



Indiana University Health

Bloomington Hospital

MEDICAL STAFF BYLAWS

Rules and Regulations

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Article 1. Introduction

1.1 DEFINITIONS

“ADVANCE DIRECTIVE” means a document or documentation allowing a person to give directions about future medical care, or to designate another person(s) to make medical decisions if the individual loses decision-making capacity. Advance directives include a “Declaration of a Desire for a Natural Death”

Do-Not-Resuscitate Orders and similar documents expressing the individual’s preferences as specified in the Patient Self-determination Act.

“APPOINTEE” means any medical physician, osteopathic physician, oromaxillofacial surgeon, or podiatrist holding a current license to practice within the scope of his or her license who is a member of the Medical Staff.

“CLINICAL PRIVILEGES” means the authorization granted to a practitioner to render patient care and includes unrestricted access to those hospital resources (including equipment, facilities, and hospital personnel) that are necessary to effectively exercise those privileges.

“EMERGENCY” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

“FAMILY” means those persons who play a significant role in the individual’s life. This may include persons who are not legally related to the individual.

“HEALTH CARE AGENT” means an individual designated in a health care power of attorney to make health care decisions on behalf of a person who is incapacitated.

“INVASIVE PROCEDURE” means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

“PATIENT” means any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the Hospital.

“PHYSICIAN” means an individual with a Doctor of Medicine or Doctor of Osteopathy degree as recognized by the Indiana Medical Licensing Board and who has a current valid license to practice medicine and surgery in Indiana.

“ADMITTING PHYSICIAN” means the physician is responsible for the patient’ admission to the hospital and is ultimately responsible for the medical record documentation if attending physician declines.

“ATTENDING PHYSICIAN” means an individual who is responsible to each patient admitted to the Hospital, and is an appointee of the Medical Staff with admitting privileges. The attending physician will be responsible for the medical care and treatment of each patient in the Hospital. The attending physician is responsible for the preparation of a complete and legible medical record for each patient. At all times during a patient’s hospitalization, the identity of the attending physician shall be clearly documented in the medical record. (See Section **“ATTENDING PHYSICIAN 4.1.1”** for detailed responsibilities).

“UNASSIGNED CALL PHYSICIAN” applies to patients arriving to the hospital without an ongoing relationship with a physician on staff and may need further outpatient or inpatient follow up. The unassigned call physician shall provide either further inpatient or outpatient follow up. A copy of the unassigned physician call schedule is maintained by the Medical Staff Service Office and posted on the Bloomington Hospital Intranet and the Provider Portal.

“PRACTITIONER” means an appropriately licensed medical physician, osteopathic physician, dentist, podiatrist, or Advanced Practice Provider who has been granted clinical privileges.

“SURGEON” refers to any practitioner performing an operation or invasive procedure on a patient, and is not limited to members of the Clinical Service of Surgery.

“TEXT MESSAGE” The exchange of brief plain text messages between cellular phones using short message services (SMS); and excluding Personal Health Information. Text messages may also contain images, videos or sound content.

“UNABLE TO CONSENT” or **“INCOMPETENT”** means unable to appreciate the nature and implications of the patient’s condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner. This definition does not include minors unless they are married or have been determined judicially to be emancipated [Adult Health Care Consent Act].

Any definitions set forth in the Medical Staff Bylaws shall also apply to terms used in these Rules and Regulations.

1.2 APPLICABILITY

These Rules and Regulations are adopted by the Medical Executive Committee, and approved by the Board of Directors, to further define the general policies contained in the Medical Staff Bylaws, and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges.

1.3 CONFLICT WITH HOSPITAL POLICY

Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict.

1.4 AMENDMENT

These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Medical Staff Bylaws.

1.5 ADOPTION

This article supersedes and replaces any and all other Medical Staff rules and regulations pertaining to the subject matter thereof.

Article 2. Admission and Discharge

2.1 ADMISSIONS

2.1.1 General

The hospital accepts short term patients for care and treatment provided suitable facilities are available.

- a. **Admitting Privileges:** A patient may be admitted to the hospital only by an appointee to the Medical Staff with admitting privileges.
- b. **Admitting Diagnosis:** Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been written in the medical record. In the case of emergency, such statement will be recorded as soon as possible.
- c. **Patient Access:** Admissions must be scheduled with the Hospital's Admission Department. A bed will be assigned based upon the medical condition of the patient and the availability of hospital staff and services. Except in an emergency, the admitting practitioner designee shall contact the Hospital's Admitting Department to ascertain whether there is an available bed.

2.1.2 Admission Priority

The Patient Care Director will admit patients on the basis of the following order of priorities:

- a. **Emergency Admission:** Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. This patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient will be admitted immediately to the first appropriate bed available.
- b. **Urgent Admissions:** Urgent admission patients meet the criteria for inpatient admission; however their condition is not life-threatening. Urgent admission patients will be admitted as soon as an appropriate bed is available. Urgent admissions include admissions for observation as determined by Center for Medicare/Medicaid Services (CMS) criteria.
- c. **Elective Admissions:** Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for his/her health's sake. These patients may be admitted on a first-come, first-serve basis. A waiting list will be kept and each patient will be admitted as soon as a bed becomes available.

2.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care will be routed to the Emergency Department for stabilization and transfer to the appropriate treatment area. Patients in active labor will be admitted directly to Labor and Delivery. Patients with potential acute myocardial infarcts will be routed directly to the cath lab.

Attribution should fall to the attending physician and recommend the following process.

1. The admitting physician designates the attending physician in the electronic ordering system.
2. If the attending physician is handing off responsibility/accountability to another physician, enter the order to change the attending physician into the electronic ordering system.
3. The attending physician listed in the electronic ordering system at the time of discharge is the attending physician for purposes of attribution of data.

2.2 EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists.

2.2.1 Definition of Unassigned Patient

Patients who present to the Emergency Department and require admission and/or treatment shall have a practitioner assigned by the Emergency Department physician if one or more of the following criteria are met:

- a. The patient does not have a primary care practitioner or does not indicate a preference;
- b. The patient's primary care practitioner does not have admitting privileges; or
- c. The patient's injuries or condition fall outside the scope of the patient's primary care practitioner.

2.2.2 Call Service

- a. **Call Schedule:** The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Each Medical Staff Clinical medical staff leader, or his/her designee, shall provide the Emergency Department and the Medical Staff Services Office with a list of physicians who are scheduled to take emergency call on a rotating basis. Emergency call shall be defined by the service.
 - i. **It is the responsibility of the physician or his/her designee to keep the Medical Staff Services Department updated on contact information.**
- a. **Response Time:** It is the responsibility of the on-call physician to respond in an appropriate time frame. The on-call physician or his/her designee should telephonically respond to calls from the Emergency Department within a reasonable and prudent response time. If the patient needs immediate specialty evaluation a response time of 30 minutes is expected. If the patient is stable and able to be admitted they can be seen on the patient unit. If the patient is stable and the specialist requests to see the patient in the Emergency Department their presence is expected within 1 hour.

- b. If the on-call physician does not respond to being called or paged, from the original page, the physician's Clinical Service Chief shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action. (These limits may change depending on the hospital's designation of Trauma Level. Response time may vary based on clinical service patient requirements).
- c. **Substitute Coverage:** It is the on-call physician's responsibility to arrange for coverage and notify the Emergency Department if he/she is unavailable to take call when assigned. Failure to notify the Emergency Department of alternate and notify the call center "3EDMD" (33363) may result in the initiation of disciplinary action.
- d. **Call Schedules:** All call schedules will be maintained through the Medical Staff Services Department and changes to call schedule reported through the 3EDMD line (353-3363).
- e. **Responsibilities of the on call physician include:**
 - 1. responding to the call from the ED or referring physician in a timely manner as described above
 - 2. participating in the evaluation and stabilization of the patient's condition in as it applies to the call service involved
 - 3. treating the patient for the condition for which the call service is involved
 - 4. in the instance the physician does not possess the skills or credentials to provide definitive treatment, the physician will still evaluate/stabilize the patient and will work with the ED provider to identify an alternative treating physician, preferably internally, or transfer to an alternative facility

2.2.3 Patients Not Requiring Admission

In cases where the Emergency Department consults with the unassigned call physician and no admission is deemed necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. The Emergency Department physician shall specify the time frame in which the unassigned patient shall be seen. It is the unassigned call physician's responsibility to provide a timely and appropriate follow-up evaluation for the patient following the Emergency Department visit. Service/Sections may specify how they wish to be notified and will inform both the Emergency Department and the Medical Staff Services Office of their preference.

2.2.4 Unassigned Patients Returning to the Hospital

Unassigned patients who present to the Emergency Department after discharge will be referred to the practitioner taking unassigned call that day.

2.2.5 Guidelines for Clinical Service Policies on Unassigned Call

Pursuant to the Medical Staff Bylaws, Clinical Services may adopt rules, regulations, and policies that are binding on the members of their Clinical Service. The following rules should be used in developing Clinical Service policies regarding unassigned emergency call obligations:

- a. Unassigned call duties should be based on the appointee's clinical privileges; only physicians on the medical staff with admitting privileges are expected to serve on the unassigned call roster regardless of their staff category.
- b. Unassigned call duties shall be apportioned equally among all eligible Clinical Service members.
- c. Unassigned call duties may be divided by division, specialty, or subspecialty.
- d. Clinical Services may establish policies for excusing members from service, based on their age or length of service, within their clinical service when approved by the Service and MEC. These policies must be consistently applied, and shall not compromise the Clinical Service's ability to fulfill the Hospital's EMTALA obligations.
- e. An impairment which is alleged to limit an appointee's ability to provide unassigned call services shall also be grounds for limiting the appointee's privileges for providing care to their assigned or private patients.
- f. Clinical Service rules and regulations concerning unassigned call must be approved by the Medical Executive Committee.

2.3 TRANSFERS

2.3.1 Transfers from Other Acute Care Facilities

Transfers from other acute care facilities must meet the following criteria:

- a. The patient must be medically stable for transfer;
- b. The patient's condition must meet medical necessity criteria for inpatient admission or observation status;
- c. The patient must require, and Bloomington Hospital must be able to provide, a higher level of care or a specific inpatient service not available at the transferring facility or the patient and/or family must request the transfer;
- d. Responsibility for an inpatient must be accepted by a physician with admitting privileges at Bloomington Hospital; and
- e. The Patient Care Director must be notified of transfer.

2.3.2 Transfers within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital with consent of the attending physician. The attending practitioner will be notified of all transfers.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The admitting practitioner is responsible for providing the Hospital with necessary information to assure the protection of the patient from self harm and to assure the protection of others.

2.5 PROMPT ASSESSMENT

New admissions must be personally examined and evaluated by the attending physician or his/her designated covering physician or his/her designee within twenty-four (24) hours. Patients admitted to critical care units must be seen within eight (8) hours. Unstable patients must be seen as soon as possible in a time period dictated by the acuity of their illness.

2.6 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician or his or her designee who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. These instructions should include:

- a. A list of all medications the patient is to take post-discharge via the electronic medication reconciliation process;
- b. Dietary instructions and modifications;
- c. Medical equipment and supplies, if appropriate;
- d. Instructions for pain management, if appropriate;
- e. Any restrictions or modification of activity;
- f. Follow up appointments and continuing care instructions;
- g. Referrals to rehabilitation, physical therapy, and home health services; and
- h. Recommended lifestyle changes, such as smoking cessation.

2.7 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient leave the hospital against the advice of the attending physician, or without a discharge order, the following actions will occur:

- a. The patient will be asked to remain in the hospital until the attending physician can be notified;
- b. The patient will be asked to read and sign the Hospital's "Discharge Against Medical Advice" form;
- c. The patient will be assisted in leaving the facility, and will be informed that they may not return directly to the patient care unit. If the patient chooses to return to the Hospital, such return will be treated as a new admission.
- d. The patient will have safety needs addressed prior to leaving.
- e. Documentation of the attending physician's notification, date, time, and mode of transfer will be made in the patient's record.

2.8 DISCHARGE AND READMISSION ON THE SAME DAY

If a patient is discharged and readmitted on the same day, the readmission will be considered a new admission.

2.9 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

2.10 THERAPEUTIC LEAVE OF ABSENCE

Therapeutic leaves of absence are limited to patients on the Rehabilitation Unit, or patient leaves for procedure not available on the Bloomington Hospital Campus. Psychiatric Unit patients may have leaves for medical reasons. Medical unit patients can be granted special approval for leave of absence by the attending physician.

Article 3. Medical Records

3.1 GENERAL REQUIREMENTS

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organizational performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access to and make entries into the medical record. The attending physician is responsible for the preparation of a complete and legible medical record for each patient. Its contents will be pertinent, current, and age-specific. If the attending physician refuses completion of the medical record then the responsibility falls upon the admitting physician.

To facilitate consistency and continuity of patient care, the medical record shall include:

- a. The patient's identification data including a picture ID and the name of any legally authorized representative;
- b. The legal status of patients receiving mental health services with a mental status exam performed on all psychiatric patients;
- c. Emergency care provided to the patient prior to arrival, if any;
- d. The record and findings of the patient's assessment, and the conclusions or impressions drawn from the medical history and physical examination;
- e. The diagnosis or diagnostic impression;
- f. The reason for admission or treatment;
- g. The goals of treatment and the treatment plan;
- h. Evidence of known advance directives;
- i. Evidence of informed consent, when required;
- j. Diagnostic and therapeutic orders, if any, including nutrition orders;
- k. All diagnostic and therapeutic procedures and test results relevant to the management of the patient's condition;
- l. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
- m. Daily progress notes shall be legibly documented by the attending physician of the Medical Staff. Consulting physicians should visit and document on frequency depending on patients clinical condition. The exception to this rule is Acute Rehabilitation patients who must be seen and have progress notes legibly documented at least three times per week according to state regulations;
- n. Consultation reports;
- o. Every medication ordered or prescribed for an inpatient, every medication dispensed to an ambulatory patient or an inpatient on discharge, and every dose of medication administered and any adverse drug reaction;

- p. All relevant diagnoses established during the course of care;
- q. Any referrals and communications made to external or internal care providers and to community agencies. A Physician Admission Order for a Post Hospitalization Facility shall be completed and include a complete discharge summary dictated and transcribed STAT prior to discharge to accompany the patient upon transfer;
- r. Conclusions at termination of hospitalization;
- s. Discharge instructions to the patient and/or family as relevant;
- t. A written Physician Discharge Orders form to discharge is required and will include the following:
 - Diagnosis
 - Diet
 - Medications
 - Follow-up Appointment
 - Activity Levels
 - What to do if symptoms worsen
 - Special care needs
- u. A complete discharge summary, transfer summary or short stay summary or a final progress note as applicable.

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated with the practitioner's legible signature or by approved electronic means.

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the medical record shall be made in black ink and shall be clear, complete, and legible. Light colored ink and gel pens are prohibited for documentation. The clarity, completeness, and legibility of medical record documentation may be considered in evaluating the practitioner at the time of reappointment. Practitioners whose medical record entries are habitually unclear, incomplete, or illegible may be subject to one or more of the following corrective actions as determined by the Medical Executive Committee:

- a. Required attendance at educational programs on documentation and penmanship as determined by the Medical Executive Committee;
- b. A requirement that medical record entries be recorded by electronic means; NOTE: HIMS does not have staff to transcribe all reports by physicians with bad penmanship.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in handwritten documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

Prohibited Abbreviations, Acronyms, and Symbols: The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders. [See Appendix A, Sections 4.4.1(e), 4.4.2(b), and 4.4.10(g)] These prohibited abbreviations may be found on the Bloomington Hospital's Intranet.

Situations Where Abbreviations Are Not Allowed: Abbreviations, acronyms, and symbols may not be used in recording the final diagnoses and procedures or any dictated report or written Physician Discharge Order Form. Approved medical abbreviations may be found on the Bloomington Hospital's Intranet. **CORRECTION OF ERRORS**

Medical records should not be improperly altered. When it is necessary to correct an error in the medical record these guidelines should be followed:

- a. A single line should be drawn through the erroneous entry; under no circumstances should the original entry be obscured;
- b. The corrected entry must be authenticated with the practitioner's signature and the date and time.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

A medical history and appropriate physical examination must be entered in the medical record no more than thirty (30) days before or twenty-four (24) hours after a hospital inpatient or observation admission. If the History and Physical was completed before admission, an update with any changes or documentation of no changes shall be recorded in the medical record in accordance with section 3.6.5.

3.5.2 Who May Perform and Document the Admission History and Physical Exam

The History and Physical Examination shall be performed and recorded by a doctor of medicine or osteopathy, oromaxillofacial surgeons (for patients admitted only for oromaxillofacial surgery), or podiatrists (for patients admitted only for podiatric service). All or part of the H & P may be delegated to other practitioners or Advanced Practice Providers with privileges in accordance with State law and hospital policy, but the MD/DO must sign the H & P and as applicable, the update note and assume full responsibility for the H & P. This means that a nurse practitioner or a physician assistant meeting these criteria may perform the H & P, and/or the update assessment and note.

3.5.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. The History and Physical Examination report must include the following information:

- a. Chief complaint or reason for the admission or procedure;
- b. A description of the present illness;
- c. Past medical history, including past and present diagnoses, allergies, current medications, illnesses, operations, injuries, treatment, and health risk factors;

- d. An age-appropriate social history;
- e. A pertinent family history;
- f. A relevant review of systems;
- g. Relevant physical findings;
- h. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

3.5.4 Attending Physician is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the attending physician or his/her designee. If attending defers the completion of the admission history and physician exam, then the admitting physician will assume the responsibility.

3.5.5 Updated History and Physical Examination

If a History and Physical Examination has been performed and documented within thirty (30) days of the patient's admission to the Hospital, a legible copy of that history and physical examination may be used in the patient's hospital medical record provided that an "Updated History and Physical Examination" is entered in the medical record no more than twenty-four (24) hours after admission or prior to surgery. This Updated History and Physical Examination must:

- a. Address the patient's current status and/or any changes in the patient's status (if there are no changes in the patient's status, this should be specifically noted);
- b. Include an appropriate physical examination of the patient to update any components of the exam that may have changed since the prior history and physical, or to address any areas where more current data is needed;
- c. Confirm that the necessity for the admission, procedure, or care is still present;
- d. Be written or otherwise recorded on, or attached to, the previous History and Physical; and
- e. Be placed in the patient's medical record within twenty-four (24) hours after admission and prior to surgery or performance of an invasive procedure for which an H&P is required per section 3.7.1.

The Medical Executive Committee may adopt a form for documenting the Updated History and Physical.

3.5.6 Focused History and Physical Examination

A focused history and physical examination may be used for outpatient surgeries and any procedure requiring moderate sedation in place of a full history and physical.

Basic procedures that do not require moderate sedation do not require an H& P. However it does require a procedure note.

3.6 PREOPERATIVE DOCUMENTATION SURGICAL CARE

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

- f. All invasive procedures performed in the Hospital's surgical suites under moderate sedation;
- g. Certain procedures performed in the Radiology Department and Cath Lab that requires, at the least, moderate sedation. (and
- h. Certain procedures performed in other treatment areas (bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, central arterial line insertions, and elective electrical cardioversion).

3.7.1.1 Except in an emergency, no surgical or other invasive procedure shall be performed until:

- a. The medical history and physical examination has been completed and recorded on the chart.
 - 1. All inpatients and outpatients undergoing surgical or other invasive procedures shall have a written H&P on the chart before the patient arrives in the Operating Room of the Surgery Department or other Departments where said procedures are performed.

An Invasive procedure is defined as "Procedures involving puncture or incision of the skin or insertion of an instrument or foreign material into the body, including, but not limited to percutaneous aspirations and biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties and implantations, and excluding venipuncture and intravenous therapy."

b. Recommended Ways to Comply:

- 1. Complete a History and Physical up to 24 hours prior to surgery. HIMS will then take responsibility for routing the H&P to the appropriate department.
- 2. Send a faxed H&P to Hospital ASAP before day of surgery.
- 3a. A Short Stay H&P Form is acceptable for outpatient surgical categories 1 and 2.

Patient Category 1

Surgical Risk – Minimal, Degree of Invasiveness – Minimal, independent of anesthesia, Blood Loss – Little or no blood loss

Patient Category 2

Surgical Risk – Mild, Degree of Invasiveness – Minimal to Moderate, independent of anesthesia, Blood Loss – < 500 cc

- 3b. A dictated or long-handed detailed H&P, with the exception of an emergency case, is required for surgical categories 3, 4, and 5.

Patient Category 3

Surgical Risk – Moderate –Degree of Invasiveness – Moderate to significant, independent of Anesthesia, Blood Loss – 500 cc to 1500 cc

Patient Category 4

Surgical Risk – Major, Degree of Invasiveness – Highly Invasive, independent of anesthesia, Blood Loss – > 1500 cc

Patient Category 5

Surgical Risk – Critical risk to patient – independent of anesthesia, Degree of Invasiveness – Highly invasive, Blood Loss – > 1500 cc and includes usual postoperative Critical Care stay with invasive monitoring.

- c. Recommended Hospital personnel process:

1. Inpatients:
 - a. The Unit Coordinator reviews the patient record after 24 hours of admission.
 - b. If no H&P on the chart, the Unit Coordinator calls HIMS to check if the H&P has been dictated.
 - c. If the H&P has been dictated, the report will be transcribed in order received within 24 hours of dictation and sent to appropriate department.
2. Pre-procedural Patients:
 - a. If no H&P/Short Stay Summary can be found prior to the procedure, the nurse will call HIMS to see if one has been dictated.
 - b. If no H&P has been dictated, the nurse will call the physician

informing her/him that no H&P is on the chart and the patient cannot be sent to surgery (or other designated place) until a written H&P is placed on the chart.

- c. The procedure will then be canceled. A Morrissey Report will be completed and forwarded to the Medical Staff Office.
 - d. If H&P has been confirmed as dictated, HIMS will contact Transcription Services and request the report as stat. Upon completion of the H&P it will be faxed to Surgery. If no confirmation is obtained, the procedure will be delayed, canceled, or rescheduled according to department protocol. The case may not be started until the H&P is on the chart.
- d. The routine laboratory examinations have been completed and recorded on the Patient's chart, this includes outpatient surgeries.
 - e. The pre-operative diagnosis has been established and recorded.
 - f. The informed consent for surgical and medical treatment has been signed by the patient before medication, or by the responsible party, and has been properly witnessed. Special consents are required for tubal ligations, vasectomies, and D&C's for incomplete abortions. Elective abortions require a special consent signed 24 hours in advance.
- 3.7.1.2 Only authorized personnel shall be admitted to the surgery hall. Authorized personnel shall be determined by the Chief of Surgery and the Director of Surgical Services.
- 3.7.1.3 All operations performed shall be fully described by the operating surgeon. Upon completion of surgery, the surgeon shall write a Post Operative Summary and then dictate the surgical report so that it can be on the chart by the first postoperative night.
- 3.7.1.4 All tissues removed at operations, with the exception of artificial prostheses and other tissues not requiring pathological evaluation determined by the Medical Executive Committee, shall be sent to the hospital pathologist who shall make such examination, as necessary to arrive at a tissue diagnosis. The authenticated report shall be made a part of the patient's medical record. Artificial prostheses may be sent at the discretion of the surgeon.
- 3.7.1.5 The surgeon shall secure a surgical assistant for any procedure, which in his/her opinion and judgment a physician assistant is necessary.
- 3.7.1.6 A qualified anesthesiologist shall be made available to all patients through a voluntary rotating call schedule.
- 3.7.1.7 The anesthesiologist shall maintain a complete anesthesia record to include:
- a. Pre anesthesia evaluation prior to induction of anesthesia
 - b. Anesthesia record during procedure
 - c. Post anesthetic evaluation

3.6.2 Procedure

- a. **Inpatient/Observation Patient who subsequently requires Surgery:** This patient should already have an Admission History and Physical on their chart. The surgeon should enter a preprocedure progress note or consultation note documenting the provisional diagnosis, the indications for the procedure, and any changes in the patient's condition since the Admission History and Physical. If there are no changes in the patient's condition, this should be specifically noted.
- b. **New Inpatient/Observation Patient Surgical Admission:** The attending physician must record an Admission History and Physical Examination" as described in section 3.6. If the Admission History and Physical Examination is performed by a physician other than the surgeon (e.g., the patient's attending physician or a consulting physician) the surgeon should enter a preprocedure progress note or consultation note documenting the provisional diagnosis, the indications for the procedure, and any changes in the patient's condition since the Admission History and Physical Examination. If there are no changes in the patient's condition, this should be specifically noted.
- c. **Outpatient Surgery:** The surgeon should complete a History and Physical that may include an abbreviated physical examination focused appropriately to correspond to the planned procedure as noted in Section 3.7.1. A form may be developed by the Medical Executive Committee and may be approved through the forms process.
- d. **Outpatient Surgery Patient Subsequently Admitted to Observation/Inpatient:** The surgeon should have already completed an "H&P/Short Stay Summary". Upon admission, a progress note should be documented within 24 hours by the attending physician or his/her designee, specifically addressing any changes in the patient's condition since completion of the H&P/Short Stay Summary.

3.7 PROGRESS NOTES

The attending physician or his/her covering physician will record a progress note each day on all hospitalized patients. Progress notes must document:

- a. Pertinent subjective history from the patient;
- b. Objective examination and record of pertinent testing; and
- c. The treatment plan and reason for continued hospitalization.
- d. May be hand written and clear, complete, and legible. Electronic notes may be provided by the physician for inclusion in the progress notes.
- e. Progress notes must be signed dated, timed.

3.8 OPERATIVE REPORTS

Operative reports will be written after surgery and the report promptly signed by the surgeon and made a part of the patient's current medical record. If there is a delay, a brief summary operative note is completed immediately and recorded in the progress notes outlining the procedure performed. Operative notes shall be dictated immediately and will include:

- a. The name of the surgical procedure,
- b. A detailed account of the findings at surgery,
- c. The technical procedures used,
- d. The tissues removed or altered,
- e. Estimated blood loss,
- f. The post operative diagnosis, and
- g. The name of the primary surgeon and any assistants.

3.9 CONSULTATION REPORTS

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The Consultation Report should be completed, recorded and placed on the patient's chart within the time frame specified by the physician ordering the consult and no later than twenty-four (24) hours.

If the report is not on the chart within the prescribed time, an explanatory note should be recorded in the chart. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation.

3.10 OBSTETRICAL RECORD

The obstetrical record must include a medical history, including a complete prenatal record (if available), and an appropriate physical examination. A copy of the practitioner's office prenatal record may serve as the history and physical if it is legible and complete. If the office prenatal record is used as the history and physical examination, an Updated History and Physical Examination as described in subsection 3.6.5 will be recorded that includes pertinent additions to the history and any subsequent changes in the physical findings.

A discharge summary is required for the following:

- Delivery with complications or high risk;
- Hospital stays exceeding 72 hours (three overnights, starting with admission)
- Cesarean deliveries

3.11 DISCHARGE SUMMARIES

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries will be authenticated by the attending physician or his/her designee and a copy will be sent to the Primary Care Provider.

Content

- Pertinent Diagnoses
 - Procedures
 - Summary of hospital course, including complications
 - Condition and disposition at discharge
 - Instructions for patient and family, including medications, follow-up, diet, activity, worsening symptoms, and wound care
- a. Short-term Stays:** A discharge summary is not required for uncomplicated hospital stays of less than **48**-hours, uncomplicated deliveries, and normal newborn infants, provided the discharging physician enters a final progress note or completes the discharge section of the H&P/Short Stay Summary:
- Instructions given to the patient and family, including medications, referrals, and follow-up appointments.
 - Outcome of the treatment, procedures, or surgery
 - Disposition of the case
 - Discharge diagnosis
- b. Deaths:** A clinical summary is required on all inpatients that have expired and will include:
- Reason for admission;
 - Summary of hospital course; and
 - Final diagnoses, including cause of death, if known.
- c. Timing:** A Discharge Summary must be entered in the medical record within seven (7) days of discharge, transfer, or death.

3.12 DIAGNOSTIC REPORTS

Diagnostic reports (including but not limited to EEGs, EKGs, echocardiograms, stress tests, Doppler studies, sleep studies and PFTs) must be read by the physician scheduled to provide the interpretation service within a timely fashion. Failure to provide prompt interpretation of diagnostic tests may result in removal from the reading list. This timeframe excludes pathology specimens requiring fixation techniques.

3.13 ADVANCED PRACTICE PROVIDER (aka Allied Health Professional)

The attending or supervising physician will review Admission Status Order (admit to/assign to), Progress Notes, Codes Status, and Dictation entries made in the medical record by members of the Advanced Practice Provider Staff, as required by state licensure within seventy-two (72)

hours (or compliant with applicable state law), or as made available by HIMS. The electronic signature signifies the attending or supervising physician has reviewed the patient's medical record and approved the care rendered by the Advanced Practice Provider. The Advanced Practice Provider must designate the attending or supervising physician of record on Admission Status Order (admit to/assign to), Progress Notes, Codes Status, and Dictation.

3.14 AUTHENTICATION OF OUTSIDE RECORDS

It is the duty of the attending physician to review any patient information obtained from sources outside of the Hospital (such as the practitioner's office records, diagnostic test results, prenatal records, etc.). Only the attending physician, after performing a review, can append patient information received from outside sources. Outside records received and used in the treatment and shall be placed in the chart as part of the patient's permanent record. The physician shall place an "X" and/or initial document in the lower right hand corner.

3.15 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, the record will be made available to any member of the Medical Staff attending the patient and to members of medical staffs of other hospitals upon written consent of the patient or by the appropriate Hospital authority in an emergency situation. Upon properly executed authorization, signed by the patient or the patient's legal representative, the hospital will disclose and/or furnish copies of the patient's medical record to the requesting hospital, insurance company, attorney and/or the patient according to the policies of Bloomington Hospital. Medical records will otherwise be disclosed only pursuant to court order, subpoena, or statute. Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

- a. **Access to Old Records:** In case of readmission of a patient, all previous records will be made available to the admitting practitioner whether the patient was attended by the same practitioner or by another practitioner.
- b. **Unauthorized Removal of Records:** Unauthorized removal of charts from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the Medical Executive Committee.
- c. **Access for Medical Research:** Access to the medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of the Institutional Review Board. The written request will include: (1) The topic of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.
- d. **Access for Former Members:** Former members of the Medical Staff will be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

3.16 MEDICAL RECORD COMPLETION

A medical record will not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee.

3.16.1 Requirements for Timely Completion of Medical Records

Medical records must be completed in accordance with the following standards:

- a. An Admission History and Physical Examination or Updated History and Physical Examination must be entered in the medical record by the attending physician or his/her designated covering physician within twenty-four (24) hour of admission;
- b. A Preoperative History and Physical Examination or Focused Preoperative History and Physical Examination must be entered in the medical record prior to the surgery or procedure;
- c. An Admission Prenatal Record must be entered in the medical record by the attending physician or designated covering physician within twenty-four (24) hours of an obstetrical admission;
- d. An Operative Report or brief ops note must be entered in the medical record by the performing practitioner immediately following the surgery or procedure. (The operative report must be dictated immediately following surgery or procedure);
- e. An Inpatient Progress Note must be recorded and authenticated by the attending physician or designated covering physician at the time of each encounter, and on a daily basis;
- f. An Emergency Department Record must be completed by the responsible practitioner within twenty-four (24) hours of the encounter;
- g. A Consultation Note must be completed by the consulting physician within twenty-four (24) hours of the consult request;
- h. A Diagnostic Report must be completed by the interpreting physician within twenty-four (24) hours of the test or procedure;
- i. Ideally the Discharge Summary would be dictated in the medical record by the attending physician or his/her designee prior to discharge extended care facility (ECF); Any referrals and communications made to external or internal care providers and to community agencies shall include. A completed Physician Admission Order for a Post Hospitalization Facility; and include a complete discharge summary dictated and transcribed STAT prior to discharge to accompany the patient upon transfer.
- j. A Discharge Summary must be entered in the medical record by the attending physician or his/her designee seven (7) days of an inpatient or observation discharge, transfer, or death; and

- k. The Inpatient or Observation Medical Record must be completed within thirty (30) days of discharge, including the authentication of all progress notes, consultation notes, operative reports, verbal and written orders, final diagnoses, and discharge summary. Following discharge, the patient's medical record will be scanned, indexed and analyzed to assure a complete medical record to be maintained in the electronic medical record, the designated legal record. Late reports and pertinent information will be received in the HIMS Department to allow for insertion into electronic medical record.
- l. These complete and incomplete records are available 24 hours a day within the electronic medical record system for physician access. Peer Review and Proctor Review forms will be placed in the appropriate practitioner's incomplete record area for completion.

3.16.2 Suspension of Clinical Privileges for Incomplete Records

A practitioner will be declared delinquent if his/her medical records are not complete within the time periods specified in Section 3.17.1. After the practitioner has been declared delinquent, his or her clinical privileges will be suspended with the exception of emergency admissions/procedures and unassigned call responsibilities [See Section 2.2]. Inpatient and outpatient procedures scheduled prior to the practitioner being placed on the suspension list will be honored; however, no new procedures will be scheduled until all delinquent records are complete. The practitioner will be notified by HIMS prior to being suspended to give the practitioner an opportunity to complete his/her record(s). Suspension of clinical privileges shall continue until all delinquent records are completed.

3.16.3 Suspension of Medical Staff Appointment

If a practitioner's clinical privileges have been suspended for fourteen (14) consecutive days as described in Section 3.17.2, and the record which caused the suspension has not been completed, his/her Medical Staff appointment will be suspended. The practitioner shall not be allowed to schedule admissions or inpatient/outpatient procedures shall not be allowed to order diagnostic tests or therapeutic procedures, shall not be allowed to evaluate or treat patients in any department of the Hospital, and may not exercise any of the prerogatives of Medical Staff appointment. This suspension of appointment shall continue until all delinquent records are completed. The practitioner may be assessed a fine, as established by the Medical Executive Committee, each day for every record that is not completed. Failure to pay fines assessed for medical record delinquency shall be grounds for suspension and/or termination.

3.16.4 Termination of Medical Staff Appointment

- a. Failure to complete a medical record within thirty (30) days of being declared delinquent shall constitute an automatic termination of Medical Staff appointment.
- b. If a practitioner's Medical Staff appointment is suspended, as described in Section 3.17.3, six (6) times within any twelve (12) month period, this shall also constitute an automatic termination of Medical Staff appointment.
- c. Automatic termination due to medical record delinquency shall not be reported to the National Practitioner Data Bank or to the Indiana Medical Licensing Board.

3.16.5 General Rules Regarding Medical Record Delinquency

- a. Medical record delinquency will not be declared while on vacation or leave of absence provided that the Health Information Management Department is notified prior to the date of the vacation or leave or serious illness. A practitioner will not be declared delinquent while on vacation provided that all records are completed at the time the practitioner gives notice of vacation and are completed within one week of return.
- b. It is the responsibility of the delinquent practitioner to notify HIMS when documentation is completed.
- c. If a physician demands admission of a patient despite suspension of his or her privileges and appointment, Hospital personnel will direct the physician to contact his or her Clinical Service Chief or the Chief of Staff. The Clinical Service Chief or Chief of Staff may consider allowing the admission in an emergency situation.
- d. No references will be provided for any practitioner who leaves the staff until all medical records are complete.

3.17 ELECTRONIC RECORDS AND SIGNATURES

“Electronic signature” means any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

3.18 MEDICAL RECORD FORMS

- a. **Required-use Forms:** The Medical Executive Committee may adopt and require the use of specific forms in the medical record. Prior to adoption, these forms should be reviewed and approved by the Health Information Management Director and approved by the Bloomington Hospital Forms process.
- b. **Practitioner-created Forms:** Forms created by Medical Staff appointees for their individual use may be used in the medical record if they are approved by the forms process.
- c. **Periodic Review:** Medical record forms shall be periodically reviewed through the Forms Committee, and approved by Patient Care Committee and Medical Executive Committee.

Article 4. Standards of Practice

4.1 ATTENDING PHYSICIAN

4.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending physician who is an appointee of the Medical Staff with admitting privileges. The attending physician will be responsible for:

- a. the medical care and treatment of each patient in the Hospital;
- b. Making daily rounds;
- c. The prompt, complete, and accurate preparation of the medical record;
- d. Necessary special instructions regarding the care of the patient;
- e. Arrange specialty consults, if necessary, and
- f. Transmitting reports of the condition of the patient.

4.1.2 Identification of Attending Physician

At all times during a patient's hospitalization, the identity of the attending physician shall be clearly documented in the medical record. An attending physician can not remove himself from a case until another physician has accepted the patient.

4.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending physician are transferred to another Medical Staff appointee, a note covering the transfer of responsibility will be entered on the order sheet of the medical record by the attending physician.

4.1.4 Patient Requests Change of Attending Physician

If a patient requests a change in practitioner, the practitioner is informed. If the practitioner cannot resolve the dispute or conflict with the patient, the practitioner shall arrange for another physician of appropriate discipline to assume care of the patient. The appropriate clinical service chair, Chief of Staff and/or Chief Medical Officer, may be called on to assist or facilitate this change. The relinquishing physician remains responsible for the patient's care until another practitioner agrees to assume the care. (See Medical Staff Policy MS 118 Patient Requests Change of Attending Physician).

4.2 COVERAGE AND CALL SCHEDULES

Each physician shall provide the Medical Staff Services Office with a list of designated Medical Staff appointees (usually the members of his/her group practice who are members of the same Clinical Service and have equivalent clinical and procedure privileges) who shall be responsible for the care of his/her inpatients in the Hospital and meet the parameters of call when the physician is not available. Each physician is responsible for providing the Medical Staff Services Office and the Emergency Department with a current and correct on-call schedule. Changes to contact information need to be made by calling the "EDMD" line 353-3363 and the physician's call service.

4.3 RESPONDING TO CALLS AND PAGES

Practitioners are expected to respond in a timely fashion, with twenty (20) minutes as a suggested response time from the Hospital's patient care staff regarding their patient. Other service response time may require quicker response times depending on the needs of the patient.

4.4 ORDERS

4.4.1 General Principles

- a. All orders for treatment will be in writing or approved electronic format.
- b. Orders must be clear and unambiguous.
- c. All orders must be specifically given by a practitioner who is privileged by the Medical Staff or designee operating as an agent of the medical staff member.
- d. Vague or "blanket" orders (such as "continue home medication" or "resume previous orders") will not be accepted.
- e. Instructions should be written out in plain English. Prohibited abbreviations may not be used. [See Section 3.4, Appendix A]
- f. All orders for treatment shall be recorded in the medical record and authenticated by the ordering practitioner with his/her legible signature, date, and time.
- g. Orders may be received and executed only by an authorized individual: A Medical Staff appointee, a registered nurse or a licensed practical nurse who has demonstrated competence, under supervision, to administer medications safely; a pharmacist who may receive orders; or an authorized Advanced Practice Provider or others who may accept orders that are specific to treatment within their scope of practice or service.
- h. A complete order for outpatient services shall contain:
 - Patient Name
 - Test or Service Requested
 - Reason for Test (Diagnosis or Symptom or ICD-10-CM Code)
 - Physician or Practitioner Signature and Date and Time
- i. Length of time an order is valid for outpatient services is as follows:
 - Ancillary/Diagnostic Service 1 year
 - Therapeutic Service 1 year
 - Outpatient Surgery 30 days
 - Outpatient Rehab Services 30 days

4.4.2 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in a computer. Verbal/telephone orders must comply with the following criteria:

- a. The order must be given to a Bloomington Hospital authorized individual as defined in subsection 4.4.1(g).
- b. Verbal/telephone orders should be dictated slowly, clearly, and articulately to avoid confusion. Verbal/telephone orders, like written orders, should be conveyed in plain English without the use of prohibited abbreviations.
- c. The order must be read back to the prescribing practitioner by the authorized person receiving the order and must be verified by the prescriber.
- d. It is not acceptable for physician or licensed independent practitioners to text orders for patients to the hospital or other healthcare settings. This method provides no ability to verify the identity of the person sending the text, and there is no way to keep the original message as validation of what is entered into the medical record.
- e. All verbal orders shall indicate whether the order was received as an in-person verbal order or a telephone order through use of the relevant acronym.
- f. The following orders may not be given verbally:
 - Orders for cancer chemotherapy.

4.4.3 Facsimile Orders

Orders transmitted by facsimile shall be considered properly authenticated and executable provided that:

- a. The facsimile is legible and received as it was originally transmitted by facsimile or computer;
- b. The order is legible, clear, and complete;
- c. The identity of the patient is clearly documented;
- d. The facsimile contains the name of the ordering practitioner, his address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law;
- e. The original order, as transmitted, is signed, dated, and timed; and
- f. The facsimile, if received unsigned, requires signature by the attending physician or ordering practitioner within thirty (30) days of discharge. A signed facsimile order is considered complete.

4.4.4 Electronic Orders

The Medical Executive Committee shall develop and maintain policies regarding the use of electronic orders and computerized order entry consistent with federal and state law.

4.4.5 Illegible, Unclear, and Incomplete Orders

A practitioner's handwritten orders shall be made in black ink on forms approved by the Medical Executive Committee, and will be written clearly, legibly, and completely. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly written (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately if there are implications for patient safety. The authorized individual will contact the practitioner, request a verbal order for clarification, read back the order, and write the clarification in the medical record. This verbal order must be signed by the ordering practitioner as described in Subsection 4.4.2.

4.4.6 Error Correction

Improperly corrected orders can lead to medical errors. If an error is made in writing an order, the entire order should be rewritten. A single line should be drawn through the erroneous order followed by the words "cancel" or "error" and the practitioner's initials, date and time.

Making additions or modifications to previously written orders are prohibited.

4.4.7 Cancellation of Orders Following Surgery or Transfer

All previous orders are canceled when the patient:

- a. goes to surgery,
- b. is transferred to a critical care area,
- c. is transferred to a general medical unit from a critical care area,
- d. is transferred to, and readmitted from, another hospital or health care facility. New orders shall be specifically written following surgery or the aforementioned transfers. Instructions to "resume previous orders" will not be accepted.

4.4.8 Range and Conditional Orders

The ordering practitioner is responsible for evaluating the patient's status and reviewing all existing therapies before ordering, modifying, or discontinuing a particular therapy. Details of orders of this kind find in policy Medication Administration INTER-M-110

4.4.9 Medication Related Orders

- a. **Hospital Formulary:** To assure the availability of quality pharmaceuticals at a reasonable cost, practitioners shall comply with the formulary system established by the Medical Executive Committee upon the recommendation of the Pharmacy Director, the Pharmacy and Therapeutics Committee, and the Patient Care Committee. Any practitioner may submit a request for addition of a drug to the Hospital formulary prior to its need. These requests shall be submitted to Pharmacy. Drugs will be added to, or removed from, the formulary based on evidenced-based criteria. Practitioners shall have the ability to order ‘Do Not Substitute’ or ‘Dispense as Written” when adequate patient justifications are present. Non-formulary medications will not be stocked and it will take some time to obtain them. Patient’s own medications will not be used unless pharmacy does not stock the medication and there is no acceptable alternative.
- b. **Substitution:** Medication orders written for trade-name drugs may be dispensed as the formulary generic drug unless the physician specifically writes “Do Not Substitute” on the patient order sheet. The Medical Executive Committee shall adopt policies concerning automatic therapeutic substitution upon the recommendation of the Pharmacy Director, the Pharmacy and Therapeutics Committee and the Patient Care Committee.
- c. **Approved Drugs:** Only FDA approved medications may be administered to patients in the Hospital, the only exception being drugs for bona fide clinical investigation.

Medications approved for formulary addition may be prescribed for non FDA approved uses provided the unapproved use is supported in recognized medical literature or recognized medical compendia. The Pharmacy and Therapeutics committee may place specific limitations on unapproved uses.

- d. **Investigational Drugs:** Investigational drugs shall be used in full accordance with the guidelines established by the Hospital’s Institutional Review Board, and shall comply with all regulations of the US Food and Drug Administration and Drug Enforcement Administration.
- e. **Controlled Substances:** Only practitioners holding a currently valid DEA (Drug Enforcement Agency) and Controlled Substances Registration Certificate may write orders for narcotics or drugs classified in the DEA Controlled Substances Category.

- f. **Definition of a Complete Order:** All medication orders shall include the drug name, the dose, the dosage form, the route of administration, the schedule of administration, and if appropriate, the date and time of discontinuation. If appropriate, a dilution and rate of administration should be specified. All medication orders that are incomplete will be called to the attention of the ordering practitioner for clarification prior to being dispensed. The use of “PRN or As Directed”, by themselves does not constitute a legitimate frequency.
- g. **Nomenclature:** When ordering medications, standard nomenclature must be employed, using the United States Adopted Names-approved generic name, the official name, or the trademarked name (if a specific product is required). Prohibited abbreviated names and symbols should not be used.
- h. **Dosing Formats:** Prescribers will order medications in total dose desired without regard to how the drug is supplied.
- i. **Hold Orders:** Instructions to “hold” a medication should be specific and must include the name of the medication to hold.
- j. **Indication for Medications:** “PRN” or “as needed” orders must have indications identified within the medical record.
- k. **Automatic Stop Orders:** Drugs and biologicals not specifically prescribed as to time or number of doses will automatically be stopped after (30) thirty days.
- l. **Titrating orders** - When medication orders are written for titration, parameters for titration must be included, unless pre-specified by an approved protocol.
- m. **Taper orders** - When medication orders are written for tapering or weaning, the medication will be adjusted per approved policy (Emergency Drug Guide Book)
- n. **Herbal orders** - Herbal supplements, not regulated by the FDA or not approved by Pharmacy and Therapeutics, will not be ordered or administered regardless of intent for use.
- o. **Look alike, sound alike orders. (LASA) orders** - Orders for LASA medication names will be written legibly (see section 4.4.5). When ordered electronically, safety measures, such as tall man lettering will be instituted to reduce potential for medication errors.
- p. **Weight-based orders** - Weight based dosing is required on the medication orders written for pediatric patients.

4.4.10 “Stat” Orders

“Stat” or “now” orders should only be used when the practitioner expects hospital personnel to discontinue all other tasks so that they may execute the order as soon as possible. “Stat” and “now” orders should be reserved for true emergency situations, and should not be used for the convenience of the practitioner. Inappropriate use of “stat” and “now” orders may be grounds for corrective action.

4.4.20 Medication Errors: A medication error is any preventable event within the medication administration continuum that may cause or lead to inappropriate medication use. Medication administration errors, adverse drug reactions, and medication incompatibilities as defined by the hospital are immediately reported to the attending physician or clinical psychologist and as appropriate to the organization-wide quality assessment and performance improvement program. The following procedure will be followed: Refer to Policy #INTER-M-350 (TJC MM.07.01.03).

4.5 CONSULTING PHYSICIAN

- a. Any qualified practitioner with clinical privileges may be requested for consultation within his/her area of expertise. The attending physician is responsible for obtaining consultation whenever patients in his/her care require services that fall outside his/her scope of delineated clinical privileges, and has full discretion over the choice of the Consulting Physician. Physician to physician communication is expected. The attending physician will provide written authorization requesting the consultation permitting the consulting practitioner to attend or examine his/her patient. This request shall specify:
 - the reason for the consultation;
 - the urgency of the consultation (urgent—within 4 hours; today—before midnight; or routine—within 24 hours); and
 - whether the attending physician requests the consulting practitioner to only render an opinion, provide treatment in his or her area of specialty, or assume the role of attending physician.
- b. If a nurse has any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to the attending physician and/or a group associate. If unresolved, the nurse should contact the practitioner's Clinical Service Chief. All practitioners should be receptive to obtaining consultation when requested by patients, their families, and hospital personnel.
- c. Consultants have the right to refuse consultation when requested.
- d. If no consultants will agree to consult on a patient, the emergency on-call physician will have the responsibility of performing the consultation. The medical staff leader will be notified by the emergency on-call physician.
- e. Consultants can order perform evaluations, order tests and perform procedures without additional approval from the Attending Physician. However, they cannot involve additional Consulting Physicians without the explicit agreement by the Attending Physician, unless the urgency of the clinical situation precludes communication.
- f. Consultant Physicians cannot designate the identity of the Attending Physician, e.g. if a physician called from the ED/Transfer Center and declines to be the Admitting Physician and opts for the consulting role, the Attending Physician will be determined by the usual assignment mechanism used by the ED/Transfer Center

4.6 CRITICAL CARE UNITS

4.6.1 Critical Care Unit Privileges

The critical care units are open to all privileged providers. The medical director has the direct oversight of appropriateness and quality of care of the use of the critical care unit.

4.6.2 Prompt Evaluation of Critical Care Patients

Each patient admitted or transferred to a critical care unit shall be examined by a physician within eight (8) hours of admission or transfer.

Exception: Intensive Post Operative Care

4.6.3 Critical Care Services

Certain services and procedures may be provided to patients only in critical care units. The Medical Director of the ICU, in conjunction with critical care nursing leadership, shall develop policies that specify which services may be provided only in a critical care unit.

4.7 DEATH IN HOSPITAL

4.7.1 Pronouncing and Certifying the Cause of Death

In the event of a hospital death, the deceased will be pronounced by the attending practitioner or his/her designee (including designated nursing personnel) within a reasonable time. The attending physician or his/her designee is responsible for certifying the cause of death, and completing the Death Certificate in a timely manner.

4.7.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.

4.8 AUTOPSY

For autopsies performed at Bloomington Hospital, it is the duty of the attending physician to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medicolegal or educational interest. A provisional anatomic diagnosis will be recorded on the medical record within seventy-two (72) hours, and the complete autopsy report will be made part of the medical record within sixty (60) days unless an explanatory note is written. The attending physician or designee should be available to speak with family if the family wishes. This contact may be by phone.

4.9 SUPERVISION OF ADVANCED PRACTICE PROVIDER

4.9.1 Definition of Advanced Practice Provider

Advanced Practice Provider, including Clinical Psychologists, Advance Practice Registered Nurses, Certified Nurse Midwives, Physician Assistants, and Anesthesiologists Assistants, are licensed or certified health care practitioners whose license or certification does not permit and/or the hospital does not authorize the independent exercise of clinical privileges. The qualification and prerogatives of Advanced Practice Provider are defined in Part III, Section 2.2 of the Medical Staff Bylaws. Advanced Practice Provider may provide patient care only under the supervision of a physician who is an appointee to the Medical Staff, and are not eligible for Medical Staff membership.

4.9.2 Guidelines for Supervising Advanced Practice Provider

- a. The physician is responsible for managing the health care of patients in all inpatient settings.
- b. Health care services delivered by physicians and by Advanced Practice Provider under their supervision must be within the scope of each practitioner's authorized practice, as defined by state law.
- c. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the Advanced Practice Provider, ensuring the quality of health care provided to patients.
- d. The physician is responsible for the supervision of the Advanced Practice Provider in all inpatient settings.
- e. The role of the Advanced Practice Provider in the delivery of care shall be defined through mutually agreed upon Collaborative Practice Agreements/Supervisory Agreement that are developed by the physician and the Advanced Practice Provider.
- f. The physician must be available for discussion with the Advanced Practice Provider at all times, either in person or through telecommunication systems or other means.
- g. The extent of the involvement by the Advanced Practice Provider in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the Advanced Practice Provider, as adjudged by the physician. Any request from another physician for immediate involvement by the supervising physician will be honored.
- h. Patients should be made clearly aware at all times whether they are being cared for by a physician or an Advanced Practice Provider.
- i. The physician and Advanced Practice Provider together should review all delegated patient services on a regular basis, as well as the mutually agreed upon Scope of Practice Guidelines.
- j. The supervising physician is responsible for clarifying and familiarizing the Advanced Practice Provider with his/her supervising methods and style of delegating patient care.

- k. Each Advanced Practice Provider must document the identity of their supervising physician and one or more alternate supervising physician.

4.9.3 Collaborative Practice Agreements/Supervisory Agreement

Each dependent Advanced Practice Provider must have on file in the Medical Staff Services Office a written Collaborative Practice Agreement that describes all health care-related tasks which may be performed by the dependent Advanced Practice Provider. This document must be signed by the dependent Advanced Practice Provider, the supervising physician, and all alternate supervising physicians. The Collaborative Practice Agreement shall be submitted to the Credentials Committee and the Medical Executive Committee for approval before the dependent Advanced Practice Provider can provide services to patients at the Hospital. The Collaborative Practice Agreement must include:

- a. the name, license number and addresses of all supervising physicians;
- b. the name and practice address of the Advanced Practice Provider;
- c. the date the agreements were developed and dates they were reviewed and amended;
- d. medical conditions for which therapies may be initiated, continued, or modified;
- e. treatments that may be initiated, continued, or modified;
- f. drug therapies, if any, that may be prescribed with drug-specific classifications; and
- g. Situations that require direct evaluation by or immediate referral to the supervising physician.

4.9.4 Supervising Physician

The Advanced Practice Provider may perform Admitting History and Physical examinations, perform consultations, make rounds, and perform duties within the provider's scope of practice. The attending physician is ultimately responsible for care of the patient. In situations where the condition of the patient warrants the personal care of the physician, or the patient specifically requests to be evaluated by the physician, the physician must personally evaluate the patient in a timely manner. The physician shall personally assess new patients within a clinically appropriate timeframe, not to exceed 24 hours. Physicians who are the attending physician on the patient are required personally to visit on a daily basis. Consulting physicians shall visit on a frequency which is appropriate for the clinical situation, or if requested by the attending physician.

The supervising physician is required to personally evaluate the patient on new admissions and consults within 24 hrs and cosign the initial History and Physical or Consultation. Direction and supervision must be personally rendered by supervising physician, who must be physically present or immediately available at all times. The supervising physician shall review medical services provided by the APP within a reasonable time, not to exceed 72 hours or as mandated by state law, and provide documentation in the medical record.

4.9.5 Medical Record Documentation

Advanced Practice Provider may enter clinical narratives (e.g. H&P, Progress Notes, Consults, and Discharge Summaries) in accordance of the written Scope of Practice Guidelines which has been approved by the Credentials Committee.

4.9.6 Other Limitations on Advanced Practice Provider

An Advanced Practice Provider may not:

- a. Provide a service which is not listed and approved in the privileges on file in the Medical Staff Services Office;
- b. Prescribe drugs, medication, or devices not specifically authorized by the supervising physician and documented in the Collaborative Practice Agreement; and
- c. Provide a medical service that exceeds the clinical privileges granted to the supervising physician.

4.10 INFECTION CONTROL

Physicians have an important role in the prevention of nosocomial infection. All practitioners are responsible for complying with Infection Prevention policies and procedures in the performance of their duties. An essential part of this program incorporates patient infection prevention measures as well as systems of barrier precautions. Universal Precautions are to be used by practitioners for contact with blood, moist body substances, and non-intact skin of all patients, regardless of the patient's diagnosis.

4.11 CLINICAL PRACTICE GUIDELINES

Clinical practice guidelines provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Clinical practice guidelines assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment, and management of selected conditions. Clinical practice guidelines can also be used in designing clinical processes, or checking the design of existing processes.

The Medical Executive Committee may adopt evidence based clinical practice guidelines upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel, and those health care providers who are expected to implement the guidelines.

The Medical Executive Committee shall consider such sources as the Agency for Healthcare Research and Quality, professional medical societies and physician organizations, professional health care organizations, and local organizations. Guidelines shall be adapted to the community, the needs of the patient population, and the resources of the Hospital. Clinical practice guidelines so adopted must anticipate and capture variance.

4.12 CONTINUING MEDICAL EDUCATION (CME)

All active medical staff must accrue fifty (50) hours of AMA PRA category I credit by the time of each biennial re-appointment period. Provider will be expected to sign an attestation at the time of reappointment that they have completed the required fifty (50) hours of CME. Random audits will be conducted to ensure compliance with the required CME. If the provider is unable to

supply documentation of the mandatory CME's for the required time period at the time of an audit, a three (3) month limited reappointment will be recommended to the Board giving the provider time to locate and submit documentation.

Maintenance of ACLS, PALS, NRP, ATLS or BLS would reduce this requirement by ten (10) hours for a total of forty (40) hours (clarification – 10 credits maximum per year).

Physicians may further reduce their CME requirements by a maximum of ten (10) hours per biennial period by attending approved hospital meetings that have an educational component (cancer conference, vascular section, etc.). An hour long meeting can count for ½ hour of credit. Credit for these meetings must have the prior approval of the CME Committee.

Board Certification or recertification during the two (2) year reappointment period would reduce the requirement to zero (0) hours for that period.

If a physician accrues more than fifty (50) hours of category I CME in any reappointment period, they may carry forward a maximum of twenty (20) hours from one reappointment period to the next.

Article 5. Patient Rights

5.1 PATIENT BILL OF RIGHTS & DELIVERY OF PATIENT CARE

Refer to Policy #ADMIN-2-102

5.2 INFORMED CONSENT

Refer to Policy #INTER P-120

5.3 PROCESS FOR COMMUNICATING LIMITATIONS TO CARE.

5.4 Refer to Policy #MS 120DO-NOT-RESUSCITATE ORDERS

Refer to Policy #INTER D-167

5.5 DISCLOSURE OF UNANTICIPATED OUTCOMES

Refer to Policy #ADMIN-2-111

5.6 RESTRAINTS AND SECLUSION

5.6.1 Definitions - A physical restraint is any device, garment, material, or object that restricts a person's freedom of movement or access to his or her body. The restraint must be clinically justified and a part of the prescribed medical treatment and plan of care, and all other less restrictive measures must be tried first.

5.6.2 Restraints for Acute Medical and Surgical Care - Refer to Policy #INTE-R-117

5.6.3 Restraints and Seclusion for Behavioral Management - Refer to Policy #INTE-R-117

5.7 ADVANCE DIRECTIVES

Refer to Policy #INTER-A-195

5.8 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board.

Refer to SOP-RR-409 and SOP-IC-701

Article 6. Surgical Care

6.1 SURGICAL PRIVILEGES

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the Medical Executive Committee. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The Medical Staff Services Office will maintain a roster of practitioners specifying the surgical privileges held by each practitioner.

6.2 SURGICAL POLICY AND PROCEDURE MANUAL

All practitioners shall comply with the Hospital's Surgical Policy and Procedure Manual. The current Surgical Policies and Procedures can be located on the hospital intranet by accessing the following links: Intranet Navigator, Policies & Procedures, and Surgical Services.

6.3 ANESTHESIA

6.3.1 Organization: All anesthesia policies, rules and protocols used within IU Health Bloomington Hospital inpatient and contiguous outpatient facilities will be approved and maintained by the Anesthesia Director, who is the anesthesia service chief or his/her, appointee who is a privileged anesthesiologist at IU Health Bloomington Hospital. Individual service/sections (E.g. Emergency, Gastroenterology) may develop policies regarding anesthesia within their scope of practice, and these must be approved by the Anesthesia Director.

6.3.2 Anesthesia providers: Anesthesia may only be provided by members of the medical staff or hospital staff who are either: a qualified and credentialed anesthesiologist, a non-anesthesiologist MD/DO, a dentist, an oral surgeon, a podiatrist, a certified registered nurse anesthetist, or an anesthesiologist's assistant.

6.3.3 Credentialing Providers: The Anesthesia Director will develop criteria for privileging based on the type and depth of anesthesia administered (topical, minimal sedation, moderate conscious sedation, deep sedation, regional anesthesia and general anesthesia). Qualified providers must apply for privileges according to the anesthesia type and depth, which will be reviewed by the Anesthesia Director, the credentials committee, the Medical Executive Committee. All privileges will ultimately be reviewed and granted by the hospital board.

6.3.4 Policies on pre-assessment, monitoring, documentation and post-anesthesia evaluation will be approved and maintained by Anesthesia Director, in accordance with the most recent anesthesia literature and practice, and in compliance with internal and external regulations

6.4 TISSUE SPECIMENS

All specimens, except those noted on the Tissue Exempt List, removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. The pathologist's report will be made a part of the patient's medical record.

**6.5 UNIVERSAL PROTOCOL: PREVENTING WRONG PERSON, WRONG SITE,
WRONG PROCEDURE ERRORS**

Refer to policy INTER-U-140

Article 7. Rules of Conduct

7.1 GENERAL

Members of the Medical Staff are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior by a Medical Staff member will be dealt with according to the procedures defined below.

7.2 DISRUPTIVE BEHAVIOR

- a. The goal of the process is provide opportunity for a safe and enjoyable workplace, which supports the highest level of clinical care and professionalism.
- b. Definition of disruptive behavior, which includes interactions with other members of the medical staff, the hospital staff, patients and patient families on the premises of the IU Health Bloomington Hospital or affiliated locations:
 - i. Verbal assault or intimidation,
 - ii. Use of obscenities or demeaning language
 - iii. Sexual assault, intimidation, or inappropriate nonconsensual physical contact
 - iv. Refusal to provide care to patients as specified in the Bylaws
 - v. Violation of local, state or federal law
 - vi. Other behavior which adversely impacts the delivery of care
 - vii. Sexual activity, regardless of relationship to the medical staff member and mutual consent
- c. Incidents should result in a written incident report in accordance to current practice.
- d. Incident reports will be further investigated by the medical staff leader, and where appropriate the chief of staff/designee. Investigation will attempt to establish the facts of the situation, as well as the perceptions of involved parties, including medical staff, hospital staff, patients and their families.
- e. The involved medical staff member is expected to submit in either written or verbal format his/her perception of the event, and to participate actively in any corrective action taken.
- f. The medical staff leader will determine whether the staff member's behavior was inappropriate, and if present, engage the physician in collegial manner to alter behavior. The medical staff leader shall document the conversation and action plan, and submit this to the medical staff office for submission to the medical staff members file. A copy of this report will also be provided to the involved individual. These actions are not reportable to the NPDB.
- g. Repeated disruptive events, a single egregious event, or those involving the medical staff leader will lead to involvement of the chief of staff and/or the chief medical officer. Progressive disciplinary actions may include, but are not limited to:
 - i. internally determined corrective action plan,
 - ii. appearance before the MEC to discuss the incident,
 - iii. mandatory participation involvement in an external corrective action plan, with any incurred expenses remaining the responsibility of the disruptive staff member.
- h. Repeat or egregious behavior may result in restriction of privileges, temporary suspension of privileges, limited reappointment, or termination from the medical staff. These activities will follow the rules Peer Review, as discussed in the Bylaws. Any censure will be reported, if required, to the NPDB.

- i. Records of incidents and action plans will be retained in the medical staff office, and will not be released to outside parties except as required by law. They will remain part of the providers credentialing file, and may be referenced at the time of reappointment.

7.3 PHYSICAL EXAMINATION GUIDELINES

In order to prevent misunderstandings and protect physicians and their patients from allegations of sexual misconduct, the following guidelines as recommended by the State of Indiana Medical Licensing Board for performing physical examinations shall be followed by all practitioners:

- a. **Patient Dignity:** Maintaining patient dignity should be foremost in the practitioner's mind when undertaking a physical examination. The patient should be assured of adequate auditory and visual privacy and should never be asked to disrobe in the practitioner's presence.
- b. **Location and Equipment:** Physical examination shall be conducted in a safe, clean and well-maintained location, with appropriate equipment for the examination and treatment. Gowns, sheets, and/or other appropriate apparel shall be made available to protect patient dignity and decrease embarrassment to the patient while promoting a thorough and professional examination.
- c. **Chaperones:** A third party shall be readily available at all times during a physical examination, and it is suggested that the third party be actually present when the physician performs an examination of the sexual and reproductive organs or rectum. It is incumbent upon the practitioner to inform the patient of the option to have a third party present. This precaution is essential regardless of the sex of the practitioner and the patient.
- d. **Consent for Examination:** The practitioner should individualize his/her approach to physical examinations so that the patient's apprehension, fear, and embarrassment are diminished as much as possible. An explanation for the necessity of a complete physical examination, the components of that examination, and the purpose of disrobing may be necessary in order to minimize the patient's apprehension and possible misunderstanding.
- e. **Procedures Requiring Disrobing:** The practitioner and his/her assistants shall exercise the same degree of professionalism and caution when performing diagnostic procedures (i.e., electrocardiograms, electromyograms, endoscopic procedures, and radiological studies, etc.) as well as surgical procedures and post-surgical follow-up examinations when the patient is in varying stages of consciousness.
- f. **Handling Inappropriate Patient Behavior:** The practitioner should be alert to suggestive or flirtatious behavior or mannerisms on the part of the patient, and should not put him or herself in a compromising position.
- g. **Allegations of Exploitation:** The practitioner shall not exploit the physician-patient relationship for sexual or any other purposes. Moreover, such an allegation against a Medical Staff appointee shall constitute grounds for investigation and corrective action pursuant to Article II of the Medical Staff Bylaws.

7.4 SUSPECTED IMPAIRED PRACTITIONERS

- When hospital personnel, a colleague, a patient or patient's family expresses concern that a physician appears acutely impaired, the hospital employee must contact the Medical Staff Services Department or the Patient Care Director immediately. The Chief of the medical staff or his/her designee will be contacted immediately and asked to come to the hospital.

- The staff person will inform the physician in question of this procedure and that this is the medical staff procedure for this concern. This physician will be requested to wait until the designated superior arrives (i.e., chief of staff or his/her designee) at which time a urine drug screen and/or blood alcohol level will be obtained. Chain of custody procedure will be followed in the collection of the specimens. The physician will be required to wait under supervision until test results are obtained.
- Should the above urine screen and/or blood alcohol level be positive, or if it is negative and/or the designated superior determines the physician to be otherwise psychiatrically and/or physically impaired, the physician in question shall be required to cease patient care immediately. The designated superior will arrange for immediate care of the physician's patients and for safe transport of the physician from the hospital by family or other appropriate party.
- All information is to be given to the Hospital and the Professionalism and Behavior Review Board (PBR) for immediate review within 3 business days. The physician in question should be apprised of this procedure. The physician may or may not be involved in patient care until an evaluation has been obtained. This decision will be made through the PBR in consultation with the ISMA PAP.
- The ISMA PAP (Physician Assistance Program) Coordinator and/or Medical Consultant working in conjunction with the PBR will evaluate and investigate the complaint. The ISMA PAP will develop a course of action, and the PBR Board will be notified. Options include but are not limited to the following:
 - If an initial report/reports lacks sufficient information to warrant further action, it will be kept in a confidential file. If further information is received, the case will be reinvestigated.
 - If the reports prove substantial and the physician is recommended to undergo an appropriate evaluation by a facility or physician approved by the Commission on Physicians Assistance, the physician must agree to follow the recommendations of the evaluation. Consent to undergo evaluation and follow treatment recommendations are verified by the physician entering into an evaluation contract with the ISMA PAP.
- If treatment is recommended, the physician will sign a contractual arrangement with the ISMA PAP. This contractual agreement will be effective for at least 5 years.
- The contract will cover but is not limited to the following areas:
 - Weekly random urine drug screens, if appropriate to the impairment;
 - Attendance at weekly Alcoholics/Narcotics Anonymous meetings, if appropriate to the impairment;
 - Attendance at Caduceus meetings, a support group for physicians, if appropriate to the impairment;
 - Monthly meetings with an approved physician advocate;
 - Continued therapy if recommended by the treating physician;
 - Other items appropriate to the impairment; and
 - Approval to send regular reports to the appropriate hospital personnel documenting contract compliance.
- Failure to comply with requests for evaluation or the terms of the contract will result in a report to the Executive Committee of the hospital medical staff and may result in a report to the Indiana Medical Licensing Board.

7.5 SMOKING POLICY -

Refer to Administration Policy – Tobacco Free Campus Policy #ADMIN-7-101

Article 8. APPENDIX A

DO NOT USE ABBREVIATIONS

Refer to Interdisciplinary Policy – INTER-A100