate, dated, timed and authenticated. **(See Policy: Legibility of Medical Records)**

1.2-2 COMPONENTS OF THE MEDICAL RECORD

a. <u>History and Physical</u>

The history and physical shall be completed and on the medical record within 24 hours of admission/observation or prior to any operative/invasive procedure

requiring a history and physical, whichever comes first. A history and physical performed within 30 days of admission/observation or operative/invasive procedure may be used, if appropriate update is documented. **(See Policy: History & Physical Policy)**

b. Admission Progress Note
A clinically pertinent admission progress note shall be recorded. **(See Policy: Medical Staff Progress Notes Policy)**

c. Progress Notes
Progress notes shall be recorded at least daily by the practitioner(s) caring for the patient. In the event that a consultant is assuming a majority of the patient's care, his/her note may suffice on a given day. Notes shall be recorded concurrently, with sufficient information so as to permit continuity of care. **(See Policy: Medical Staff Progress Notes Policy)**

d. Operative/Invasive Procedure Reports
A clinically pertinent post-procedure progress note must be prepared immediately following the procedure. An operative report must also be prepared after completion of the procedure for the continuity of care of patients undergoing operative/invasive procedures. **(See Policy: Operative Report Policy)**

e. Orders
Orders shall only be provided by practitioners with appropriate licensure and clinical privileges. All orders shall be legible, dated, timed and authenticated when written. Routine use of verbal orders is prohibited. Verbal orders must be signed within 48 hours and may be signed by a covering physician. **See Policy: Medical Staff Verbal Orders Policy**

f. Discharge Summaries
A discharge summary shall be completed in a timely manner on all patients. **(See Policy: Discharge Summary Policy)**

g. Pre-Procedure Documentation/History and Physical Update
1. Inpatients: Patients with completed history and physical need only daily clinically pertinent progress notes prior to procedures.

2. Outpatients: When a pre-procedure history and physical is required, it must be complete and on the chart prior to the procedure. **(See Policy: History and Physical Policy**)

1.2-3 MEDICAL RECORD STANDARDS—VARIATIONS: SHORT-STAY ADMISSIONS, HISTORY AND PHYSICALS PERFORMED ELSEWHERE WITHIN 30 DAYS,

READMISSIONS TO UPPER VALLEY MEDICAL CENTER WITHIN 30 DAYS AND EMERGENCY ADMISSIONS. (See Policy: History and Physical Policy)

1.2-4 MEDICAL RECORD COMPLETION REQUIREMENTS

A medical record shall be defined as delinquent if incomplete 30 days after patient discharge, transfer or death. **(See Policy: Notification of Past Due Medical Records)**

1.2-5 CONSULTATIONS

To the extent that a Medical Staff Practitioner seeks to provide care outside the scope of his/her clinical privileges, consultation must be obtained. Consultations must be ordered by the Medical Staff Practitioner attending the patient or designee with clinical privileges to order consultation. The consult should be called physician to physician whenever possible and especially in emergency situations.

The consultation order should include: name of consultant, reason for consultation and urgency of consultation, not to exceed 24 hours. Consultation reports must be legible, complete and performed within 24 hours. **(See Consultation Report Policy)**

1.2-6 OBSTETRICAL RECORDS

The obstetrical record shall include a complete prenatal record. The prenatal record may include a legible copy of the attending Medical Staff Practitioner's office record and interval update information as appropriate. All other medical record requirements will be as stated in this section. **(See Policy: History and Physical Policy)**

1.2-7 AUTHENTICATION OF MEDICAL RECORD ENTRIES

All entries in the patient's medical record shall be authenticated. Authentication may be in the form of written/fax signature or computer key (electronic signature) as appropriate for the entry. **See Policy: Electronic and Rubber Stamp Signatures for Medical Staff Practitioners and Allied Health Professionals**

1.2-8 SYMBOLS AND ABBREVIATIONS

(See Policy: Abbreviations Policy)

1.2-9 FINAL DIAGNOSES

For all patients, final diagnoses shall be recorded in full, without the use of symbols or abbreviations, by the responsible Medical Staff member as near to the time of discharge as possible. If a diagnosis is pending pathological or other diagnostic results, this shall be so noted.

1.2-10 REMOVAL OF CHARTS FROM DEPARTMENT/HOSPITAL

Charts are the property of the hospital, and may be removed from Upper Valley Medical Center property only in accordance with a court order, subpoena, statute, or with approval of the Director of Health Information Services, Chief Operating Officer, Vice

President/Chief Medical Officer, or designee.

Medical Staff Practitioners may remove records from the HIS Department for use in another hospital department only in accordance with the **"Removal of Records from the Hospital"** policy. The record(s) must be secured by the practitioner at all times. This record(s) must be returned to HIS prior to the end of the day.

Medical records viewed and/or printed via the computerized clinical information system adhere to the same standards as the original hardcopy version of the medical record maintaining confidentiality and medical staff professionalism.

1.2-11 PERMANENT FILING OF MEDICAL RECORDS

A medical record shall be permanently filed when it is complete.

1.3 GENERAL RULES REGARDING SERVICE OF SURGERY

1.3.1 SURGERY

a)PRE-ANESTHESIA EVALUATION

The anesthesiologist or certified registered nurse anesthetist (CRNA) shall perform and record a pre-anesthesia evaluation for each patient undergoing an operative and/or invasive procedure for which their services have been requested. If anesthesia is being provided by the Medical Staff practitioner performing the operative or invasive procedure the same requirements shall pertain. The pre-anesthesia evaluation by a CRNA shall be co-signed by the supervising anesthesiologist or surgeon attending the patient. Any pre-anesthesia evaluation shall include pertinent anesthesia history, physical examination, findings of diagnostic studies, ASA Classification, oropharyngeal classification and plan of anesthesia treatment. The anesthesia provider will also obtain informed consent for anesthesia after discussing risks, benefits and options, and alternatives with the patient. The pre-anesthesia evaluation shall consider data from other assessments and collects information needed to: 1)select and plan anesthesia care; 2)safely administer anesthesia, and 3)interpret findings of patient monitoring.

b)ROLE OF THE SURGEON - SURGICAL PRE-OPERATIVE EVALUATION

The surgeon shall provide appropriate historical and physical information prior to performing an operative and/or invasive procedure. ***(Refer to Medical Records Section 1.2).*** This shall include plan of care and informed consent. If a change in Do Not Resuscitate (DNR) is to be made while the patient undergoes an operative or invasive procedure, this shall be so noted in the medical record. ***(Refer to Policy "DNR").***

1)**<u>Informed Consent</u>**

Informed Consent shall be obtained prior to any operative or invasive procedure except in those situations where the patient's life is in jeopardy and this situation is constituted as an emergency. The LIP shall inform the patient of the nature, risks, benefits and alternatives of the procedure to be performed in accordance with the statutes of the State of Ohio. The consent shall be appropriately signed by parties legally responsible for the care and management of the patient ***(Refer to the Consent Policy).***

c)SURGERY SCHEDULING

In as much as possible surgery shall be performed during normal working hours. ***(Refer to policy regarding surgeries during normal working hours)*** Surgeons shall also make every attempt to begin procedures in a timely fashion to provide for the optimum efficiency in the surgery scheduling process. ***(Refer to policy regarding surgery delays and surgery scheduling)***

d)SURGICAL ASSISTANTS

In any major surgical procedure an attending surgeon shall choose a qualified assistant who shall scrub and assist with the procedure. The assistant may be a physician with appropriate credentials or a registered nurse first assistant (RNFA), or other member of the Allied Health Professional Staff appropriately credentialed to assist in surgery. In an acute emergent situation such requirement may be waived.

e)EXAMINATION OF TISSUE BY PATHOLOGIST

All pertinent, clinically relevant materials and tissues removed during operative and invasive procedures shall become the property of the hospital and shall be examined by the hospital pathologist whose report shall form a part of the patient's clinical record. The same applies to any pertinent tissue and/or cytological material and pertinent body fluid removed or obtained other than in surgery. Tissue and non-tissue specimens may be requested by the surgeon (medical staff practitioner) to be examined "gross only". This includes items to be identified and recorded for documentation purposes. These items may be examined microscopically as deemed appropriate, by the pathologist. Additionally, upon request of the attending surgeon, tissue specimens will be prepared by the hospital pathologist to send to any recognized pathologist for opinion. All foreign bodies of a forensic nature shall be sent to the laboratory for evaluation. Placentas shall be sent for pathological examination in accordance with College of American Pathologists guidelines. Materials and tissues removed during an operative and invasive procedure that are not sent to pathology shall be described by the surgeon in the medical record.

f)DISCHARGE OF PATIENT FROM POST-ANESTHESIA CARE UNIT (PACU)

Discharge of the patient from the PACU is made upon the order of the surgeon or anesthesiologist attending the patient. Such discharge may be based on criteria-

base Aldretti score determination.

1.3-2 WOMEN'S SERVICES GENERAL RULES REGARDING SERVICE OF OBSTETRICS AND GYNECOLOGY

a)COMPLIANCE WITH OHIO DEPARTMENT OF HEALTH OBSTETRICAL RULES AND THE OFFICE OF THE INSPECTOR GENERAL

Rules promulgated by the State of Ohio Department of Health with reference to the Women's Services Department and the Office of the Inspector General will be followed.

b)OBSTETRICAL RECORDS

The current obstetrical record shall include a complete prenatal record, which may be a legible copy of the attending physician's office record, provided to the hospital prior to admission.

c)SCREENING EXAMS FOR OBSTETRICS

The obstetrical screening exam may be performed by a qualified obstetrical nurse in the Women's Services Department in consultation with the physician. ***(Please refer to policies in Women's Services for specifics).***

1.3-3 GENERAL RULES REGARDING EMERGENCY SERVICES

a)PHYSICIAN COVERAGE OF EMERGENCY SERVICES

All patients presenting to the Upper Valley Medical Center Emergency Services Department shall be seen by a physician. The Administration of the hospital will maintain continuous physician coverage of Emergency Services via contract with individual or groups of physicians. The details of the contract will be an administrative function. However, each individual contracting physician working in Emergency Services will be approved through the credentialing process of Upper Valley Medical Center.

b)EMERGENCY SERVICES ON-CALL SCHEDULES

(1) The Medicine, Surgery, and Support Services Departments specialty sections will maintain call schedules for Emergency Services. Such call schedules shall be composed of all Active and Affiliate members of each such section, unless a Medical Staff member for good cause shown as determined by the Medical Executive Committee in its sole discretion, is specifically exempted from being required to provide such coverage.

(2) If a department chair believes that additional Medical Staff members are

needed in order to adequately meet on-call coverage responsibilities, the department chair shall make such recommendation to the Medical Executive Committee setting forth the basis for the chair's concern as well as the time period, if possible to determine, when additional staffing is necessary. Upon approval of the recommendation by the Medical

Executive Committee, Associate Medical Staff members of the specialty section(s) where such concerns exist shall be obligated to participate in the emergency on-call schedule in the same manner as Active Medical Staff members and for such period of time as designated by the Medical Executive Committee. No Associate Medical Staff member shall be exempted from this requirement unless the Medical Executive Committee determines, in its sole discretion, that good cause exists for granting such exemption.

(3) In a rare personal emergency situation wherein the practitioner is unavailable or unable to take or arrange coverage for his/her patients, the Section Chief or Department Chair should be contacted. The ED physician and Section Chief should attempt to locate a volunteer willing to accept the emergency coverage. If such coverage cannot be arranged, the ED call schedule to which the individual is assigned will automatically shift forward by one day to fill the newly vacated date. The new schedule for that month, for that specialty, will then be prepared and distributed by the Medical Staff Services Department on the next business day. If this change in schedule creates hardship for any Medical Staff practitioner, the Department chair will intervene as needed.

1.3-4 SPECIAL CARE

Rules governing admission, continued stay and discharge to and from special care units are noted in policies pertaining to special care units maintained in the Administrative offices.

1.3-5 DENTISTS

a)ADMISSION BY STAFF MEMBER

Patients requiring dental surgery, except as noted below, shall be admitted only as patients of a member of the Medical Staff. The staff member may then select from those persons having dental surgical privileges with the hospital such person, as he/she desires to perform the dental surgery. All surgical procedures performed by dentists are under the jurisdiction of the Department Chair of Surgery.

b)ADMISSION BY ORAL SURGEON

An appropriately qualified oral surgeon of the Medical Staff at Upper Valley

Medical Center may admit patients, without apparent medical problems, and also complete an admission history and a physical examination, and assess the medical risks of the procedure to the patient. Criteria to be used in identifying such a qualified oral surgeon will be determined in accordance with the credentialing process and shall include, but need not be limited to the following: successful completion of an accredited postgraduate course in oral surgery and evidence that the oral surgeon who admitted the patient is currently competent to conduct a complete history and physical examination to determine the patient's ability to undergo the oral surgical procedure the oral surgeon proposes to perform.

c)ORAL SURGICAL PATIENTS; JOINT MANAGEMENT AND MEDICAL RECORDS

Oral surgical patients with medical problems shall be managed jointly by the oral surgeon and a qualified physician member of the Medical Staff at Upper Valley Medical Center. The Medical Staff member (MD or DO) shall record either the admission history and physical examination or a consultation containing the pertinent history and physical findings, and shall also record progress notes.

1.3-6 PODIATRISTS

A) The Hospital practice of a podiatrist shall be limited to Podiatry, which is limited to examination, diagnosis, treatment and care of conditions and functions of the human foot as defined in the delineation of privileges. Surgical treatment shall be limited to those procedures within the scope of their license.

B) Admission of an ASA Class I or II patient may be made by a podiatrist with privileges to admit and perform a history and physical.

C) A podiatric patient who is an ASA Class III or IV will be admitted by a medical physician member of the Medical Staff of Upper Valley Medical Center with the podiatrist as a consultant. The podiatrist shall be responsible for the arrangement of the admission.

The medical physician shall be responsible for the admission of the patient, history and physical, the medical management of the patient and discharge summary.

1.3-7 HOME CARE SERVICES

Home Care Services provide care to those patients whose nursing, therapy, personal, social and related health needs can be met in the place of residence. Home Care Services shall accept patients living in Miami County and adjacent counties for care and treatment.

The admitting practitioner for Home Care Services patient shall be a member of the Active or Associate Staff of Upper Valley Medical Center. A licensed

independent practitioner who is not a member of the Active or Associate Staff at Upper Valley Medical Center may not admit a patient to Home Care Services, but may, however, provide orders for care of such patients upon verification of Ohio licensure. ***(See Home Care Practitioner Credentialing Process Policy).***

The admitting practitioner shall be responsible for the patient's plan of care in the Home Care Services in accordance with their policies and procedures. The admitting practitioner shall be responsible for a the patient's discharge from the Home Care Services in accordance with their policies and procedures.

The President of the Medical Staff, with the approval of the Medical Executive Committee, shall appoint a Medical Director to the Home Care Services

1.4 SPECIAL CATEGORIES/NON-MEDICAL STAFF (AHP AND OTHERS)

1.4-1 CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

Anesthesia Services provided by a Certified Registered Nurse Anesthetist (CRNA) shall be performed within the limits of their skills and the scope of their lawful practice as defined in their privileged delineation. CRNAs granted privileges shall participate directly in the care of patients and exercise judgment within their area of responsibility under the supervision and direction of a licensed physician, who shall be qualified to perform such supervision and direction and who is responsible for the care of the patient.

A licensed physician in good standing of the Active Staff shall assume responsibility for the supervision and regulation of the medical care of each patient cared for by the CRNA. An oral surgeon or podiatrist performing a surgical procedure shall not utilize the services of a CRNA, unless the CRNA administers the anesthesia under the supervision and direction of an anesthesiologist.

CRNAs may be employed by the Hospital. If a CRNA is providing services pursuant to an exclusive contract for anesthesia services, such privileges shall be withdrawn upon suspension or termination of such contract.

1.4-2 PHYSICIAN ASSISTANT (PA)

The Physician Assistant (PA) performs his/her duties under the direction of the supervising Medical Staff practitioner. Such practitioner must be a member of the Upper Valley Medical Center Medical Staff. The delineations/criteria for the PA for Emergency Services, and Medicine and Surgery Services are covered under separate documents. ***(See delineation forms in the Medical Staff Services Department).***

1.4-3 CERTIFIED NURSE MIDWIFE (CNM)

The Certified Nurse Midwife (CNM) performs his/her duties in collaboration with a physician. Such physician must be a member of the Upper Valley Medical Center Medical Staff with clinical privileges in obstetrics. The delineations/criteria for the CNM are covered under a separate document. ***(See delineation form in the Medical Staff Services Department).***

1.4-4 CERTIFIED NURSE PRACTITIONER (CNP)

The Certified Nurse Practitioner (CNP) performs his/her duties in collaboration with a physician or podiatrist under a Standard Care Arrangement (SCA). Such physician or podiatrist must be a member of the Upper Valley Medical Center Medical Staff with appropriate clinical privileges. The delineations/criteria for the CNP are covered under a separate document. ***(See delineation form in the Medical Staff Services Department).***

1.4-5 MEDICAL STUDENTS

Preparation/Paperwork:

A written agreement with the educational facility is required for all educational experiences, which include significant clinical activities. This may be a standing agreement, or only for the purposes of an individual student. This should include the names(s) of the student, the dates of the experience at the Upper Valley Medical Center and the name of the preceptor.

Unless the medical student is from an institution with which Upper Valley Medical Center has a pre-existing agreement, as part of an on-going educational program, the statement should state the purpose and the educational goals of the experience.

Medical students require no malpractice insurance coverage.

Medical students must meet the identification, dress and ethical codes of conduct at Upper Valley Medical Center.

The physician will be required to notify Administration and the Medical Staff Services Department prior to bringing a medical student to the facility.

Use of Facility:

Medical students will have full use of the Hospital. The Professional Library and services of the librarian will be provided, including copying of articles. The hospital dictating system may be used, subject both to approval by the preceptor and the Health Information Services Department workload.

The Health Information Services Department must be notified of all students upon

written agreement to include what year the medical student is currently in.
Medical students may dictate a history and physical, operative report or discharge summary for educational purposes, however, these reports shall not become a part of the permanent record. When dictating, the medical student will be required to identify himself/herself and the name of the physician for whom he/she is dictating.
Medical students may write progress notes **(refer to 1.2-3 Components of the Medical Record, Section "e")** which must be concurrently authenticated by the supervising practitioner.

Attendance at appropriate CME events is encouraged.

Attendance at Medical Staff committee meetings is only by permission of the committee chair.

Clinical Activities:
Medical students will have full access to the charts of the patients of the preceptor(s) appropriate to the teaching program. Access to the charts of patients of other staff members is only with permission of the staff member and patient.

Patient preference should be honored with regards to participation in the teaching program.

Medical students have no independent clinical privileges. Medical students in 3rd-4th year may write orders, but such orders cannot be acted on until direct, specific confirmation of each order is obtained from the attending physician.

1.4-6 VISITING MEDICAL PERSONNEL (VMP)

Medical personnel in any of the disciplines described in Sections 1.4-2 through 1.4-6 above must be sponsored by a member of the Medical Staff of UVMC in good standing.

The sponsoring practitioner will notify the Medical Staff Services Department and will provide the appropriate information prior to any observation activity. This will include: a)name of VMP; b)name of medical or other school currently attending for education; c)purpose of observation; d)dates of observation; and e)TB documentation. Notification of the observation activity will be sent by the Medical Staff Services Department to the appropriate department(s). All information of the VMP will be filed in the Medical Staff Services Department.

The VMP will be required to wear a nametag while on Hospital property. The VMP is categorized as "Visiting Medical Personnel" and not "student".

The VMP must be in the company of the sponsoring practitioner while on Hospital property.

The VMP must meet the dress and ethical codes of conduct at Upper Valley Medical Center.

The VMP may not dictate, write any orders, notes, history, or physicals in the Hospital chart.

The sponsoring practitioner must introduce and explain the VMP's presence to the patient. The patient must agree to the presence of the VMP.

All information observed by the VMP is confidential and shall not be disclosed. The VMP will sign a confidentiality statement prior to his/her observation activity.

The maximum duration of the observation experience will be 30 calendar days. An extension may be granted upon review/approval by the appropriate department chair.
The Hospital shall have the right to terminate the observation at any time, in its sole discretion.

1.4-7 RESIDENT/FELLOW

Resident/Fellow physicians from Wright State University Boonshoft School of Medicine training program will be under the supervision of an Active Appointee of the Medical Staff in good standing with clinical privileges in the field of study of the Resident/Fellow. The Supervising Attending Physician shall be available at all times to the Resident/Fellow. Detail of the clinical requirements of the Resident/Fellow and the supervisory requirements for the Supervising Attending Physician shall be so outlined in specific documents. The Resident/Fellow may provide History and Physical, Progress Notes, and Discharge Summary in the Medical Record. The Supervising Attending Physician will admit and discharge the patient. He/she will provide daily preceptorship with Preceptor Progress Notes and co-signed History and Physical and Discharge Summary in accordance with Medical Records Policies. The Resident/Fellow who is a licensed independent practitioner may otherwise write orders without countersignature. The Supervising Attending Physician will review the Resident/Fellow's orders on a regular basis and will be permitted to amend the orders as appropriate.

1.5 BEHAVORIAL HEALTH AT DETTMER

1.5-1 SCOPE OF SERVICES

Scope of service includes: Adult Mental Health Inpatient, Child/Adolescent Mental Health Inpatient (Youth Services), UVMC Outpatient Behavioral Health Services,

Psychology Services, Psychiatric Consultation Services and Crisis Intervention Services.

1.5-2 EMERGENCY SERVICES

The Crisis Center shall be staffed by qualified mental health professionals consistent with the Ohio Department of Mental Health Administrative rules. Staff shall possess training and credentials in crisis intervention techniques.

The Crisis Center staff will seek consultation with a psychiatrist member of the Medical Staff if patient meets criteria for psychiatric admission to the mental health units

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1.5-3 PSYCHIATRY SERVICE

The Mental Health Unit Policies and Procedures, as approved by the professional staff will be the guide for functioning of the Inpatient units. Any revisions of the Policies and Procedures must be submitted to the Psychiatric Section for approval prior to being submitted to the professional staff.

Admission and continued stay criteria are described in the program manuals of the Adult and Youth Services Mental Health Units and are based upon state code and licensure requirements.

Admission of patients is accomplished through psychiatrists, by direct referral, through Crisis Center evaluation, or through the screening process described in the Mental Health Unit Program Manuals.
The members of the Psychiatric Service staff will establish a call schedule to assure that one psychiatrist will always be available for call for psychiatric emergencies for the Behavioral Health Division and Upper Valley Medical Center. A psychiatric emergency may be broadly defined as a crisis in which a person has become a threat to self or others. Most psychiatric emergencies fall into the following categories:

a. Suicidal threats, gestures, or attempts.
b. Aggressive behavior due to mental health illness towards family, staff and/or other patients.

However, in any of the above situations in which the patient has a physical or organic illness, or has inflicted injury upon himself/herself by the ingestion of harmful preparations or by the infliction of bodily injuries, he/she shall first be treated for that medical condition at the UVMC Emergency Department or referred for other appropriate medical services. After the medical emergency has been treated and the patient's condition is medically stabilized, he may then be referred for psychiatric treatment.

An alcohol and drug dependent patient may be admitted to the Psychiatry Service only if the Psychiatry Service admission criteria are also met.

Physicians utilizing seclusion and restraint therapy will adhere to the policies and procedures as delineated in the program manual for the Mental Health Unit specific to the use of Seclusion and/or Restraint.

Multi-disciplinary treatment plans will be instituted on all patients admitted to the Psychiatry Service. These treatment plans will be developed in accordance with the respective departmental policies and procedures.

1.5-4 PSYCHIATRIC CONSULTATION SERVICES

Psychiatric consultations are available for inpatients within the acute hospital 7 days per week within 24 hours of the written consult order. Crisis Center therapist consults are generally available within 8 hours for inpatients.

1.5-5 BEHAVIORAL HEALTH RESUSCITATION POLICY

As the Inpatient Mental Health units are not attached to the Acute Care Hospital, the Behavioral Health Division's resuscitation policy has been specifically developed to address Code Blue, Advanced Directives, etc. within the Behavioral Health Division.

1.5-6 RESIDENT/FELLOW

Upper Valley Medical Center ("Hospital") and Wright State University Boonshoft School of Medicine Department of Psychiatry have agreed to collaborate in sponsoring rotations for residency program in Child and Adolescent psychiatry. "Hospital" shall provide educational, administrative and supervisory responsibility for residents rotating at the Hospital in inpatient Child and Adolescent psychiatry postgraduate Years 4 and 5. (See "clinical requirements for Child and Adolescent psychiatry residents" and "supervisory requirements for Child and Adolescent psychiatry residents" for written descriptions of the roles, responsibilities, and patient care activities of the participating resident and supervisory physicians.)

1.6 DESCRIPTION OF COMMITTEES

1.6-1 CREDENTIALS COMMITTEE

a. This committee shall be composed of five to six (5-6) Active Medical Staff practitioners chosen to ensure the broadest Medical Staff representation possible, who are voting members, the VP/CMO, and an Administrative representative who are non-voting members. The Committee shall be chaired by the Second Vice President of the Medical Staff. The members are required to attend fifty percent (50%) of the meetings per calendar year.

b. The duties of this committee shall include but are not limited to ***(refer to the Credentials Policy and Procedure Manual)***:

1. Receive and analyze applications and recommendations for appointment, reappointment, advancement to full membership or extension of the provisional period, category transfers, clinical privileges and changes therein, and recommending action thereon for all Medical Staff practitioners and Allied Health Professionals. Recommendations will be based upon evidence of current licensure, education, relevant training and/or experience, current competence and health status/ability to perform privileges requested.

2. Integrate quality review, risk management, utilization management, medical record findings, compliance with Bylaws and related documents, and other relevant information into individual credentials files.

3. Develop, coordinate, periodically review and make recommendations on the procedures and forms used in connection with each component of the credentialing process. Recommend standards for the content and organization and overseeing maintenance of the individual credential file.

4. Evaluate the merits of new procedures or devices to be performed or used by Medical Staff members and reviews and makes recommendations on protocols established by the Services for new procedures or devices.

c. This committee shall report to the Medical Executive Committee.

d. This committee shall meet as often as necessary, but at least six (6) times a year and maintain a permanent record of its proceedings.

1.6-2 PEER REVIEW COMMITTEE

a. This committee shall be composed of Active Medical Staff practitioners representing the major service areas and the Vice President/Chief Medical Officer. The Committee shall be chaired by the First Vice President of the Medical Staff. The members are required to attend at least fifty percent (50%) of the meetings per calendar year.

b. The duties of this committee shall include but are not limited to ***(refer to the Peer Review Policy)***:

1. Provide effective peer review by monitoring and evaluating the quality and appropriateness of patient care and the clinical performance of all individuals with delineated privileges.

2. Refer to the Continuing Medical Education Committee topics for educational programs based on assessed needs of the Medical Staff and community.
3. Refer potential performance improvement issues to the appropriate department/service/committee of the Medical Staff/Hospital.

c. Peer Review recommends action, specific to any Medical Staff practitioner, to the Medical Executive Committee. The committee reports findings of all peer review activities to the Medical Executive Committee.

d. Summary reports of this committee are reported to the Medical Staff, Corporate Joint Advisory Committee and the Board of Directors.

e. This committee shall meet as often as necessary, but at least ten (10) times year and shall maintain a permanent record of its proceedings.

1.6-3 CANCER PROGRAM/COMMITTEE/STRUCTURE

Mission: The UVMC Community Hospital (CHCP) Cancer Committee is a Hospital Standing Committee whose purpose is to provide quality cancer care in the community through cancer related programs. These programs are concerned with the cancer education/cancer prevention, pretreatment evaluation, staging, treatment, rehabilitation, surveillance, follow-up, support services, palliative care and clinical research.

Reporting: Performance Improvement Committee.

Membership: The Cancer Committee required membership includes:

- Diagnostic Radiologist
- Pathologist
- General Surgeon
- Cancer Liaison Physician
- Medical Oncologist
- Radiation Oncologist
- Cancer Program Administrator
- Oncology Nurse
- Social Worker/Case Manager
- Certified Tumor Registrar (Cancer Registrar)

- Performance Improvement or QA professional

Suggested additional members may include:

- Hospice
- Clinical Research Manager/Nurse
- Dietary Specialist
- Pharmacist
- Pastoral Care Representative
- Psychology/Psychiatry
- American Cancer Society Representative

Meetings: The Cancer Committee will meet at least quarterly. The schedule maybe adjusted to meet the needs of the cancer program.

Duties: The Cancer Committee will execute a portion of its duties and responsibilities through four work-groups, each with an assigned coordinator. The committees are:

- Cancer Conference
- Cancer Registry and Registry Quality Assurance
- Quality Improvement
- Community Outreach (Cancer Liaison Physician/appointee)

The work groups will meet as necessary to complete their responsibilities and report regularly to the Cancer Committee.

The Cancer Committee will also provide oversight to the following areas:

- Oncology Nursing Competency
- Inpatient Oncology (QA, policy and procedures)
- Infusion Center (outpatient QA, policy and procedures)
- Support Services
- Clinical Research

CANCER CONFERENCE WORK GROUP will supervise and assure that cancer conferences are in compliance with Commission on Cancer Standards and with the needs of the UVMC Cancer Program.
CANCER CONFERENCES meet requirements for Category I Accreditation.

Coordinate 2 general medical staff cancer conferences annually with the Continuing Medical Education Department.

Schedule 2 cancer conferences per month when there is no conflict with holidays or accreditation surveys.

Present the five major cancer sites diagnosed and/or treated at UVMC annually.

Assure multidisciplinary attendance at Cancer Conferences. Ideally, diagnostic radiology, pathology, surgery, medical oncology, and radiation oncology should provide input on patient evaluation and treatment.

Ten percent (10%) of all analytic cases treated each year should be presented at Cancer Conference. 75% of cases presented should be prospective.

CANCER REGISTRY AND CANCER REGISTRY QA WORK GROUP will assure that the Cancer Registry is in compliance with Commission on Cancer Operational Standards and will assure the quality of the Registry data collection:

Registry Staffed by a CTR by June 1, 2006.
Data on all reportable cases is collected.
More than 90% of cases are abstracted within 6 months of date of first contact to be eligible for CoC commendation.
90% follow-up rate is maintained on all analytic cases from cancer registry reference date or for the last five years to be eligible for CoC commendation.
FIPS data submission.
Data submission to NCDB is completed in a timely fashion.
Data submission to NCDB will be edited before submission to NCDB to meet established quality criteria.
Data submission to State of Ohio Cancer Incidence and Surveillance System (OCISS) is completed in a timely fashion.
Quality review and collation of medial records, abstracts and staging forms is completed for 10% of annual analytic cases by a physician reviewer.
Participate in special studies requested by NCDB.
Data confidentiality is maintained.
Identifies individuals having access to registry data.
Registrar participates in local, state, regional or national cancer registry education activity each year.

QUALITY IMPROVEMENT WORK GROUP will assure that cancer services, care, and outcomes are evaluated and improved so that patients receive care that is comparable to national standards:
Annually designs and completes one study based on registry data that evaluates and analyzes five year survival by AJCC stage.
Annually designs and completes one study that analyzes and evaluates compliance to NCCN Treatment Guidelines for a specific cancer site.
Annually implements two or more improvements that directly affect patient care. These preferably are based on needs identified by patient care evaluation studies.

COMMUNITY OUTREACH WORK GROUP coordinator shall be the Cancer Liaison Physician/appointee. The work group will assure that supportive services, prevention and early detection programs are provided to the community, cancer patients, and their families, by providing the following services for the Cancer Committee:

Each year two prevention or screening programs are provided on-site or coordinated with ACS or other local community agencies. Supportive Services are provided on-site or coordinated with community agencies i.e. Home Health, Hospice, Rehabilitation Cancer Resource Center, Nutritional Support, Mental Health, Rehabilitation, Reach for Recovery, Man to Man, I Can Cope, and HIT.

1.6-4 BYLAWS COMMITTEE

a. This committee shall be composed of at least five (5) Active Medical Staff practitioners, who are voting members, and an Administrative representative, the Nurse Executive, and the Hospital Attorney, who are non-voting members. The President of the Medical Staff and the Executive Vice President/Chief Operating Officer will serve as Adhoc members.

b. The duties of this committee shall be to:

1) Conduct a review of the Medical Staff Bylaws, Corrective Action and Reporting Requirements Plan, and the Fair Hearing Plan at least every other year.

2) Submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff structure and practices.

3) Receive and evaluate for recommendation to the Medical Executive Committee suggestions for change in the documents as stated in number one.

c. This committee shall report to the Medical Executive Committee.

d. This committee is an Adhoc committee and will meet as called by the Medical Executive Committee and shall maintain a permanent record of its proceedings.

1.6-5 PRACTITIONER EFFECTIVENESS COMMITTEE

This is an Adhoc committee and is called as the need arises. This committee reports to the Medical Executive Committee ***(Refer to Policy "Medical Staff Practitioner Effectiveness")***.

1.7 DESCRIPTIONS OF DEPARTMENT CHAIR, MEMBER-AT-LARGE, AND OFFICERS

OF THE MEDICAL STAFF

1.7-1 DEPARTMENT CHAIR

REPORTS TO: Medical Executive Committee

POSITION PURPOSE: The purpose of this position is to act as the primary Medical Administrative Officer for the Department. The individual occupying this position is responsible for all administrative and medical activities occurring within the Department and for accounting to the Medical Executive Committee concerning departmental performance, especially problems that are identified within the Department.

The Department Chair will serve as leader and manager of the department. He/she will assist in the operation of the Credentialing Program, the budgeting process, and the administration of the department; coordinate departmental activities with those of other hospital units; and relate to the Board of Directors, Administration, and Nursing Service for issues pertaining to or affecting the department. A collaborative relationship with the hospital department manager, Medical Staff Services, Performance Improvement/ Utilization Management, and Risk Management are essential.

REPORTING RELATIONSHIPS: This position reports directly to the President of the Medical Staff and the Medical Executive Committee. Additional reporting will be to the Board of Directors and to the Administration on an as-needed basis. It is also anticipated that this position will periodically make reports to the subcommittees of the Board of Directors and to the entire Medical Staff.

ACCOUNTABILITIES AND FUNCTIONS: Accounts to the Medical Executive Committee and to the President of the Medical Staff for all professional and administrative activities within the Department, particularly for the quality of patient care rendered by appointees of the Department and for the effective conduct of the patient care evaluation and monitoring functions delegated to the Department.

Submits written reports to the Medical Executive Committee as required concerning: (1) findings of the Department's review, evaluation and monitoring activities, actions taken thereon and the results of such action; (2) recommendations for maintaining and improving the quality of care provided in the Department and the Hospital; and (3) such other matters as may be required from time to time by the Medical Executive Committee. Develops and implements departmental programs, in cooperation with the President of the Medical Staff, for evaluation of patient care, on-going monitoring of clinical practice, credentials and privileges review, medical education and utilization review.

Is a member of the Medical Executive Committee, and gives guidance on the medical policies of the hospital, making specific recommendations and suggestions regarding

his/her own department. Is a member of the Corporate Joint Advisory Committee. Assures the continuing education of all persons in the department or service.

Maintains continuing review of the professional performance of all practitioners with clinical privileges and of all allied health professionals with specified services in his or her Department and reports regularly thereon to the President of the Medical Staff and to the Medical Executive Committee.

Transmits to the appropriate authorities, as required by the Bylaws, recommendations concerning clinical privileges or specified services and corrective action with respect to practitioners in the Department.

Appoints such committees as are necessary to conduct the functions of the Department and designates a committee Chair.

Enforces the Hospital and Medical Staff Bylaws, Rules, Regulations and policies within the Department, including initiating investigations of clinical performance and ordering consultations to be provided or sought when necessary.

Implements within his or her Department actions taken by the Medical Executive Committee and by the Board of Directors.

Participates in every phase of administration of the Department through cooperation with the Nursing Service and the Hospital Administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques.

Assists in the preparation of such annual reports, including budgetary planning, pertaining to the Department as may be required by the Medical Executive Committee, the President of the Hospital or the Board of Directors.

Assessing and recommending to the relevant hospital authority off-site sources for needed patient care services not provided by the department of the organization.

Has input into and provides recommendations for the following: a)sufficient number of qualified and competent persons to provide care or service, b)determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services, c)continuous assessment and improvement of the quality of care and services provided, d)maintenance of quality control

programs, as appropriate, e)orientation and continuing education of all persons in the department, and f)space and other resources needed by the department.

Performs such other duties commensurate with the office as may from time to time be requested by the President of the Medical Staff, the Medical Executive Committee or the Board of Directors.

POSITION REQUIREMENTS: Individuals occupying this position must be physician members of the Active Medical Staff and must have held that position for at least five (5) years. A working knowledge of management techniques is desired but not required.

This individual will be Board Certified or of equivalent competence in his/her specialty. The equivalent competence will be determined by a review of the individual's credentials profile by the Credentials Committee.

Individuals occupying this position may not, at the time of holding this position, be an officer or leader in any other Medical Staff organization.

Prior successful service within the Medical Staff structure as Chair of a Medical Staff committee, Member-at-Large of the Medical Executive Committee or service on a Board of Directors subcommittee is desirable.

TERM OF POSITION: The term of the department chair position will be for two years and will start on a staggered scheduled as follows: Medical – 2003 – 2 years; Surgical - 2003–1 year and 2 years thereafter; and Support Services – 2003-1 year, 2004-1 year, and 2005-2 years.

VACANCY IN POSITION: Vacancy occurring during the Medical Staff year shall be filled by the Medical Executive Committee.

RECOGNITION AND BENEFITS: Individuals occupying this position will be allowed to attend continuing education events each year devoted to medical administrative activities. Attendance at these events will be pre-approved by the President of the Medical Staff and the Administration.

This individual is also entitled to utilize the services of the Medical Staff Services Department for departmental correspondence and research needs.

OCCUPATIONAL HAZARDS: It is anticipated that there are serious occupational hazards for this position. These hazards include potential legal involvement in corporate negligence and anti-trust cases. The institution will provide certain protections to the individual holding this position in the form of indemnification and a pledge by the institution to support the actions of the Department Chair in the event those actions relate directly to the performance of the functions described in this job description or other documents. The institution's protections are permitted only when the individual acts in good faith and with the reasonable belief that he or she is acting in the institution's best

interests.

1.7-2 MEMBER-AT-LARGE

The Member-at-large will perform the following duties:

1. Position requirements shall be the same as described above for the Department Chair in Section 1.7-1 “Position Requirements”.
2. He/she shall be a member of the Medical Executive Committee.

3. He/she shall serve as the Vice Chair in the absence of the Department Chair. In said capacity, he/she will perform according to the accountabilities/ functions as described in Section 1.7-1 “Accountabilities and Functions”.

4. He/she shall perform such other duties as requested by the Department Chair or the President of the Medical Staff.

5. Occupational hazards will be as described for Department Chair in Section 1.7-1 “Occupational Hazards”.

1.7-3 DUTIES OF MEDICAL STAFF OFFICERS

A. **President:** The President shall serve as the Chief Administrative Officer of the Medical Staff in addition to the following duties:

1. Act in coordination and cooperation with the Administrator in all matters of mutual concern within the Hospital.

2. Call, preside at, and be responsible for the agenda of all general meetings.

3. Serve as Chair of the Medical Executive Committee.

4. Serve as ex-officio member of all other committees without vote.

5. Be responsible, in conjunction with the Administrator, for the enforcement of and compliance with these Medical Staff Bylaws, Organization/Functions Manual and any Rules adopted thereunder.

6. Appoint the members and chairs of all standing,

special and ad hoc committees except the Medical Executive Committee. These appointments shall be made with the approval of the Medical Executive Committee.

7. Represent the views, policies, needs and grievances of the Medical Staff to the Board of Directors and to the Administrator.

8. Receive and interpret the policies of the Board of Directors to the Medical Staff and report to the Board of Directors on the performance and maintenance of quality with respect to the delegated responsibility to provide medical care.

9. Be responsible for the educational activities of the Medical Staff.

10. Be the spokesperson for the Medical Staff in its external professional public relations.

11. During the term of office he/she will serve as a member of the Upper Valley Medical Center Board of Directors. He/she will also serve on the Corporate Joint Advisory Committee.

B. **First Vice President:** In the absence of the President, the First Vice President shall assume all the duties and have the authority of the President.

1. During the term of office he/she will serve as a member of the Upper Valley Medical Center Board of Directors. He/she will serve on the Corporate Joint Advisory Committee.

2. He/she shall be a member of the Medical Executive Committee.

3. He/she shall serve as the Chair of the Inpatient Peer Review Committee.

C. **Second Vice President:** He/she shall cause to be kept, accurate and complete minutes of all Medical Staff meetings,

call meetings on order of the President, and shall cause to be sent to all practitioners a copy of minutes, meeting notices and all correspondence and perform such other duties as ordinarily pertain to his/her office.

1. During the term of office he/she will serve as a member of the Upper Valley Medical Center Board of Directors. He/she will serve on the Corporate Joint Advisory Committee.

2. He/she shall be a member of the Medical Executive Committee.

3. He/she will serve as the Chair of the Credentials Committee.

4. He/she will be responsible for approving paying of all Medical Staff bills and will provide a Treasurer's Report on an annual basis to the Medical Executive Committee.