RULES AND REGULATIONS

OF

THE MEDICAL STAFF OF _________Hospital

___________, West Virginia

A. ADMISSION AND DISCHARGE OF PATIENTS

1. The hospital shall accept patients for care and treatment except for the following categories:

   a. Admitted only on an emergency basis - contagious diseases.
   b.---
   c.---

2. A patient may be admitted to the hospital only by a member of the medical staff. All practitioners shall be governed by the official admitting policy of the hospital.

3. A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

4. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

5. In any emergency case in which it appears the patient will have to be admitted to a hospital, the practitioner shall, when possible, first contact the admitting office to ascertain whether there is an available bed.

6. Practitioners admitting emergency cases shall be prepared to justify to the executive committee of the medical staff and the administration of the hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

7. A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable service to attend him or her. Where no such selection is made, a member of the active or associate staff on duty in the service will be assigned to the patient, on a rotation basis, where possible. The chief of each service shall provide a schedule for such assignments.

8. Each member of the staff who does not reside in the immediate vicinity shall name a member of the medical staff who is resident in the area who may be called to attend his or her patients in an emergency or until he or she arrives. In case of failure to name such associate, the chief executive officer, president of the medical staff, or chief of the service concerned, shall have authority to call any member of the active staff in such an event.

9. The medical staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and proper review thereof. These shall be developed by each clinical service and approved by the executive committee.

10. The chief admitting clerk will admit the patients on the basis of the following order of priorities:

    (a) Emergency Admissions

    Within 48 hours following an emergency admission, the attending practitioner shall furnish to the professional activities committee a signed, sufficiently complete documentation of need for this admission. Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the executive committee for appropriate action.

    (b) Urgent Admissions

    This category includes those so designated by the attending practitioner and shall be reviewed as necessary by the professional activities committee to determine priority when all such admissions for a specific day are not possible.

    (c) Pre-Operative Admissions

    This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the <u>Chief of Staff</u> may decide the urgency of any specific admission.

    (d) Routine Admissions

    This will include elective admissions involving all services.

11. Patient Transfers

Transfer priorities shall be as follows:

(a) Emergency room to appropriate patient bed.
(b) From Obstetric patient care area to general care area, when medically indicated.
(c) From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient.

No patient will be transferred without such transfer being approved by the responsible practitioner.

12. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatever.

13. For the protection of patients, the medical and nursing staffs and the hospital, precautions to be taken in the care of the potentially suicidal patient include:

(a) Any patient known or suspected to be suicidal in intent shall be admitted to the surgical area. If there are no accommodations available in this area, the patient shall be referred, if possible, to another institution where suitable facilities are available.

(b) When transfer is not possible, the patient may be admitted to a general area of the hospital, and, as a temporary measure, bars or locks may be placed on the windows of the patient's room and special nursing companionship provided. Such patients should spend the daytime hours in the area where special observation and therapy are available.

14. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the professional activities committee of this hospital, and approved by the executive committee of the medical staff. This documentation must contain:

(a) An adequate written record of the reason for the continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
(b) The estimated period of time the patient will need to remain in the hospital.
(c) Plans for post-hospital care.

Upon request of the professional activities committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized 12 days or longer, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within 24 hours of receipt of such request. Failure of compliance with this policy will be brought to the attention of the executive committee for action. Any patient remaining in the hospital over two

months must have the stay approved by the executive committee of the medical staff and by the chief executive officer.

15. Patient shall be discharged only on a written order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

16. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to the release of dead bodies shall conform to local law.

17. It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 72 hours and the complete protocol should be made a part of the record within three months.

B. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current. This record shall include identification data; complaint; personal history; family history; history of present illness; social history and allergies, physical examination; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note (clinical resume); and autopsy report when performed.

2. A complete admission history and physical examination shall be recorded within 24 hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed prior to the patient's admission to the hospital, a reasonably durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the medical staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded. Pre-operative history and physicals may be performed and recorded up to one week prior to the scheduled operation, however, on admission the physician must note that there are no changes in the patient's condition. Also pre-operative routine laboratory work may be completed in the same time frame as listed above for the pre-operative history and physicals.

3. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

4. The attending physician shall countersign (authenticate) the history and physical examination and pre-operative note when they have been recorded by another member of the staff.

5. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problem.

6. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be written or dictated within 24 hours following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record. Any practitioner with undictated operative reports 72 hours following the day of the operation shall be automatically suspended from operative privileges except for any inpatients who have already been scheduled for surgery.

7. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

8. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

9. All clinical entries in the patient's medical record shall be accurately dated and authenticated.

10. Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of approved abbreviations should be kept on file in the record room.

11. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

12. A discharge summary (clinical resume) shall be written or dictated on all medical records of patients hospitalized over 48 hours except for normal obstetrical deliveries, normal newborn infants, and certain selected patients with problems of a minor nature. These latter exceptions shall be identified by the executive committee of the medical staff, and for these, a final summation-type progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and result. All summaries shall be authenticated by the responsible practitioner.

13. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

14. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital. In case of re-admission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the executive committee of the medical staff.

15. Free access to all medical records of all patients shall 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 patients. All such projects shall be approved by the executive committee of the medical staff before records can be studied. Subject to the discretion of the chief executive officer, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

16. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the professional activities committee.

17. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated and signed by the practitioner.

18. The medical record shall be completed by the physician within thirty (30) calendar days after discharge of the patient. In the case of adverse events or the death of a medical practitioner, all said medical records will revert to the Chief of Staff for completion.

    If not completed, the physician's admitting privileges may be suspended after being notified by the administrator, and physician shall not be allowed to admit or treat patients until his incomplete records are all completed. Repeated infractions of this regulation shall be cause for review of the physician's staff privileges by the Medical Executive Committee.

C. GENERAL CONDUCT OF CARE

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

2. All orders for treatment shall be in writing. a verbal order shall be considered to be in writing if dictated to a duly licensed registered nurse functioning within her sphere of competence and signed by the responsible practitioner. All orders dictated over the telephone shall be signed by the appropriately authorized licensed registered nurse to whom dictated with the name of the practitioner per his or her own name. The responsible practitioner shall authenticate such orders at the next visit, and failure to do so shall be brought to the attention of the executive committee for appropriate action.

3. The practitioner's orders must be written clearly, legible and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "Renew", "Repeat", and "Continue" orders are not acceptable.

4. All previous orders are canceled when patients go to surgery.

5. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

6. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his areas of expertise.

7. Except in an emergency, consultation is required in the following situations:

   (a) First Cesarean sections.
   (b) Curettages or other procedure by which a known or suspected viable pregnancy may be terminated.
   (c) Cases in which the patient is not a good risk for operation or treatment, where diagnosis is obscure after ordinary diagnostic procedures have been completed, where there is doubt as to the choice of therapeutic measures to be utilized, of unusually complicated situations where specific skills of other practitioners may be needed, of instances in which the patient exhibits severe psychiatric symptoms, and when requested by the patient or members of his immediate family.

8. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He or she will provide written authorization to permit another attending practitioner to attend or examine his or her patient, except in an emergency.

9. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he or she shall call this to the attention of his or her superior who in turn may refer the matter to the director of the nursing service. If warranted, the Director of Nursing may bring the matter to the attention of the chief of the service wherein the practitioner has clinical privileges or of the president of the medical staff. Where circumstances are such as to justify such action, the chief of the service or the president of the medical staff may request a consultation.

10. A laboratory shall be provided in the hospital to insure as complete a service as possible. The Lab will be ordered as justified for surgical procedures taking into consideration the patient's age and any preexisting diagnosis.

    Routine lab shall not be done on newborns except on order of the physician. A neonatal screen shall be done.

11. The acceptable indications for operations for the sole purpose of sterilization on either male or female patients are as follows:

    (a.) Eugenic
    (b.) Therapeutic (for pathological reasons)
    (c.) After third Cesarean section
    (d.) For socioeconomic reasons if there are three living children.

    Where a sterilization procedure is performed, on either male or female, there must be an Informed Consent filed, signed by the patient; or in the case of unwed minor, by parent or guardian.

D. GENERAL RULES REGARDING SURGICAL CARE

1. Except in severe emergencies, the preoperative diagnosis and laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. In any emergency the practitioner shall make at least a comprehensive note regarding the patient's condition prior to the induction of anesthesia and start of surgery.

2. A patient admitted for dental care is a dual responsibility involving the dentist and the physician member of the medical staff.

(a) Dentists' Responsibilities:

(1) A detailed dental history justifying hospital admission.
(2) A detailed description of the examination of the oral cavity and pre-operative diagnosis.
(3) A complete operative report describing the findings and technique. In cases of extraction of teeth the dentist shall clearly state the number of teeth and fragments removed. All tissue excluding teeth and fragments shall be sent to the hospital pathologist for examination.
(4) Progress notes as are pertinent to the oral condition.
(5) Clinical resume (or summary statement).

(b) Physicians' Responsibilities:

(1) Medical history pertinent to the patient's general health.
(2) A physical examination to determine the patient's condition prior to anesthesia and surgery.
(3) Supervision of the patient's general health status while hospitalized.

3. Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from the parents, guardian, or next of kin, these circumstances would be fully explained on the patient's medical record. A consultation in such instances may be desirable before emergency operative procedure is undertaken if time permits.

4. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. There shall be preanesthetic physical examination of the patient with findings recorded by the physician, within seven (7) days of surgery, and repeat CBC and UA recorded if ordered by physician. Postanesthesia notes shall be written within 24 hours following operation.

5. In any surgical procedure with unusual hazard to life there must be a qualified assistant present and scrubbed.

6. Tissues removed at the operation shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record. A gross pathology report shall be completed by surgeons in cases deemed appropriate and shall be made a part of the patient's medical record.

E. GENERAL RULES REGARDING OBSTETRICAL CARE

The policies, rules and regulations relating to the obstetrical suite shall be formulated by nursing services with input from anesthesia. All said policies will be reviewed annually by the medical staff and the governing board at the time of the Critical Access Hospital annual healthcare policy review.

F. EMERGENCY SERVICES

1. The medical staff shall adopt a method of providing medical coverage in the emergency services area in accordance with COBRA regulations. This shall be in accord with the hospital's basic plan for delivery of such services, including delineation of clinical privileges for all physicians who render emergency room care. The professional activities committee shall have overall responsibility for emergency medical care.

2. The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedural manual relating specifically to this outpatient facility. The contents of such a manual shall be developed by a multi-specialty team including representatives from medical staff, nursing service and hospital administration. All said policies will be reviewed annually by the medical staff and the governing board at the time of the Critical Access Hospital annual healthcare policy review.

3. A nursing assessment may be utilized by a physician, physician assistant, certified nurse practitioner as part of a medical database to perform a medical screening evaluation. In such circumstances, the physician, physician assistant or certified nurse practitioner is accountable to determine if the nursing assessment is complete and comprehensive, and to determine if a medical emergency exists. A nursing assessment cannot substitute for a medical assessment. In some circumstances a physician, physician assistant, or certified nurse practitioner may collaborate and consult with an RN via telecommunications to make a determination regarding medical diagnosis and treatment.

4. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record, if such exists. This record shall include:

   (a) Adequate patient identification
   (b) Information concerning the time of the patient's arrival, means of arrival, and by whom transported
   (c) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital
   (d) Description of significant clinical laboratory and roentgenologic findings
   (e) Diagnosis
   (f) Treatment given
   (g) Condition of the patient on discharge or transfer; and
   (h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

5. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

6. There shall be a monthly review of emergency room medical records by the professional activities committee and by appropriate clinical services to evaluate quality of emergency medical care. Reports shall be submitted to the executive committee of the medical staff monthly.

7. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by the safety committee, which includes a multi-disciplinary team of staff members, the director of nursing services or his or her designee, a member of the medical staff and a representative from hospital administration. This plan shall be reviewed annually by the medical staff and the governing board at the time of the Critical Access Hospital annual healthcare policy review.

8. The disaster plan should make provision within the hospital for:

   (a) Availability of adequate basic utilities and supplies including gas, water, food, and essential medical and supportive materials.
   (b) An efficient system of notifying and assigning personnel
   (c) Unified medical command under the direction of a designated physician (the chairman of the committee or designated substitutes)
   (d) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.
   (e) Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care.
   (f) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved
   (g) Procedures for the prompt discharge or transfer of patients in the hospital who can be moved without jeopardy
   (h) Maintaining security in order to keep relatives and curious persons out of the triage area; and
   (i) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will help to provide organized dissemination of information.

9. All physicians shall be assigned to posts either in the hospital or in the auxiliary hospital, or in mobile casualty stations, and it is their responsibility to report to their assigned stations. The chief of the clinical services in the hospital and the chief executive officer of the hospital will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the hospital to another or evacuation from hospital premises, the chief of the clinical services during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the service chiefs and the chief executive officer of the hospital. In their absence, the deputy chiefs and alternate in administration are next in line of authority respectively.

10. The disaster plan should be rehearsed at least twice a year preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the medical staff, as well as administrative, nursing and other hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills shall be made.

G. MEDICAL STAFF MEETINGS

1. The annual meeting of the medical staff shall take place the last month of fiscal year of the hospital. Notice regarding time and place shall be mailed to each member of the staff at least two weeks in advance. Regular meetings shall be determined by the medical staff.

2. No notice of regular meetings need be given other than this statement herein contained. Written notice may be sent at the request of the president of the medical staff.

H. ORGANIZED HEALTH CARE ARRANGEMENT

PRIVACY RULES APPLICABLE TO PRACTITIONERS. _____________ has adopted a formal Compliance Plan to address its responsibilities under the privacy and security standards of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Parts of the Compliance Plan are made applicable to practitioners at Jefferson Community Health Center/Gardenside by this Rule.

A. Definitions:

Practitioner means an individual granted clinical privileges at ________Hospital

Covered practitioner means a practitioner who is directly regulated as a covered health care provider under HIPAA.

Non-covered practitioner means a practitioner who is not directly regulated by HIPAA.

Protected health information means information that relates to the past, present or future physical or mental health, health care or condition of an individual or payment for health care, including identifying demographic information, which identifies an individual, regardless of whether the information is gathered, stored or transmitted in written, electronic or even oral form.

Health care operations means those activities which practitioners engage in on behalf of_________ Hospital, such as hospital and Medical Staff quality improvement, utilization management, peer review and similar functions, which involve access to protected health information. Medical Staff committee and departmental activities are typically health care operations.

Patient means the individual whose information is protected under HIPAA (usually a

registered inpatient or outpatient). The term includes personal representatives entitled to make health care decisions on behalf of individuals.

Workforce means, for this Rule, practitioners who are employed by _________ Hospital.

B. Coverage:

All practitioners are covered by this Rule. Practitioners who are **covered practitioners** are also subject to subsection "c" and automatically participate with _________ Hospital in an organized health care arrangement as described below, unless they are members of the workforce. Practitioners who are **non-covered practitioners** are subject to subsection "d" and must provide ________ Hospital with a signed business associate agreement, unless they are members of the workforce. All **practitioners** are subject to the rules governing information practices in subsection "e".

C. Organized Health Care Arrangement: _________ Hospital is a clinically-integrated care setting in which individuals typically receive health care from _________ Hospital personnel and practitioners (other than workforce). As permitted under HIPAA, all **covered practitioners** participate with _______ Hospital in an organized health care arrangement, with the following characteristics:

1) **Description:** This is an arrangement among _______ Hospital and participating practitioners under which:
   - i. They satisfy their separate notice and acknowledgement requirements under HIPAA by posting and delivering a Joint Notice of Privacy Practices and obtaining or documenting efforts to obtain a single acknowledgment of receipt;
   - ii. They individually agree to follow the information practices described in the Joint Notice of Privacy Practices; and
   - iii. Participating practitioners may access and use **protected health information** ________ Hospital records in order to perform health care operations.

2) **Subject Matter**: The arrangement covers only information practices related to:
   - i) Inpatient and outpatient encounters at _________ Hospital involving hospital patients; and
   - ii) Health care operations of ________ Hospital .

3) **Records:** Records and designated record sets covered by the arrangement consist of existing ________ Hospital records and designated record sets identified in hospital policies and procedures.

4) **Excluded Subjects:** This arrangement does not cover:
   - i) Information practices, protected health information, records and designated record sets of practitioners and their practice groups relating to their private office practices or their other (non-_________ Hospital) practice sites – for example, their separate office clinical and billing

records, or their records or practices at other hospitals and facilities.

ii) Activities other than information practices – for example, this arrangement does not pertain to the actual care or services of the participants. Under no circumstances shall this Rule imply joint and several responsibilities for clinical services or alter in any way the independent status of the participants involved.

5) **Joint Notice of Privacy Practices:** ________ Hospital Notice of Privacy Practices will be drafted to describe the organized health care arrangement and its participants and to serve as the Joint Notice of Privacy Practices. The notice will:

i. Describe service delivery sites covered by the notice;

ii. Describe the participants in the arrangement; and

iii. State that the joint notice covers only ________ Hospital sites and records and does not cover the information practices of practitioners in their offices or at other sites.

6) **Acknowledgment:** _______ Hospital, following its established policies and procedures, will be responsible to obtain, or document reasonable efforts to obtain, the patient's signed acknowledgment of receipt.

D) **Business Associate Agreements:** Non-covered practitioners, in order to participate fully in health care operations, must execute and return a business associate agreement on __________ Hospital's standard form and thereafter comply with the terms and assurances therein.

E) **General Terms**: The following terms apply to all practitioners:

1) **Notice of Privacy Practices:** ______ Hospital Notice of Privacy Practices governs access to and use and disclosure of protected health information by all practitioners when using ________ Hospital's protected health information or engaging in activities at ________ Hospital's.

2) **Disclosures for Treatment and Payment Purposes of Practitioners:** As a convenience to practitioners, ________ Hospital's may furnish protected health information to practitioners, and practitioners may request, use and disclose protected health information from ________ Hospital's, for the treatment and payment purposes of such practitioners, without consent, authorization or other special permission, provided that the following conditions are met:

i) The requesting practitioner must have or be about to have a treatment relationship with the patient supporting the need for the information;

ii) The practitioner (and those for whom the practitioner is responsible) must use and disclose information furnished by ________ Hospital's solely for the treatment or payment purposes.

iii) The manner of furnishing protected health information to practitioners for their treatment and payment purposes will be per guidelines for

arrangements established by ________ Hospital.

iv) Each practitioner who is subject to this Rule will be presumed to meet the conditions for disclosure, unless ________ Hospital has information of a pattern or practice by such practitioner (or his or her group) constituting a material breach of this Rule.

3) **Voluntary Restrictions:** From time to time, patients may request that ________ Hospital voluntarily accept restrictions or limitations on how it uses or discloses protected health information about the individual. ________ Hospital has designated that the Privacy Officer, the Director of Health Information Services or designee receive and act on such requests. No individual practitioner may agree to or accept voluntary conditions or restrictions requested by the patient, if the effect could be binding on ________ Hospital or other practitioners. All requests for acceptance of voluntary conditions or restrictions must be referred to ________ Hospital for consideration and processing.

4) **Reporting and Mitigation:** Practitioners must promptly report to ________ Hospital's Privacy Officer and the CEO/Administrator any improper use or disclosure of protected health information constituting a material breach of this Rule of which they have first-hand knowledge in order that ________ Hospital may determine whether any harmful effects may be mitigated. This reporting requirement includes improper use and disclosure by the reporting practitioner, members of his/her office staff (with respect to ________ Hospital's protected health information covered by this Rule), other practitioners and members of ________ Hospital's workforce.

Each practitioner must cooperate in efforts to mitigate the harmful effects of any improper use or disclosure attributable to such practitioner or people for whom such practitioner is responsible, such as members of his/her office staff.

5) **<u>Access Controls:</u>** Practitioners are responsible, in addition to the requirements in this Rule, to follow all access controls established by________ Hospital. Where policies permit access by members of a practitioner's office staff, practitioners will be responsible for the compliance of his/her office staff.

6) **<u>Other Policies Applicable to Medical Staff.</u>** Practitioners are also subject to other ________ Hospital and Medical Staff Bylaws, Rules and Regulations, and policies and procedures of ________ Hospital which by their terms are applicable to practitioners and members of the Medical Staff.

ADOPTED by the Medical Staff of ________ Hospital's, the __ day of_____, 2008

____
Chief of the Medical Staff

APPROVED by the governing body of. ________ Hospital, on the _-rd day of ______, 2008

____
President of the Governing Body