PARKVIEW MEDICAL STAFF
Parkview Regional Medical Center
MEDICAL STAFF DIVISION RULES AND REGULATIONS

RECOMMENDATION / APPROVAL
Medical Staff Executive Committee:
12/09/04, 12/13/05, 03/13/07, 04/10/07, 05/08/07, 06/12/07, 06/08/10; 06/12/12; 03/12/13; 04/09/13; 12/09/14; 01/13/15; 03/08/16, 08/09/16, 11/08/16, 09/10/19, 8/10/21, 10/11/22, 2/15/24

I. DIVISION ORGANIZATION AND GOVERNANCE

Divisions shall be established and facilitated as described in the Medical Staff Bylaws. Specifically, within these Rules and Regulations, each Division shall further describe their Division's operations as needed.

A. Facilitation of Medical Staff Affairs

Medical Staff Divisions/Division Leadership Committees convene for the purpose of facilitating medical staff affairs to support safe and quality patient care. Examples of medical staff affairs include those things listed below as Medical Staff Issues. Operational Issues may be broached at Division meetings for purposes of awareness and communication; however, the authority to address such subjects does not rest solely with the Division.

Medical Staff Issues – Physician-to-Physician with or without assistance from hospital staff

Peer Review

1. Qualification for initial and ongoing medical staff membership
2. Qualifications for individual privileges
3. Establishment of privilege criteria (cross specialty being the most challenging)
4. Collegial Intervention when questions about clinical or behavioral performance arise
5. Establishment of Inquiry Body process when concerns about performance become serious
6. Chart review / Quality Assurance as needed beyond the efforts of specialty-specific peer review committees
7. Proctoring
8. Addressing medical staff roles in preventing adverse events
9. Ensuring members' rights are protected in all things

Medical Staff Performance

1. Ensure quality care by identifying opportunities for individual or organizational performance improvement; for example, care criteria, order sets, clinical pathways, etc.
2. Plan processes to resolve unique/ad hoc/cross specialty issues
3. Manage adherence to established rules, like medical record completion, formulary usage, consultation, equitable unattached call coverage, etc.
4. Ensure "rules" are reasonable, contemporary, and consistently applied to all
5. Understand medical staff and hospital processes for decision making to assist individual members in voicing their needs
6. Develop, nominate, and elect future leaders
7. Plan for and hold effective and efficient meetings
8. Safely implement new equipment affecting the medical staff
9. Establish guidelines and monitor appropriate use of dependent allied health professionals (i.e rounders, extenders)

Communication

1. Ensure constituency is fairly represented in all matters affecting them at all levels
2. Ensure constituency has opportunity to share concerns and opinions about any medical staff or hospital matter
3. Ensure constituency is informed about issues and happenings that affect them
4. Ensure the right medical staff members are consulted about "operational" issues such as strategic planning, capital purchases, etc.

Operational Issues – Matters in which both medical staff and hospital have interest and must collaborate

1. How a specific unit (ex: ED, OR, ICU) functions – usually handled by unit medical director
2. How resources are allocated within a specific unit
3. Block time allocation
4. Budget and Capital expenditure decisions
5. Surveys and Accreditation activities
6. Benchmarking and establishing of unit performance indicators, ex: OR turnaround time
7. Consideration of new services
8. Unit prevention of adverse events

9. Strategic planning

Medical Staff committees do not need to be routinely engaged in operational issues; however, medical staff member involvement may be needed and expected from time to time. Division Leadership, including specialty Reps, will stay informed of operational activities and can help ensure communication and consultation occurs as needed.

B. Division Leadership Committee (DLC) Meetings

Division Leadership Committees will meet as needed, which is expected to be at least nine times per year. Agenda items must be defined at least 10 days in advance of a Division Leadership Committee meeting to allow adequate time for the Division Leader to review the agenda and for materials to be distributed to members for review. "Consent Agenda" mechanism will be utilized as much as possible for Division Leadership Committee meetings. Non-controversial items or items unique to one or a few specialties only will be distributed before the meeting for review, and a single motion taken for approval. Reports will be received from multi-disciplinary committees prior to presentation to the MSEC when their recommendations would benefit from broad medical staff input or awareness or may be controversial. Division newsletters will be utilized for communication to the entire Division.

C. Division Meetings

Division Meetings will be held as business warrants at the discretion of the Division Leadership Committee. If there is interest, DLC's are encouraged to hold at least one Division Meeting per year. Should members of a Division desire a meeting of the full Division, they are encouraged to speak with the Division Leader to make arrangements. Should this interaction not yield the desired result, members may by written petition of 10 Active Staff members of the Division call a meeting. Adequate notice (at least 7 days) shall be provided to all members, stating the purpose of the meeting. The agenda of the meeting will be only for the stated purpose.

D. Specialty-Specific Activities

When an issue affects a single specialty, the Specialty Representative will determine to what extent review is needed by other or all members practicing in that Specialty, how that review will be accomplished, and for reporting the resultant recommendation.

When an issue affects multiple specialties, the Specialty Representatives from all affected specialties will collaborate to determine extent and mechanism for review, as well as the outcome report.

Should an impasse occur on any issue, members of the Division Leadership Committee who are "disinterested" in the subject will form an Ad Hoc Committee to study the issue, consulting affected parties, and render a recommendation to the Division Leadership Committee for resolution. When issues cross Divisions, all Divisions shall have participation.

E. Individual Issues

Should any individual member of the medical staff have an issue of concern, they are encouraged to approach medical staff leadership in the following order, depending on the scope of the issue: Specialty Representative, Division Leader, Division Vice Leader or Member At Large, President Elect, or President of the Medical Staff. The Chief Medical Officer and Medical Staff Services may also be used as an intermediary to ensure communication occurs.

Division members who are not members of the Division Leadership Committee may attend DLC meetings without vote with notification to the Division Leader. Division members may be excused from DLC's meetings at the discretion of the Leader. For example, non-DLC members may be excused from specific peer review discussions when appropriate.

F. Credentialing and Privileging

All applicants for appointment or reappointment must continuously meet the qualifications and standards of performance outlined in the Medical Staff Bylaws, Quality Management Plan, specialty-specific privilege forms and other associated policies, rules, and regulations.

The Bylaws describe the minimum eligibility requirements for medical staff membership. Under the oversight of the respective Division and the Credentials Committee, each recognized specialty and subspecialty shall develop and maintain privilege request forms specific to each specialty inclusive of minimum eligibility requirements for basic education, training, certification, and experience. Core privileges by specialty must be defined as well as those

privileges that are “advanced” or for any other reason require additional evidence of current competency. Examples of such acceptable evidence shall also be defined.

Reappointment assessment of activity during the past two years may include any of these resources or a combination thereof:

1. response to the questions asked on the Application for Reappointment
2. the absence of any concerns brought to the attention of their Specialty Representative or Division Leadership
3. the response received to an evaluation form sent to the hospital or health care facility where the individual holds active staff status and conducts primary practice
4. the response received to requested peer evaluations

Individual review of each applicant for initial appointment and privileges, for additional privileges, and reappointment and renewal of privileges shall occur, and recommendation formed for consideration by the Credentials Committee. The Division Leader is ultimately responsible to ensure such review occurs but may delegate review to another member of the Division Leadership Committee as appropriate; for example, for specialty-specific review. This same mechanism shall be used to obtain review of Allied Health Practitioners and address matters related to the individual use or performance of Allied Health Practitioners by the Medical Staff.

G. Collegial Intervention and Peer Review

Reference Medical Staff Bylaws and related policies

H. Leadership Nominations

Annually, each Division Leadership Committee will assess need for elections, based on term requirements described in the Bylaws and/or desire of the individual currently serving, of Specialty Representatives, Division Leader, Vice Leader, and Member at Large for the following year and facilitate the following activities:

1. Specialty Representatives
   Will be nominated by their Specialty for election prior to end of calendar year, as needed.
2. Division Leader, Vice Leader, and Member at Large
   Division Leaders are elected by the members of the Division for a term of two years beginning in January.

II. RULES AFFECTING ALL MEDICAL STAFF

A. EMTALA Compliance

Reference EMTALA Medical Staff Participation Policy

B. Consultations

Practitioners requesting consultation should be responsible for directly calling the consultant requested. Physician-to-physician communication is always preferred. When a written order is issued, this information shall be transmitted by Nursing at the time the order is noted.

1. Written Order Requirements
   The written order must include the name of the practitioner or group to be consulted, the reason for the consultation, and the timeframe in which the consultation should occur. If the written order is incomplete, nursing staff shall transmit the information available. The consulting practitioner is responsible for contacting the referring practitioner for clarification.
2. Transmission of Written Orders
   Nursing staff shall be responsible for directly contacting the office of the designated practitioner or group to relay the request for consultation, if the order is issued during office hours. After office hours, nursing staff will contact the practitioner on call for the designated practitioner or group through the answering service. The transmission of the written order shall be noted in the patient record.
3. Responsiveness to Consult Request
   Medical Staff Bylaws, Article III Section 4.4 require timely consultation, which shall be defined as within 24 hours, unless otherwise defined in the applicable Division Rules and Regulations and related policies. A face-to-face physician response to a consultation request is the normal expectation. In the event a physician consultant, or another physician from the physician’s group, is not personally seeing the patient in response to the consultation request, mutual understanding must exist between the requesting physician and the physician consultant on how the service will be provided.

Other acceptable alternatives to physician face-to-face consult may be allowed dependent upon specialty specific patient population and/or needs, with quality of patient care the primary consideration. A credentialed Advanced Practice Provider (APP) may respond on behalf of the supervising physician to an inpatient specialty consult to determine if quality care of the patient requires face-to-face physician consult. This model is offered to consultation services on

a. A group and specialty area requesting consideration of an Alternative Consultation Model must submit such request in writing to Medical Staff Officers using the Alternative Consult Request form to determine appropriateness of a proposed addition to that Specialty section in the Rules and Regulations. The request must identify a mechanism to ensure overall quality which shall include specialty specific training model for APPs and quality metrics specific to the Alternative Consultation model. It should represent an expansion of services to our patients.
    1. All Alternative Consultation Model requests by specific group and specialties will be initially approved (by MSO, both Divisions and MSEC) for a probationary period of six months of practice.
    2. At the end of the probationary period, the specialty involved will present to the Medical Staff committees (MSO, both Divisions and MSEC) quality metrics including, at minimum: average time of APP consult and average time of MD teleconsult, explanation of any delays, number of consults, readmission rate, complications, patient satisfaction, colleague testimonials and Midas events, as well as any variance from initial proposal and exemptions.
    3. Upon review of quality data presented after six months of practice, MSO will recommend approval of request for long term practice of Alternative Consult model for that group and specialty to Medical Staff Executive Committee, who will make the final approval. Changes will be made to Rules and Regulations at that time.
    4. Failure to comply by the Rules and Regulations and / or specific details of Alternative Consult model may lead to revocation of the Alternative Consult model for that group and specialty in addition to potential corrective measures toward individual APP and/or physician.
b. An APP requesting Alternative Consult privileges for a specific group and specialty must meet a minimum of the following requirements before Alternative Consult privilege can be considered.
    1. Must have been with their current group and specialty and held privileges at Parkview a minimum of one year (approximately 1600 hours) OR have verified experience in the same specialty at another facility for a minimum of one year, plus a minimum of six months onboarding at Parkview (Approximately 800 hours).
    2. Additional, more in depth, specialty specific credentialing requirements should be included in the model as proposed to Medical Staff committees. a. Any additional requirements to a specific specialty will be noted in the specialty specific section of the Rules & Regulations
    3. Every APP will be credentialed for this privilege separately from the specialty request.
    4. Every physician in the group requesting this model will need to be credentialed for Telemedicine.
c. Requirements for Alternative Consultation
    1. All consults by the APP require a conversation between the APP completing the consultation and the supervising physician within 24 hours. A conversation to include a video telemedicine visit between the supervising physician and the patient is required unless one of the exceptions below are met:
        i. If an optimal video consult technology is unavailable, then a phone conversation between the physician and the patient is acceptable.
        ii. Specialties may choose to propose three to five diagnoses of lower acuity and complexity which may be excluded from the video consult requirement.
    2. APP consult documentation must include name of the supervising physician. Both physician and APP should use their respective smart phrase: .APPAC (438467) and .PHYSAC (438468).
    3. Alternative consults are not allowed in the event the patient or physician requesting the consult specifies “physician-only” response. If at any time during the admission there is need for physician involvement based on a request of the admitting physician or the patient, then the physician is expected to respond for face-to-face consultation.
    4. APP should introduce themselves to the patient including appropriate credentials and inform the patient which physician is serving as the supervising physician for that encounter and inform the patient that they have the right to request to see that physician.
d. Definitions:
    1. Alternative practice of APPs: APPs providing face to face visit with patient and supervising physician providing a video telemedicine consultation within 24 hours
    2. Video visit: physician video visit with patient after initial APP consult
    3. Supervising physician: the physician that is responsible for the care provided by the APP in the specific encounter of care. They will also be the physician attesting the APP note.
    4. Sponsoring physician: the physician of note approved by Credentials.

C. Process for Changing Physicians for Hospitalized Patients

Parkview Medical Staff recognizes that circumstances may occur where patients or physicians may no longer wish to continue the patient-physician relationship. When these difficult circumstances occur, it is critical to manage them as professionally as possible to prevent any erosion of relationship between the patient, physician, and/or nursing staff or loss of confidence in the other care providers associated with the case. The following procedure must be followed to ensure continuance of appropriate patient care and the medical staff member's compliance with the responsibility to assure such care. Under no circumstances should a staff nurse be placed in an intermediary role between the patient and the physician(s).

1. The patient or physician must state that they no longer wish to continue the relationship.
2. The decision must be documented in the medical record.
3. Physician or nurse notifies house supervisor of the situation and the precipitating circumstances.
4. In turn, the house supervisor notifies the Chief Medical Officer for assistance in securing physician coverage for the patient.
5. The patient must be asked if they have a request for a specific physician to assume their care.
6. The CMO will contact appropriate alternative physician(s), considering the desires of the patient, until a new physician has indicated their willingness to assume care. As appropriate, the CMO may contact the Hospitalist on duty and/or Specialty Representative for assistance. When transfer of care is accepted by the new physician, this acceptance is documented on the chart. Ideally, the exiting physician provides report to the accepting physician.
7. The original physician may be contacted for orders of an urgent nature until an accepting physician has documented his or her acceptance on the chart.

It is not appropriate to force patients to change physicians against their will. If the physician is uncomfortable with the relationship, the patient shall be given 30 days' notice of the physician's intent to no longer provide care. During this time the physician will continue to provide appropriate care, unless or until another physicians assumes care. This would apply to cases in which the patient is not willing to consent to treatment plans outlined by the physician but does not wish to change physicians. If there is an ethical issue involved, the Ethics Committee may be consulted for an ad hoc meeting to make recommendations.

D. Hospitalists Service

The purpose is to set reasonable expectations for admission by Parkview Hospitalist Service.

<u>Inpatient Transfer of Care after Admission</u>

Parkview Hospitalists will accept all adult patients referred from the Emergency Department and from referring facilities after communication with an Emergency Physician or another referring physician.

Care will be provided from admission to discharge, unless a transfer of care is mutually agreed upon between an admitting physician and a consultant on a patient followed together, after the patient or representative of the patient is personally notified of the transfer of care by the admitting physician.

A transfer of care to the Hospitalist service through a verbal or written order hours or days after admission, without physician-to-physician communication and without clear communication to that effect to the patient or patient's representative, is considered suboptimal and a deviation from standard of care.

Upon receiving such request from a non-physician third party such as a floor nurse, the Hospitalist will ask that the referring physician directly communicate with the Hospitalist before a transfer is accepted to the Hospitalist service. If such a communication is not received within 30 minutes, the Hospitalist will attempt to contact the referring physician through the operator. After obtaining clear objectives of transfer of care, the Hospitalist will ask that the patient or patient's representative be notified by the referring physician about the planned transfer of care before care is assumed by the Hospitalist service.

If the referring physician cannot be reached within one hour of such referral or if the Hospitalist otherwise deems it necessary to assume care without proper communication for the best interest of an unstable patient, the Hospitalist will assume care of the patient, and this deviation from standard of care will be referred to a medical staff officer or other appropriate medical staff leader.

Inpatient Consult Response Time

Upon notification of an inpatient consult request, the Parkview Hospitalist Service will complete the consultation within six hours. A consult requested between midnight and 7:00 AM will be completed between 7:00 AM and 11:00 AM.

A consultation for a patient requiring more urgent or immediate attention will require a personal or telephone conversation - from THE PHYSICIAN requesting the consult to the Hospitalist - explaining the circumstances and reason for urgent evaluation of the patient.

Direct Supervision of Outpatient Therapeutic Services at Parkview Hospital - Randallia

Hospitalist must be immediately available, physically present and able to furnish assistance and direction throughout the performance of the procedure as required by the Centers for Medicare and Medicaid (CMS). Impacted services include, but may not be limited to observation services, outpatient infusion therapy services and blood transfusion services.

E. Patient Visit by Advanced Allied Health Practitioners in Place of Physician Daily Visit

In accordance with Medical Staff Bylaws and Policy, the physician may request an Advanced Practice Provider (APP) who has been granted privileges as an Advanced Practice Provider at Parkview Hospital to visit hospitalized patients of the Sponsoring physician in place of the physician. Advanced Practice Providers at Parkview Hospital is defined as an APP credentialed at Parkview Hospital in one of the following categories: Advanced Practice Nurses (NP, CNM, CNS) Physician Assistant-Certified (PA-C), Neuropsychologist.

1. Request for substitute visit in place of the physician daily visit may not be appropriate for certain units (pediatric and neonatal intensive care, for example), and such requests must include guidelines for medical practice to be considered. Other requests for substitute visit will be reviewed by Officers as they are identified, for consideration of approval to request these privileges. It is noted, however, a patient being discharged from the ICU may be seen by the APP without a physician visit the day of discharge.
2. The attending/sponsoring physician must visit the patient at a minimum of every other day and is responsible for the initial visit and admitting History and Physical examination.
3. This privilege must be requested by both the sponsoring physician and the APP by completing the applicable section of the APP privilege form.
4. The attending/sponsoring physician must attest to the competency of the applicant to visit the patient within their scope of practice and privileges.
5. All requests are subject to review by the applicable specialty representative for appropriateness and suitability to the specialty and patient need. Upon recommendation by the specialty representative, the request is to be forwarded for review by the Credentials Committee and Medical Staff Executive Committee and approval by the Board of Directors.
6. Visits by APPs are subject to ongoing monitoring by the Parkview Hospital Quality Review Department.

For the Psychiatry subspecialty

1. A board-certified, advance practice provider, trained in Psychiatry (such as a Psychiatric NP or PA) can be assigned to daily inpatient hospital follow-up for patients deemed appropriate by the Attending Psychiatrist.
2. The Psychiatrist must do the admission assessment and provide daily care for complex patients.
3. During hospital course, the Psychiatrist must coordinate with the Psychiatric NP or PA on the assigned cases and review during inpatient unit treatment team meetings.
4. On the day of discharge, the Psychiatrist must see the patient and do the discharge assessment if APP saw more than 2 consecutive days.

F. EPIC Training

Purpose is to advance proficiency in navigating the electronic medical record in the EPIC system, the Parkview Hospital Medical Staff has established the following training requirements:

1. To be issued a username and password and have the ability to practice as a member of the Medical Staff at Parkview Hospital (including its locations at any of the following: Parkview Hospital Randallia, Parkview Regional Medical Center and Parkview Behavioral Health), a minimum of ten (10) hours of classroom training in inpatient EPIC training is required prior to initial EPIC implementation date.
2. To the extent that it is determined that a Medical Staff member needs to devote additional time to navigating the electronic medical record for either the inpatient EPIC training or the physician office EPIC training, then the Medical Staff member shall devote such additional time to education as is required for the Medical Staff member to demonstrate proficiency and to ensure competent operation within the EPIC system.

G. Waiver of Requirement for Covering Physician

Waiver of the requirement to provide the name of a covering physician may be granted. Waiver may be reviewed by Medical Staff Officers or Divisions to determine appropriateness and must be approved by the Medical Staff Executive Committee. Consulting physicians in the following specialties, and telemedicine providers, are not required to provide a covering physician: allergy/immunology, dermatology, general dentist, endocrinology, medical genetics, rheumatology.

III. SPECIALTY SPECIFIC INFORMATION

A. Anesthesia

Responsibilities of each anesthesiologist in the hospital should routinely:

1. Make pre-anesthetic evaluations and will write a pre-anesthetic summary that shall include examination of patients to determine the degree of surgical risk, type of anesthesia to be administered, known drug allergies, and an evaluation of the patient's physical status, labs, and pre-operative sedation.
2. Anesthesiologists will utilize the pre-anesthesia orders on their surgical patients, unless otherwise ordered by the anesthesiologist. Pre-anesthesia orders will be placed on all surgical charts, initiated as a standing order from the Anesthesia Committee, and completed by Nursing. Pre-anesthesia orders will be signed by the individual anesthesiologist within 48 hours.
3. Advise and consult with attending physicians regarding the patient's general condition and risk involved.
4. Utilize monitoring equipment as per ASA standards, administer anesthetic in a manner prescribed by general medical standards, and help positioning of patient as surgical procedures mandates.
5. Observe anesthetized patient for adverse reactions and initiate remedial measures.
6. Maintain record of anesthetic administered, record condition of patient prior to and throughout perioperative period, order immediate post-anesthetic medications, record condition of patient in the Recovery Room.
7. For surgical procedures where anesthesiology services are utilized, the anesthesiologist will be physically present for the entire perianesthetic period, except in the most unusual circumstances.
8. The anesthesiologist administering anesthesia shall remain in the PACU in attendance of the patient until the patient is ready for transfer to the care of the recovery room nurses and shall give a verbal report to the nurse. When the admitting or attending physician or surgeon is not immediately available, the anesthesiologist will undertake the care of the patient (in the interim) until the attending (primary) physician can be notified and can assume the care of his/her patient.
9. The anesthesiologists will manage and treat anesthesia-related complications of which they are aware or which are reported to them. All other complications are the responsibility of the attending physician.
10. The attending anesthesiologist may be consulted by PACU nurses before analgesic or sedative drugs are administered to patients recovering from anesthesia.
11. All inpatients to whom anesthesia care has been administered from the PACU may be discharged by nursing to the floors, using the criteria established by the Anesthesia Specialists or upon order of the anesthesiologist or surgeon. Outpatient may be discharged using this same criteria. Endotracheal tubes may be removed by Recovery Room nursing staff when Anesthesia Department criteria are met or when so ordered by the anesthesiologist.
12. ICU, NICU, or NICN patients will generally be recovered in the ICU, NICU, or NICN unless the anesthesiologist feels the patient is too unstable to transfer.
13. A mutual understanding should exist between the primary surgeon and anesthesiologist regarding appropriate timing of patient induction. This understanding may be implied based on standard practice, or may be specific to a given case as related through operating personnel. If uncertainty exists, it is essential that the surgeon and anesthesiologist interact directly.

    Reference Surgery Section H - Required Testing Prior to Sedation-Anesthesia

B. Diagnostic Imaging/Radiology

Diagnostic Imaging services shall be available to meet the needs of patients referred by the Medical Staff. Radiologists shall be available for consultation and interpretation in person or telecommunication 24 hours per day, 7 days per week and shall respond promptly to requests for emergency services. All requests for imaging services shall contain adequate medical reason for the procedure ordered. All imaging procedures shall have a written interpretation produced in a prompt and orderly fashion by a physician.

Requests for multiple imaging services shall be scheduled by the Radiologist in the appropriate sequence to assure proper patient care without unnecessary delay.

The Medical Director or his designee shall have ultimate authority for scheduling emergency procedures.

Requests for invasive procedures (i.e. angiography, biopsy, drainage) shall be accompanied by appropriate consultation between referring physician and performing physician. Reports of consultations and interpretation of procedures shall be included in the patient's medical records. Documentation of appropriate laboratory values and/or medications shall be available prior to the performance of the imaging procedure. Consent forms shall be completed for indicated procedures.

The parental administration of iodinated contrast or radionuclide in the Department shall require:
1. Approval of a Radiologist and the presence of supervising physician in the hospital.
2. Completion of consent forms when indicated.

C. Emergency Department

Coverage

At all times there will be a primary attending physician on duty in the Emergency Department who is board certified, or by reason of education, training, and experience is judged admissible to sit for board examination, and possesses Type I Emergency Medicine privileges. There may be a second attending emergency physician as previously defined that has either Type I or Type II privileges. There may be a licensed Physician's Assistant on duty practicing under a supervising physician and in accordance with State law, I.C. Articles 25-27 et. sec. The Physician Assistant must be authorized as an Allied Health Practitioner under the direct, on-site supervision of an attending emergency physician.

The attending emergency physician will treat all critical patients and those requiring immediate attention, and to render emergency treatment at his/her discretion. The attending physician will be responsible for the management of all emergency department patients unless prior arrangements have been made.

The emergency department primary physician is responsible for the approval of all helicopter transports. The same person is also responsible for the medical direction given each patient while under the care of the helicopter transport team that is outside of the protocols that are established by the medical director of the transport program.

Use of Emergency Department by Other Medical Staff Members

Any Medical Staff member may utilize the emergency department to see pre-arranged private patients, when beds are available, provided the staff member is practicing within the normal scope of their practice as defined by their clinical privileges. Patients may be asked to remain in the waiting area during busy times. Physicians are discouraged from performing lengthy procedures that utilize beds or nursing time (i.e. blood transfusions, recovery from anesthesia, etc.). Some beds in the ED may be designated for outpatient procedures and tests. The ED physician will not have responsibility for these patients, as the care of these patients remain the responsibility of the ordering physician.

Physician extenders seeing patients for emergency admission must have direct supervision of the admitting physician or attending emergency physician, as described in their Scope of Practice.

Privileges to evaluate and treat patients in the trauma section of the Emergency Department shall be defined by the attending physician's privileges. Parkview Hospital and its staff maintain very high standards for care in the Emergency Department, and these are expected to be maintained by any physician caring for patients in the emergency department. When a physician asks a patient to meet them in the Emergency Department, the physician should call the department and leave instructions. Requests by patients to have their personal physician called to evaluate and treat them in the department will be honored by the emergency department staff after appropriate EMTALA requirements are met.

Admission and Referrals

Communication is very important to everyone if our patients are to receive timely and appropriate care. The emergency physician will contact any local family physician for all admissions and referrals of their patients as directed by their physician preference. They may also be contacted for follow-up if the emergency physician feels it is appropriate and would be in the best interest of the patient and or physician.

The attending physician is to be notified at the time of admission by the Emergency Department. If he/she is signed out, it is his/her alternate's responsibility to inform him.

Primary care physicians whose patients are admitted to the hospital through the ED will be contacted through the exchange, radio page, home or to who is taking their calls.

Consulting providers should engage in a peer-to-peer discussion to share their recommendations after evaluating the patient in the emergency room.

When the attending physician is notified and the patient is admitted, the patient becomes the attending physician's responsibility. If the patient remains in the ED waiting for bed placement, it is the responsibility of ED nurses on duty to notify the attending physician of a change in the patient's condition. If requiring immediate attention, the emergency physician will be notified and evaluate the patient.

Direct admits that come to or through the emergency department will not be seen by the ED physician unless the patient's condition as determined by nursing personnel dictates that they be seen immediately and the attending physician is not immediately available. Those patients going to the CCU or ICU will proceed as soon as the condition allows.

D. Obstetrics

Parkview Randallia

The Parkview Hospital Randallia campus will function as a Level I for Obstetrical Care and Level I for Neonatal Care. As such, guidelines for admission and transfer of patients to and from that unit will be consistent with the guidelines within Indiana Perinatal Standards, latest revision 2015, and within the departmental Admission/Transfer/Discharge criteria.

The hospitalist team will care for unattached patients presenting to the Parkview Randallia campus. Care for that patient will continue to be the responsibility of the hospitalist team until discharge of the patient.

Family practice residents are encouraged to be involved in the above patients care unless they are otherwise unavailable. However, they can only assist in the management of the patient. The OB hospitalist is is still the responsible party.

Parkview Regional Medical Center

The Parkview Regional Medical Center campus will function as a Level III for Obstetrical Care and Level III for Neonatal Care. As such, guidelines for admission and transfer of patients to and from that unit will be consistent with guidelines within the Indiana Perinatal Standards, latest revision 2015, and within the departmental Admission/Transfer/Discharge criteria.

Unattached Patients: The OB hospitalist shall be required to participate in a rotational list assigning responsibility for unattached obstetrical patients.

An unattached patient may be:

1. a current pre-natal patient of any clinic or provider that does not have Parkview Hospital Medical Staff privileges.
2. a Neighborhood Health Clinic patient presenting at Parkview Regional Medical Center.
3. any patient who presents with an obstetrical problem who has had no care for her pregnancy to date.

Unattached patients will be cared for per the OB hospitalist. The physician on call is responsible for the care of that patient until she is discharged from the unit. This may be ante-partum or post-partum/post-op

Family practice residents on OB call are encouraged to be involved in the above patients care unless they are otherwise unavailable. However, they can only assist in the management of the patient. The OB hospitalist is still the responsible party.

Care Recommendations: For the protection of patients cared for in the Obstetrics and Women's Health Units of Parkview Regional Medical Center and Parkview Hospital Randallia, the following guidelines are a non-exclusive list of approaches recommended by those practicing in Obstetrics at Parkview:

Clinical and Administrative Guidelines for Obstetrical Patients

1. Physicians will be notified within 45 minutes of the admission of a laboring patient unless the patient has been scheduled for admission.
2. Oxytocin rates will not exceed 30 miliunits/minute with a live, undelivered baby.

3. Ergot preparations are to be administered only during or after the delivery of the baby.
4. In the event a patient's physician or his alternate is not available at the time of delivery, any member with obstetric privileges will be immediately contacted. Family Practice residents may respond as well to precipitous deliveries.
   Note: Any member with delineated clinical privileges may provide emergency care to any patient in a life-threatening emergency or a situation that threatens serious harm, provided that the care provided is within the scope of the individual's license.
5. Consultation with a board certified or board eligible obstetrician is required by a delivering physician that does not have C-section privileges for:
   a. breech presentation for vaginal delivery (planned vaginal breech deliveries are not permitted)
   b. previous C-section planning vaginal delivery
   c. multi-fetal gestation
   d. first C-section without a trial of labor and cephalic presentation
6. For all C-sections with the infant at high risk; i.e., fetal distress, prematurity, multiple gestation, a neonatologist will be available for consult. Attendance at birth will be determined jointly between attending physician and neonatologist.
7. For all C-sections where the fetus is not deemed at risk; i.e. repeat C-section, CPD, FTP, breech, a physician or qualified NICU personnel trained in infant resuscitation will attend the infant.
8. Typing for Rh and antibodies screen is to be done on every woman admitted for a pregnancy related problem who does not have documentation of type and Rh for current pregnancy.
9. Patients' HBSAG results from the prenatal record or inpatient stay must be available within 12 hours of delivery of the infant. In the event that maternal status remains unknown or unconfirmed, the newborn protocol will be followed for initiation of hepatitis immunization.
10. Mothers of stillborn infants, infants who have died, or infants being adopted may be transferred to another patient care area.
11. Patients must be NPO for eight (8) hours prior to elective surgery unless otherwise ordered by the anesthesiologist.
12. Requests for siblings/children to attend normal vaginal deliveries will require
    a. approval of the physician performing the delivery
    b. the child to be a minimum of eight (8) years of age
    c. an adult must be present to supervise and manage the child
13. Guidelines for Induction:
    a. Elective induction or elective/repeat cesarean section requires documentation of 39 weeks of pregnancy confirmed by ACOG Criteria or MFM physician recommendation:
       1) fetal heart tones have been documented for 20 weeks by non-electronic fetoscope or for 30 weeks by Doppler
       2) it has been 36 weeks since a positive serum or urine HCG pregnancy test was performed by a reliable laboratory
       3) An ultrasound measurement of the crown-rump length, obtained at 6-12 weeks, supports a gestational age of at least 39 weeks
       4) An ultrasound obtained at 13-20 weeks confirms the gestational age of at least 39 weeks determined by clinical history and physical examination
    b.
    c. Inductions at less than 39 weeks require:
       1) ACOG mandated medical indication
          a) abruptio placentae
          b) chorioamnionitis
          c) fetal demise
          d) pregnancy-induced hypertension
          e) premature rupture of membranes
          f) maternal medical conditions (i.e. diabetes, renal disease, chronic pulmonary disease, chronic hypertension)
          g) fetal compromise (i.e. severe fetal growth restriction)
          h) isoimmunization, unfavorable cord doppler
          i) pre-eclampsia, eclampsia
       2) a "mature" amniocentesis will no longer be acceptable to perform an elective induction before 39 weeks
    d. Indication for induction to be documented on chart

14. VBAC (Vaginal Birth After Cesarean) Guidelines:

Inclusive Criteria to assist physicians in decision for VBAC (Vaginal Birth After Cesarean) delivery:

a. No more than two prior low-transverse cesarean deliveries
b. clinically adequate pelvis
c. no other uterine scars or previous rupture
d. Physician must be physically present on-site, or have informed the OB hospitalist for back-up coverage, throughout active labor and capable of monitoring labor and performing emergency cesarean delivery
e. availability of anesthesia and personnel for emergency cesarean delivery

Exclusive Criteria to assist physicians in decision for VBAC (Vaginal Birth After Cesarean) delivery:

a. prior classical or T incision or other trans-fundal surgery
b. contracted pelvis
c. medical or obstetric complication that precludes vaginal delivery
d. inability to perform emergency cesarean delivery because of unavailable surgeon, Anesthesia, sufficient staff, or facility

Prohibited in management of a viable fetus

prostaglandins

Appropriate measures to be taken at time of admission

a. confirm with the patient (with designated form in chart)* and admitting physician patient's desire to VBAC
b. appropriate counseling documented on chart at time of admission
c. obstetrician responsible for emergency identified and notified on admission
d. anesthesia notified on admission

15. Day of Discharge Visit

In the occasional situation where a newborn is ready for discharge, but Mother has not yet been seen by a physician that day, discharge may occur if the following criteria are met:

a. Mother's delivery was uncomplicated; and
b. Mother's condition has not deteriorated in the past 18 hours; and
c. Mother has been seen daily by a physician since delivery; and
d. Progress notes document a detailed plan for follow up care in lieu of a daily physician visit prior to discharge.

E. Inpatient Palliative Care

Alternative Consult Model for Palliative Care: Patient Encounters by Advanced Allied Health Practitioners in place of Physician Consult

The palliative care physician may request an Advanced Practice Provider (APP) who has been granted Alternative Consult privileges to visit hospitalized patients of the supervising physician in place of the physician.

Existing Palliative Care APPs will become certified as Advanced Certified Hospice and Palliative Nurses. All new APPs hired into the Palliative Care Service will be required to become certified within 3 years of eligibility.

1. A palliative care physician must participate in interdisciplinary team meeting on weekdays and be available to APPs to review cases, assist with patient care, and develop care plans as needed.
2. A palliative care physician must validate the competency of the APP within their scope of practice.
    a. Competency is evaluated upon completion of orientation and annually thereafter.
3. APPs musts be individually credentialed for this Alternative Consult privilege at the recommendation of their sponsoring physician.
4. Patient encounters by APPs are subject to ongoing monitoring by the Parkview Hospital Quality Department.

Consultations and Subsequent Encounters

Physicians and/or APPs may see inpatient consults and follow patients during their hospitalization as deemed appropriate for the scope of palliative care:

1. Physicians will see new consults and make follow-up patient encounters based on patient complexity.
2. Physicians will attest to new consults by an APP based on patient complexity and/or payor requirements.
3. Physicians will cosign all APP notes.
4. Physicians will be available for case conference with palliative care APPs as needed.
5. Physicians will participate in weekday interdisciplinary team meetings.
6. A palliative care physician is available for APPs to consult with 24/7.

F. Pathology

The Pathology Department is under the direction of the Pathologist-Director and, as such, is responsible for the department's operation, including quality control, test result accuracy and professional standards of the personnel. Director is responsible for maintenance of standards established by the College of American Pathologists, Joint Commission, and Indiana State Board of Health.

The Pathology Department will bring forth recommendations on a regular basis regarding Transfusion Practice and Policy, Criteria for Autopsy, and Gross Tissue Exemption List for review and recommendation of Division Leadership Committees, and Medical Staff Executive Committee (Addendum A attached).

Physicians are encouraged to make comments, good or bad, directly to the Pathologist-Director. All comments should be made as soon as possible after the event in questions so that appropriate action may be taken. If the physician is not satisfied with the Pathologist-Director's action, then the matter should be brought before the appropriate Medical Staff Committee.

The laboratory encourages preadmission testing. All patients are encouraged to report to the laboratory at least 24 hours prior to admission.

Since autopsies are the basis for quality assurance, physicians are encouraged to obtain and attend autopsies. If physicians have special requests, please either document on the Autopsy Request form or contact the Pathologist.

Therapeutic drug monitoring is encouraged. All stat requests should be justified. Unnecessary stat tests are to be discouraged.

Physicians are encouraged to consult directly with the pathologists if an abnormal test result is questioned.

Specimen Handling

Reference Tissue Exempt List and Gross Only List

All specimens sent to the laboratory should be properly labeled individually, and accompanied by a requisition form. Information required for a proper label consists of patient name, hospital number, room number and attending physician's name. Improperly labeled specimens will not be accepted. The names of consult-physicians who need a report should appear on the requisition form. In doing this, the patient's safety will not be jeopardized in any way.

The Parkview Health laboratory will perform all tests requested. If certain tests are not available, the pathologist will determine the reference laboratory. Requests for special handling or special tests should be addressed to the pathologist. "Split sample" tests are considered in the latter category and after consultation with the pathologist should be sent to the laboratory for "splitting."

The surgical request slip accompanying the tissue specimen should be completely filled out, especially the information regarding previous surgery, preoperative diagnosis and findings.

All tissues, foreign bodies, calculi, etc., removed at operation shall be sent to the hospital pathologist, who shall make such examination as he may consider necessary to arrive at a pathologic diagnosis, and record same on the patient record. The surgeon shall have the discretion to recommend that "no microscopic examination be performed" noted on the specimen. In the clinical lab we acknowledge that the physician may request not to have the written consultation or interpretation associated with the test. If the physician so wishes, the written consultation or interpretation will be forgone.

G. Pediatrics

Reservations for admission are made with the admitting office. When beds in Pediatrics are available, patients up to 18 years of age must be accommodated. At the discretion of the physician, teenagers may be admitted to an adult service. Acutely ill children have priority over elective surgeries and admissions. Cancellation of elective cases may be done by the pediatric patient care manager when absolutely necessary.

Weights and blood pressure of children will be taken on admission and weekly unless otherwise ordered. Patients' weight in kilograms will be placed on all initial order sheets. Growth charts to be done on all admissions.

On the Pediatric Unit temperatures will be taken as per nursing guidelines unless otherwise directed by the physician. In Intensive Care Nursery and Newborn Nursery, axillary temperatures will be taken on all infants and

children. In the Pediatric Intensive Care Unit the mode of taking temperatures will be determined by the physician caring for the patient and/or policies established by the Pediatric Intensive Care Unit.

Reportable contagious diseases will be reported to the County Board of Health by the infection control nurse when diagnosis is established.

All IV's will be on a pump.

Visiting hours on the Pediatric Unit will be individualized to support family focused care.

Protocol for routine emergency treatment of infants in Intensive Care Nursery, Newborn Nursery, Pediatric ICU, and Pediatrics are available in Patient Care Policies and Procedures.

Any parenteral medication dose which is calculated by nursing shall be checked by two (2) nurses before administration. This will include medications from multiple dose vials and titrated medication infusions.

If stable, infants should be at least 12 hours of age to undergo circumcision. If the patient is younger than 12 hours the physician must justify the decision in writing for placement in the patient's chart. Documentation of a circumcision procedure will include a brief Progress Note and the name and date of the procedure on the summary sheet.

Management of ventilators in Pediatric ICU and NICU will be defined by the appropriate subcommittees/policy statements.

A newborn examination by the infant's physician must be done prior to discharge and documented in the patient's chart. In the occasional situation when a newborn is discharged with mom before a physician visit, the progress notes must document a detailed plan for follow up care in lieu of a physician visit prior to discharge.

Any prior admission will automatically be ordered to the floor for all pediatric and PICU admissions.

H. Psychiatry

Consults:
A credentialed Advanced Practice Provider (APP) in Psychiatry may respond on behalf of the psychiatrist to an inpatient consult request of minimal psychiatric complexity. The psychiatrist will determine, based on collaboration and clinical judgment, whether the patient seen by the APP should also be seen by the psychiatrist face-to-face. All consults by the APP must be reviewed and co-signed by the psychiatrist.

Such consults to be of minimal psychiatric complexity, such as:

1. evaluation for antidepressant treatment
2. restarting psychiatric medications
3. follow up on patients' response to treatment
4. adjustment disorders not requiring further inpatient treatment or pharmacotherapy
5. evaluation of behavioral problems
6. assessment and recommendations for treatment of uncomplicated substance use disorders

<u>Medical Record Documentation</u>
Reference Inpatient Medical Records Completion Regulations

1. Psychiatric Evaluation must be completed by a physician within 24 hours of admission
2. Progress Notes must include:
    a. acknowledgment of medical H&P findings
    b. rationale for adjustments to drug regimen
    c. clinical indications for initiating specific drug regimen
    d. problem
    e. goal or intervention from ITP being evaluated or successful completion
3. Physician Orders reflect: prescribed treatments are concordant with documented exam findings and history
4. Electroconvulsive Therapy (ECT) is conducted in accordance with the American Psychiatric Association Task Force Guidelines (Second Edition, 2001), and per PBH ECT Policy and Procedure

<u>Suicide Precautions</u>
When suicide precautions (SP) are ordered for adult patients, the following procedure is to be followed:

1. The order for suicide precautions will be ordered by the admitting and/or attending physician.

Physicians will actively participate in Individual Treatment Planning sessions

Transfers of psychiatric patients from other areas of the hospital will be prioritized on the basis of clinical needs with the other admission requests. An order to admit to Parkview Behavioral Health must be written on the chart.

Patient Visit by Advance Practice Providers (NP/PA) for Daily Visit

1. See section II.E.

I. Surgery

The scope and extent of surgical procedures performed by dentists, and podiatrists shall be specifically delineated and granted in the same manner as all other surgical privileges. All dental or podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician member of the Medical Staff shall be responsible for the admission of any patient under the care of a podiatrist or dentist. A physician member of the Medical Staff may be responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization.

No one shall be permitted to observe or work in the operating rooms beyond the retracting doors unless properly garbed with cap, mask, gown or special shirt and trousers, and operative shoes or shoes with shoe covers, most of which are provided by the hospital. Guests are to be authorized according to policy.

In all cases of major operation, it shall be the decision of the surgeon as to whether a physician assistant should be used. No operative procedure shall be done in this hospital which does not conform to general staff rules. A physician declaring a life- or limb-threatening emergency will be given priority for assignment of an operating room and anesthesia.

Scheduled operations that are not started on time without good reason may be canceled by the operating room supervisor, if in her opinion the delay would seriously interfere with completion of the remaining cases for the day. In cases where there is unavoidable delay in meeting a scheduled operation, the individual responsible for that delay is also responsible for notifying all parties involved.

Therapeutic abortions will not be done unless the OB/GYN Department has a written approval of the procedure on the patient's chart before operation. Sterilization procedures that meet criteria adopted by the medical staff may be performed without committee approval. In cases of emergency, sterilization may be done with mandatory subsequent referral to the committee, regardless of indication. Any sterilizing procedure in patients under age 18 should have approval of the OB/GYN Department. Hysterectomy for primary sterilization only will not be done regardless of age. The cases will be handled on an individual basis for extenuating circumstances.

A mutual understanding should exist between the primary surgeon and anesthesiologist regarding appropriate timing of patient induction. This understanding may be implied based on standard practice, or may be specific to a given case as related through operating personnel. If uncertainty exists, it is essential that the surgeon and anesthesiologist interact directly.

Test	Indications	Age, If Appropriate	Comments
Urine Pregnancy	Menstruating Females, unless history of surgical sterilization		Within 5 days of surgery
Hemogram	Scheduled hysterectomy, if menstruating or recent bleeding		
ECG	Hx of heart disease, hypertension, renal disease, diabetes, smoking	51 or greater	General or spinal epidural anesthesia, ECG's done in previous 3 mos are acceptable, if symptomatic redo ECG. For all other anesthesia, ECG w/in 12 mos is acceptable.
ECG		60 or greater	
BUN, Creatinine, Hemogram	Major joint, intra-abdominal, intra-thoracic, all vascular OR hx of renal dysfunction, anemia, cancer, or bleeding IF receiving general or spinal/epidural anesthesia		
INR/PT	Hx of DVT or current anticoagulant use.		
Serum K+	Pts taking diuretics or dialysis.		

All elective surgery patients requiring moderate sedation, major block (epidural, spinal or arm, etc.) or general anesthesia, shall show on the record the following routine laboratory work outlined in the table above unless otherwise ordered by the physician.