HealthPartners
Institute for Medical Education

Graduate Medical Education

Resident Handbook
2012-2013

This manual contains the policies and procedures for the IME residency programs at Regions Hospital

The Institute for Medical Education is licensed as a private career school with the Minnesota Office of Higher Education pursuant to Minnesota Statues, sections 141.21 to 141.32. Licensure is not an endorsement of the institution. Credits earned at the institution may not transfer to all other institutions.

TABLE OF CONTENTS

DEPARTMENT DESCRIPTIONS | CLINICAL **PAGES**

Anesthesiology 1
Center for International Health 2-3
Compliance Operations 4
Compliance Documentation Management Program 5
Utilization Management 6
Emergency Medicine 7-8
Food and Nutrition 9-14
Foot and Ankle Surgery/Podiatry 15
Hand Surgery 16-17
Health Information Management 18-65
Medical Record Documentation Requirements .... page 20
Uniform Hospital Discharge Data Set .... page 25
Him Bylaws .... page 26
Dictaphone Dictation Guide .... page 27
"Do Not Use" Abbreviation, Symbol List .... page 33
E-Sig .... page 34
E-Sig Phase 2 .... page 36
Edits & Addendas .... page 39
Regions Hospital Abbreviation List .... page 41
Symbol Definitions .... page 63
Appendix A & B .... page 64
Chart Completion in Epic 2009 .... page 65
Infection Control 66-69
Integrated Home Care 70
Internal Medicine 71-73
Medical Toxicology 74-74
Neurology 76
Neurosurgery 77
Nursing Services 78-80
Obstetrics/Gynecology 81
Occupational Medicine 82
Office of Integrity and Compliance 83
Ophthalmology 84
Orthopedics 85
Otolaryngology/Head & Neck Surgery 86
Partnering Care/Transitional Care & Long Term Care Services 87
Patient Relations Department 88-90
Pathology Lab, Anatomic & Clinical 91
Pharmacy Services 92-96
Plastic & Hand Surgery 97
Psychiatry 98
Radiology 99-101
Rehabilitation Institute 102-104
Respiratory Care Services/Sleep Health Center 105-107
Surgery 108

DEPARTMENT DESCRIPTIONS | SERVICES **PAGES**

Care Management Department 109
Chaplaincy Services 110
HealthPartners Research Foundation 111-112
Linen Services 113-114
Parking 115
Regions Hospital Medical Library 116-117
Security 118
Switchboard Operators/Guest Services 119
Volunteer Services 120

IME/GME POLICIES		PAGES
IME-32	Access to Eligibility to Board Certification	121-122
IME-21	Appropriate Dress/Attire	123
IME-30	DIO Designee	124
IME-28	Disaster Response	125-126
IME-24	Duplication and Attestation of Certificates	127
IME-6	Duty Hours	128-129
IME-19	End of Training Procedure	130
IME-3	Evaluation of Residents	131-134
IME-31	Experimentation and Innovation	135-136
IME-13	Fair Hearing Process	137-139
IME-22	Freedom of Expression	140
IME-2	General Responsibilities of the Resident	141-142
IME-12	Grievance Resolution	143-144
IME-9	Health Information Management	145
IME-16	Hospital Closure/Program Elimination/Reduction in Force	146-147
IME-10	Impaired Resident/Fellow	148-149
IME-26	Meal Allotment	150-151
IME-8	Moonlighting	152-155
IME-25	Non-Discrimination	156
IME-15	Non-Renewal of Contract	157-158
IME-4	Reappointment/Promotion/Program Completion	159-160
IME-18	Registration for Affiliated Residents and Medical Students	161-162
IME-20	Resident Away Rotations	163-166
IME-29	Resident Documentation Requirements	167-168
IME-7	Resident/Fellow Leave Policy	169-170
IME-17	Resident Membership to GMEC	171
IME-1	Selection and Credentialing of Residents	172-174
IME-11	Sexual and General Harassment	175-178
IME-5	Supervision of Residents	179-180
IME-14	Termination/Dismissal of Residents	181-182
IME-23	Transfer Residents	183
IME-27	Vendor Relations and Attachment	184-189

IME/SELECTED REGIONS HOSPITAL POLICIES		PAGES
60:10:24	Alcohol and Drug Testing for Employees (Reasonable Suspicion)	190-193
50:01:28	Code of Ethics	194-195
60:10:32	Confidentiality of patient/member information	196-200
02:01	Death of a Patient	201-217
60:05:05	Employment Requirements for New Employees	218-220
60:06:11	Family Medical Leave of Absence	221-227
	Leave of Absence Guide ...... pages 224-227	
60:10:30	HIPAA Security Policy	228-233
	18 HIPAA Identifiers	234
SF:30	Injuries While on Duty	235-236
100:6	Mobile Computing and Storage Devices Policy	237-240
	Photography, Videotaping and Other Recordings of Patients and Members	241-243
	Privacy Policy	244-249
	Privacy Project: Customer Service Work Group Policy Recommendation	250-253
60:05:07	Procedure for Health Screening of New Employees	254-255
60:10:28	Professional Boundaries	256-257
60:05:31	Requests Not to Participate in an Aspect of Patient Care	258-259
	Sending Protected Information Securely	260-263
60:10:34	Social Media Use and Behavior	264-268
	Use of Email to Communicate Patient & Member Information	269-271
50:05:13	Use of Facsimile Transmission to Communicate Patient & Member Information	272-273
100:25	User Responsibilities Policy	274-276
	Verifying Patient & Member Identity Over the Phone	277-279

DEPARTMENT DESCRIPTIONS - CLINICAL

ANESTHESIOLOGY

LOCATION Regions Hospital – Third Floor
Immediately Outside the Operating Room Suites

DEPT PHONE Sue Biwer (651-254-0043)

CONTACTS Monica Knack (651) 254-0098, Administrative Secretary to:
Matthew Layman, M.D., Medical Director of Perioperative Services

HOURS 24 Hours Per Day, 7 Days Per Week

FACULTY

George Bojanov, M.D.
Richard Carr, M.D.
Sarah Castaneda, M.D.
George Caucutt, M.D.
Glenn Haller, M.D.
Chris Kehler, M.D.
Karla Larson, M.D.
Matt Layman, M.D. Residency Program Site Director
Timothy Lindsay, M.D.
Anton Rohan, M.D.
Jay Schantzen, M.D
Deanna Siliciano, M.D.
Karrin Stoehr, M.D.
Charles Torbert, M.D.
Steve Wen, M.D
Paul Yochim, M.D.

DESCRIPTION OF DEPARTMENT/SERVICE

The Department of Anesthesiology is staffed by 16 Regions based anesthesiologists with augmentation by other Twin Cities Anesthesia Associates anesthesiologists. Nurse anesthetists are also part of the anesthesia team, and work under the supervision of the attending anesthesiologist. Coverage is provided for all surgical subspecialties, labor and delivery, acute pain, hospital-wide airway management and resuscitations. Because of Level I Trauma Center certification, an anesthesiologist is on the premises 24 hours a day, seven days a week.

Surgical cases are scheduled through the Operating Room Scheduling Office. Patients are usually seen by a member of the department on the day of surgery. If specific concerns need to be addressed on either Inpatient or Outpatient **Surgery,** the patient should be brought to the attention of the Charge Anesthesiologist who can be reached via the OR main desk at 254-5003. Arrangements can then be made for an Anesthesia consult, or call 952-967-7479 to make an appointment at the Hospitalist/Anesthesia Pre-Op Clinic.

Patients scheduled for surgery during the off-shifts are booked through the Operating Room Charge Nurse. If a patient has unusual circumstances or special anesthetic needs (i.e., invasive monitoring, awake fiberoptic intubation, post-operative pain control, etc.) the in-house anesthesiologist should be contacted, and the request should be made directly to him or her. The Operating Room Charge Nurse can provide the proper telephone extension at the time of booking the surgery.

Due to limitations of resources at this time, the Department of Anesthesiology only participates in formal resident education for the Department of Emergency Medicine, and the University Of Minnesota Department Of Anesthesia.

CENTER FOR INTERNATIONAL HEALTH

LOCATION: 451 N. Dunlap Street
St. Paul, MN 55104

DEPT PHONE 651-647-2100

CONTACTS Dave Johnson, RCD

PHONE 952-883-5116

STAFF
Mikhail Perelman, MD
Ann Settgast, MD
Patricia Walker, MD
Michael Westerhaus, MD
Rob Carlson, PA-C
May Mua, PA-C
Shary Vang, MD

BEHAVIORAL HEALTH:
Bruce Field, MD
Georgi Kroupin, MA, LP
Karen Ta, MD
Chhabilall Sharma, MD

HOURS **Monday – Friday 8:00-4:30 p.m.**

DESCRIPTION OF DEPARTMENT/SERVICE

The Center for International Health was established in 1980 in response to the influx of Southeast Asians to Minnesota after the end of the Vietnam War. Initially called "The Hmong Clinic", or the "Southeast Asian Clinic", the clinic now additionally sees many Russian, Somali, Oromo, Nepali and Karen patients as immigration trends change Minnesota's demographics. Since 1980, the program has expanded to include patients from more than 30 countries, with a staff of providers experienced in International Health, Tropical and Travel Medicine, and with extensive experience practicing both internationally and in the United States. Our International Mental Health program was established in 1984.

KEY COMPONENTS This care delivery model is nationally recognized.

***Multidisciplinary care**
Adult primary care; mental health program (psychiatry, psychology, and social work); specialty care (new arrival screenings, INS adjustment of status examinations)

***Bilingual staff**
Front-line staff, medical assistants, nursing and medical staff who are bilingual and bicultural.

***Providers with expertise**
Providers who are bilingual and bicultural, from the countries of origin of our patients, – or with advanced degrees in tropical and travel medicine, public health and international health.

***Professionally trained**
Staff interpreters available on site for nine languages. Agency interpreters contracted for all other languages. Telephone interpreters available for all languages.

PROGRAM ACTIVITIES

Primary Care

- Primary care for foreign-born patients: non-English speaking, limited-English speaking, and English-proficient patients (adults only)

Consultative/Subspecialty Care

- International Mental Health
- Psychiatry
- Psychology
- Group therapy (Vietnamese political prisoner's men's group)
- Cross cultural health care consults
- New arrival screenings examinations for refugees and immigrants
- Workmen's compensation examinations for foreign born patients

- INS adjustment of status examinations for families (Civil Surgeons on staff)

Teaching

- Continuity Clinic – IM and Med-Peds: (10 residents)
- Ambulatory care rotations (average 1-2 IM, Med Peds or FP residents/month)
- PA students
- Nursing students
- School of Social Work interns

Lectures/ other educational activities

- National, state and local lectures and day-long symposia on refugee health
- LEARN Video on ERIC at Equitable Care Web site
- Book– “My Heart it is Delicious” by Billie Young, published October 2007
- Chris Newberry Video “If We Knew Their Stories” with TPT Television
- “Immigrant Medicine” textbook published October 2007
- Research
  - multiple published case studies from the CIH
  - review articles on refugee and immigrant medicine
- Consulting
  - Site visits and discussion of our care delivery model with Mayo, Maine Medical Center, HCMC, PNMC, New Hampshire and others

Community Outreach and Service

- Health Fairs, community events
- Consortium on Health and Mobility
- Outreach via ethnic media
  - Health articles in Russian newspaper
  - Radio talk shows on mental health issues
  - Hmong newspaper articles
  - MPR interviews

COMPLIANCE OPERATIONS

LOCATION	US Bank	**DEPT PHONE**	651-265-1702
CONTACTS	Derin Muchow, Director April Howie, Manager	**PHONE**	651-265-1867 651-265-1840
HOURS	8:00 a.m. to 5:00 p.m.		

DESCRIPTION OF DEPARTMENT/SERVICE

Care Systems/Compliance Operations

Our mission is to provide information or tools that allow our customers to make the right decision 100% of the time. We work side-by-side with our customers to deliver innovative, yet practical solutions that will give HealthPartners Medical Group and Clinics a competitive advantage. Our team approach integrates industry knowledge with functional specialists to solve our customers' business issues.

We offer customers in-depth expertise in:

- Strategic planning
- Business process re-engineering
- Systems design and development
- Organizational development
- Change management
- Coding and documentation integrity
- Health information management
- Reimbursement analysis

Compliance Operations supports the medical group through educational activities focused on documentation, coding, compliance and third party reimbursement requirements. Compliance Operations also participates in ongoing monitoring programs designed to enhance the overall performance of the medical group in coding and compliance areas.

COMPLIANT DOCUMENTATION MANAGEMENT PROGRAM (CDMP)

LOCATION Regions Hospital

CONTACT PERSON Joshua Brewster, Director, Care Management 651-254-3780
Mercy Paul, Supervisor of CDMP 651-254-4808

DESCRIPTION OF DEPARTMENT

The Compliant Documentation Management Program (CDMP) is a group of registered nurses who concurrently review medical records, via Epic, to ensure accurate documentation of the care provided. Using "queries" the team may ask providers for clarification about clinical documentation in charts related to under (and over) coding and around key quality measures. Additionally, CDMP staff may use Epic In-Basketing, text pages, e-mail, or in-person communication during interdisciplinary rounds to connect with providers. The compliant documentation specialists (CDSs) use a software package developed by J.A. Thomas and strong clinical experience to guide their work.

CDMP concurrently follows all Medicare, most HealthPartners insurance, and many medical assistance patients on the medical and surgical units. CDMP does not review documentation of patients in the ED, Mental Health, Rehab, Labor & Delivery, or outpatients.

KEY ROLES

- Act as translators between Medicare/payers documentation requirements and providers
- Ensure accurate documentation will support reimbursement for the level of care provided
- Ensure accurate documentation of patient acuity
- Facilitate questions and processes between providers and coders
- Active in education and preparation for ICD-10 conversion

UTILIZATION MANAGEMENT

LOCATION Regions Hospital

CONTACT PERSON

Joshua Brewster, Director, Care Management	651-254-3780
Vicki Anderson, Supervisor of UM	651-254-2826
Sue Gruenewald, UM Coordinator	651-254-2948
Kim Short, UM Coordinator	651-254-2259

DESCRIPTION OF DEPARTMENT

The Utilization Management Program group utilization review experts who evaluate the appropriateness of admission, including medical necessity, continued stay, discharge practices, use of medical and hospital services, and all related factors which may contribute to the effective utilization of hospital resources and physician services. Using InterQual criteria, the team reviews all admissions and hospital stays; as necessary they communicate with payers to ensure reimbursement. UM staff are part of interdisciplinary, team rounds on medical and surgical units to answer questions and to facilitate timely discharges.

PURPOSE

- Admission review is conducted the within one business day of admission by the UM staff. The purpose is twofold:
    1. To determine the appropriateness of an inpatient admission. Using the Severity of Illness (SI) indicators as the guide for the review should establish the medical necessity of admissions to the Acute Care Setting.
    2. To obtain payer certification as required by contract agreements.
- Concurrent review:
    1. The purpose of this review is to assess periodically the patient's need for continued treatment, using the aforementioned criteria, or standards of care. Intensity of Service (IS) indicators are used as the guide.
    2. To obtain payer certification throughout the hospital stay.

PROCESS

- Admission review and continued stay review:
    - The UM staff matches documentation of the patient's problem and physician's plan with the InterQual Acute Care Criteria. Staff notes the criteria met on the review and will review the record again concurrently.
    - If there is not adequate documentation to meet the medical necessity criteria for and/or continued stay, the UM staff contacts the attending MD.
- Third party payer denials are individually managed based on the contract requirements.
- Physician Peer Review:
    - Upon request of the UM staff, a physician reviewer will conduct a review by the end of the same day and document the findings. He/she will also contact the attending physician to discuss the case and plan of care.
    - If the physician reviewer is not available, or cannot concur with the attending provider, the case will be referred to the VP of Medical Affairs who will then review the case and contact the attending physician.
    - In cases of continued disagreement, the case will be referred to the Quality Peer Committee for a final decision. The attending physician will be contacted.

EMERGENCY MEDICINE

LOCATION 2nd Floor, Central Section, Room C2587, Regions Hospital

DEPT PHONE 651-254-4788

CONTACTS

Pat Anderson, Residency Coordinator	651-254-5091
Lori Barrett, EM Residency Manager	651-254-3666
Zabrina Evens, MD Chief Resident	651-629-2412
Joe Walter, MD Chief Resident	651-629-3035
Wendy Woster, MD Chief Resident	651-629-3040
Matt Morgan, MD, Rotation Director	651-254-5298

HOURS 24 Hours Per Day, 7 Days Per Week

FACULTY

Kurt M. Isenberger, MD, Dept. Head
Felix K. Ankel, MD, Residency Director
Kelly W. Barringer, MD
Emily S. Binstadt, MD
Aaron M. Burnett, MD
Mary E. Carr, MD
Won G. Chung, MD
Rachel A. Dahms, MD
R.J. Frascone, MD
Jason T. Gengerke, MD
Bradley D. Gordon, MD
Paul R. Haller, MD
Carson R. Harris, MD
Cullen B. Hegarty, MD
Keith D. Henry, MD
Bradley S. Hernandez, MD
Joel S. Holger, MD
Koren L. Kaye, MD
Kevin P. Kilgore, MD
Peter G. Kumasaka, MD
Robert C. LeFevere, MD
Matthew W. Morgan, MD
Levon T. O'hAodha, MD
Brian Peterson, DO
Jessie G. Nelson, MD
Karen A Quaday, MD
Martin E. Richards, Jr., MD
Samuel J. Stellpflug, MD
Stephanie A. Taft, MD
Bjorn C. Westgard, MD
Andrew R. Zinkel, MD
Michael D. Zwank, MD

DESCRIPTION OF DEPARTMENT/SERVICE

The Emergency Medicine Department at Regions Hospital Emergency Center is a Level I Trauma Center and Level I Pediatric Trauma Center as certified by the American College of Surgeons. An average of 220 patients per day is evaluated on an emergent/urgent basis covering a wide spectrum of medical, pediatric and traumatic illnesses. The department is staffed 24 hours per day by senior staff physicians who have faculty appointments in Emergency Medicine at the University of Minnesota Medical School. The staff directly supervises each resident physician in the care of each patient.

The rotation consists of 18 or 19, 10-hour shifts per 4-week block, depending on clinic assignments. All residents will have, on average, one day off in 7 and time off for clinic obligations.

Conference Schedule
Two sets of conferences on a weekly basis are mandatory for successful completion of the rotation. Thursday morning consists of a 2.5-hour block, with a weekly critical case conference and an alternating hour of trauma conference or didactic lecture topic in emergency medicine. On Wednesdays, a 1-1/2 hour workshop is held consisting of ophthalmologic evaluation and procedures, orthopedic injuries/splinting, or toxicology. A fourth 4 hour workshop on medical and trauma resuscitation is also conducted. Reading material pertinent to these topics is available online for viewing.

Purpose/Goals
1. Develop an ability to assess acute medical and/or surgical problems in an efficient manner.
2. Develop an ability to stabilize acute medical or surgical problems in a logical manner when appropriate.
3. Develop an ability to perform a focused history and physical examination based on presenting acute complaints and physical signs.
4. Develop an ability to outline appropriate interventions, differential diagnosis and treatment plans on an individual patient basis.

Teaching Methods
1. All resident physicians will see patients primarily, under direct supervision of emergency medicine staff physicians in conjunction with senior emergency medicine residents.
2. The resident will have the responsibility to implement stabilizing treatments or procedures, and order and evaluate initial laboratory and radiological studies.
3. The resident will have the responsibility to develop a rationale for the admission/discharge decision for each patient.
4. The resident will have the responsibility to develop treatment and follow-up plans for discharged patients.
5. The resident will have the responsibility to complete patient documentation in a timely manner. All charts must be complete within one week of completion of the rotation.

Patient Characteristics
The resident physician will have the opportunity to see all of the types of patients who present to the Emergency Department. These include: pediatric, psychiatric crisis, acute and urgent traumatic patients. The spectrum of patients includes those with orthopedic, eye, ENT, neurological, urologic and gynecological problems.

Procedures
The resident physician will have the opportunity to perform necessary procedures on their patients including wound repair, stabilization of fractures, lumbar puncture, and other procedures as appropriate situations may allow.

Supervision
Resident physicians will be supervised by the regular staff physicians in conjunction with the senior emergency medicine residents. They will present the details of the initial evaluation, and discuss diagnostic and treatment modalities. Procedures will also be directly supervised by the staff physicians.

Other Resources
Consultation from specialty services is available and is obtained when appropriate, and provides immediate feedback on patient problems. Follow-up of admitted patients is at the discretion of each resident physician and provides valuable information on clinical course and outcomes. An extensive quality improvement program is in place and, when appropriate, the resident physician is included in this process.

Evaluation
Resident physicians are informally evaluated during their clinical shifts. A written evaluation is completed at the conclusion of the rotation by several staff members. An evaluation of the rotation by the resident is encouraged.

FOOD AND NUTRITION SERVICES

LOCATION 2nd Floor, Main Building
Regions Hospital

DEPT PHONE 651-254-2705

CONTACTS

Richard St. Germain, Director	651-254-5180
Diane Anderson, Manager	651-254-2711
Deb Nielsen, Supervisor	651-254-3941

HOURS The weekday serving hours in the main cafeteria are:
Monday through Friday: 6:30 am to10:30am and 11:00 am-7:00 pm;
closed 10:30am – 11:00am

Weekend cafeteria hours are:

Breakfast:	7:00am to 9:45am
Closed	10:00am-11:00am
Lunch:	11:00am to 1:30pm
Closed:	2:00 pm to 4:30pm
Dinner:	4:30pm to 7:00pm

HOURS The weekday serving hours for Overlook Coffee & Deli:
Monday through Sunday: 6:30am – 9:00pm

Registered Dietitians are available for patient care with full staff weekdays (Monday through Friday) and on the weekends with limited coverage.

STAFF

Diane Anderson, RD, LD, Patient Services Manager
Sarah Johnson, MPH, RD, LD Clinical Nutrition Manager
Sina Postorino, RD, LD
Karen Prokosch, RD, LD, CDE
Wendy Gamme, RD
Julie Hemann, RD
Diane Schumacker, RD
Pam Scullin, RD, LD
Kim Nguyen, RD
Megan Turner, MS, RD
Stephanie Wetzel, MS, RD
Brittany Willard, RD, LD
Carrie Abrams, RD, LD
Nancy Bauman, Dietetic Technician
Jenny Town, Dietetic Technician
Virginia Coller, Dietetic Technician

DESCRIPTION OF DEPARTMENT/SERVICE

A. Food Service

1. Physician's Diet Orders

   The type of diet a patient will be served is ordered by the physician in the patient's chart. Dietitians may adjust the diet order according to the patient's physical and therapeutic needs. The electronic Nutrition Care Manual, from the American Dietetic Association is the guide used for prescribing diets and for the foods served on the various diets. It is available to all professional staff via the Medical Library “Database” with the icon of “Diet Manual” (Refer to the Meal Plan Crosswalk in the online Nutrition Care Manual for a description of commonly served diets, some are also listed in the Appendix below).

2. Policy on Nutritional Screening and Assessment

Nutritional screening is done on admission for nutrition risk factors such as significant weight loss (^10# in 3 mo.), decreased intake (>2 weeks), and significant open wounds via Nursing Admission Navigator for all patients. A referral is sent to Food and Nutrition Services for early nutrition assessment of the patient with a positive response to the nutrition risk questions. Other medical/surgical and pediatric patients are screened/assessed by a diet technician or clinical dietitian within 72 hours of admission according to specific risk criteria. All nutrition notes are documented in the electronic medical record as an Initial Assessment, Consult or Progress note.

3. Patient Meal Times

Patients are served three meals a day in the patient care areas by Nutrition Services Associates. Mental Health receives their meals from a centralized tray service in the main kitchen. Food carts are brought to the floors beginning at 6:45am for breakfast, 11:15am for lunch and 4:15pm for dinner.

B. Written Orders to Food & Nutrition Department

1. Use of Diet Order - Diet Change Sheet

Written electronic diet orders are required for accuracy and documentation. A diet list is printed (via computer) in the Patient Service Office prior to each meal. All diet order changes, including new admits, test diets, consistency changes are received via computerized Order Notices. In the adult medical/surgical units, patients are asked for their meal choice and served by Nutrition Services Associates.

a. All aspects of the physician's diet order must be included such as food textures, between meal feedings, dietary fluid restrictions, isolation trays, calorie checks, NPOs, hold trays, tube feedings, supplements, infant formula, test diets, dietary consultations, etc.

b. All diet orders must be in by 6:15am, 10:15am, and 3:45pm. All orders received after these times will take effect the next meal.

2. Caloric - Protein Checks and Nutrient Analysis

Caloric - Protein Checks and nutrient analysis are conducted for individual patients and are done upon written order by the attending physician and/or the request of the Clinical Dietitian caring for the patient. The standard time frame is for 2 days.

a. Nutrient calculation will be recorded on the nursing flow sheet of the patient's chart daily. Intake records with only 1 meal recorded and no other explanation (i.e., NPO) are considered incomplete and are not calculated. When only 2 meals are recorded, the caloric and protein intake will be calculated with the notation made of only 2 meals being received.

b. If nutrients other than protein and calories need to be calculated, this must be stated in the written order.

3. Tube Feedings and Oral Supplements

Available products are listed under Tube Feedings in the EMR Order section or a copy of the Regions Enteral Formulary can be obtained from a clinical dietitian. Tube Feedings are to be physician or dietitian ordered using the Enteral Nutrition Orderset for the initial order.

Additional products can be obtained should specific patient needs warrant them. A minimum of two business days may be required to obtain such products from vendors.

Orders for individual patients must include the following:

a. The complete name of the product.
b. The total amount of the product to be given in a specified time (cc/hr or cc per feeding and frequency).
c. The strength of the product must be indicated when products are ordered. Unless otherwise stated, the strength of the product will be assumed to be full strength.
d. The floor dietitian must be contacted for any special order products other than those listed on the Regions Enteral Feeding Formulary.
e. When absolutely necessary, to not delay discharge, a limited supply (1-2 days worth) of commercially packaged tube feedings or supplements can be sent home with patients being discharged or going out on pass. Contact the dietitian in that area for approval and assistance in processing the order.

4. Infant Formulas

Disposable, ready-to-feed formulas are generally fed to hospitalized infants and are supplied through Materials Management. Special infant formulas (e.g. Pregestimil and Nutramigen) can be ordered through the Department of Food and Nutrition. A minimum of two days may be required to obtain special formulas from vendors if it is not in stock.

a. Nursing is responsible for ordering ready-to-feed infant formula(s) from Materials Management.
b. The Department of Food and Nutrition will prepare <u>special</u> infant formulas not available in the ready-to-feed form if ordered through the Pediatric Dietitian or indicated on the computerized diet order.

    1) Formula orders must include the name of the formulas, the number calories/ounce, the total number of ounces per ccs per day.
    2) Unless the formula is ordered for the first time or change is necessary, formulas are routinely sent at 1:30pm.

5. Isolation Trays

Isolation trays are used only for patients on radioactive precautions. This is ordered along with the diet order.

6. Security Trays

Security trays are served to individual patients when ordered. Security trays are routinely served to patients in the in-hospital Security Unit and to Psychiatric areas if ordered.

a. The diet order-diet change sheet lists the patient's diet order and also reads: SECURITY TRAY.
b. Patients other than those in the in-hospital Security Unit receive totally disposable service and a complete set of plastic tableware. The meat is not cut.
c. Security trays for the in-hospital Security Unit include disposable service and a plastic spoon and fork. The meat is cut.

C. Nutrition Consults and Teaching

1. Nutrition Consults

   a. Consultation to the Clinical Dietitian can be ordered via electronic medical record orders and should include the specific question. Unless other arrangements are made, consults will be scheduled within 24 hours; Consults for education will be completed when the patient is ready.

2. Diet Instructions

   Diet instructions are provided for our patients after a physician or nursing order, patient request, disease specific order set, or dietitian evaluation. In-depth diet instructions for self-care nutritional management should be referred to an out-patient at HealthPartners or at the patient's primary clinic.

   Nutrition videos regarding low cholesterol, sodium restricted and weight management run daily on our closed circuit TV.

   a. Consults for diet instruction that are received less than 24 hours in advance may not be able to be completed. An out-patient referral to a HealthPartners dietitian or to a dietitian at the patient's primary clinic is recommended on discharge form.
   b. Documentation of the diet education is done in the patient education section of the electronic medical record.

3. Patient Visits

   Patients are visited on a regular basis by a member of the Clinical Dietetics Patient Care Team. Such visiting occurs at mealtime, during nutritional assessment interviews, or while teaching the patient and/or significant other(s) regarding nutrition and/or diet modification for disease.

4. Nutrition Support (NS)

   Dietitians will consult and monitor daily all adult patients receiving parenteral nutrition support and on those receiving enteral support in the ICU's. Stable enteral nutrition support patients are evaluated initially with periodic follow-up as needed. The consult will include recommendations and orders (upon request) for appropriate feeding route, formula selection and revisions, and patient nutrition monitoring. Consults for nutrition support can be ordered via the EHR or by contacting a team member. The dietitian beeper is 651-629-0100 or 651-629-2260 on the weekends.

5. Feeding Tube Placement

   Dietitians, trained to use the cortrak machine, are available to place post-pyloric Nasojejunal feeding tubes and nasal bridles at the bedside on W3, S7, S6, C5100 and the Burn Unit Weekdays (Monday – Friday) with a consult. Consults will need to be placed by 3:00 pm to guarantee same day placement. Dietitians are not available to place feeding tubes or nasal bridles on the weekends. Tubes that need placement on the weekend will need to be placed by nursing or fluoroscopy.

D. Special Services

1. Birthday Cakes for Patients
   Decorated birthday cupcakes may be ordered for patients from the Food and Nutrition Department.

2. Cafeteria Privileges for In-Patients

   a. In-patients may eat in the cafeteria when approved or ordered by the physician or clinical dietitian. The issuance of cafeteria meal passes is limited to patients who would benefit nutritionally and are able to select a cafeteria meal and the passes can be obtained from the floor dietitian. Usually this is limited to long-term patients.
   b. The patient is issued a meal permit slip, which he/she must present to the cafeteria cashier.

3. Coffee Service for Families of Critically Ill Patients

   Beverage Service machines are available for families of critically ill patients in the Surgery waiting area on 3rd floor of the Crescent Main Building.

4. Cafeteria Service for Visitors
   The Food and Nutrition Services Department provides cafeteria meal service in the main cafeteria. Disposable containers are available for take-out in the cafeteria.

5. Vending services are available in the main cafeteria vending area 24 hours daily, including hot beverages, candy/snack machines, and cold food machines with fruit, yogurt, pastries and microwavable sandwiches. Soda machines are located on all patient floors. Snack machines (chips, candy, gum) are available in North Lobby, 1st floor ER lobby, 1st floor East Building, and 3rd floor Surgery Waiting.

6. Guest Trays for Families
   Guest trays for families will be provided at a cost payable in advance. The patient's account cannot be billed for guest trays.

APPENDIX

The following chart gives a brief description of the most common diets served. (For additional detail on other diets, consult the Nutrition Care Manual on the Regions Intranet.

Regular	Regular diet, no modification
Soft Textured	Whole, soft foods producing a moderate amount of fiber and mild seasonings
Mechanical Soft	Whole, soft foods with ground/diced meat
Dysphagia Diets	3 Levels available: NDD#1 Pureed foods, NDD #2 chopped foods, NDD#3 soft foods: Consistency of the liquids are also identified as thin, nectar, honey, spoon thick.
Fractured Jaw	All foods pureed and thinned to go through a straw
No Added Salt	(3-5 grams of NA+) Minimal amount of salt in cooking, no salt on meal tray No salt added in cooking; no salt on meal tray - includes special low sodium products
Consistent Carbohydrate	Consistent carbohydrate or specific calorie level
Low Fat	Low fat, low cholesterol or specify 50 grams a day
Cardiac	300 milligrams of cholesterol, low fat, No Added Salt
Pediatric Strained	Specified diets for 4-6 mo. 6-8 mo., 8 mo.-1yr.
Pediatric Ground	Whole, soft foods with ground meat
Pediatric Chopped	Diced food
Pediatric Soft	Soft textured foods
Pediatric Toddler	Finger Foods appropriate for children of approximately 1-2 years of age
Pediatric Regular	Regular foods directed toward food preferences of children: For children under 16 years of age
Protein Restricted	60 gram protein, 2gm NA
Renal	Renal, mineral restricted. 2gm NA, 3gm K, low phos (no protein restriction) Renal, protein and mineral restricted: 60gm protein, 2gm NA, 3gm K, low phos Hemodialysis: 70-80gm protein, 2gm NA, 3gm K, low phos Peritoneal Dialysis: 90gm+ protein, No Added Salt All renal diets can be combined with Consistent Carbohydrate for diabetes Exclude red meat, all meat, fish, poultry, and/or dairy and eggs per patient choice.
Neutropenic	No fresh fruits.
Kosher	No pork; disposable dishes; frozen kosher entrees available.
Southeast Asian	Foods commonly preferred are served including rice, chicken, and, tea.
Fiber	High, low or minimum available.
Bariatric Surgery	Clear liquid, pureed or regular (all small serving sizes).

FOOT AND ANKLE SURGERY / PODIATRY

LOCATION 2nd Floor, North Section, Suite N2001
Regions Hospital

DEPT PHONE 651-254-8333

CONTACTS Willie Braziel, Manager — 651-254-1530
Barb Thompson, Coordinator — 651-254-3074

PHONE 651-254-1530, 651-254-3074

HOURS 24 Hours Per Day, 7 Days Per Week. Please check AMION.com for the on-call resident.

STAFF
Troy Boffeli, DPM, Residency Program Director
John Donohue, DPM
William Kuglar, DPM
Long Le, DPM
Audra Mintz, DPM
Brad Olson, DPM
Ryan Pfannenstein, DPM

RESIDENTS
Rachel Collier, DPM, Chief Resident, PGY 3
Ryan Reinking, DPM, Chief Resident, PGY 3
Kyle W. Abben, DPM, PGY2
Jonathan C. Thompson, DPM, PGY2
Shelby Swanson, DPM, PGY1
Jessica Tabatt, DPM, PGY1

DESCRIPTION OF DEPARTMENT / SERVICE

The Foot and Ankle Surgery / Podiatry Service provides care for all foot and ankle disorders. Inpatient consultation is available 7 days per week. Please contact the on-call resident for questions or acute concerns. Stable decubitus wounds requiring dressing changes and toenail care consults should be directed to the inpatient Wound Care service.

Outpatient Foot and Ankle Surgery / Podiatry services are available at the following sites: HealthPartners Specialty Center, HealthPartners Riverside Clinic, HealthPartners West Clinic, HealthPartners Anoka/Riverway and HealthPartners Bloomington Clinic.

The Foot and Ankle Surgical Residency Program is an accredited 3-year, postgraduate program. This program currently consists of two residents per year with a total of six residents. Residents rotate through a variety of departments including: Anesthesia, Behavioral Science, Biomechanics, General Surgery, Internal Medicine, Emergency Medicine, Infectious Disease, Orthopaedics, Pathology, Podiatric Orthopaedics, Radiology, Plastic Surgery and Vascular. The Foot and Ankle Surgery / Podiatry Service also provides rotations for Medicine Residents who rotate through the Adult Health Care Clinic.

HAND SURGERY FELLOWSHIP PROGRAM

LOCATION North Building, 2nd Floor, N273
Regions Hospital

DEPT PHONE 651-254-4870

CONTACT Willie Braziel, Manager — **PHONE** 651-254-1530
Deb Collier, Program Associate — 651-254-1504

STAFF: Regions

Loree Kalliainen, MD Program Director
James Fletcher, MD, Chief of Hand and Wrist
Cherie Heinrich, MD
Martin Lacey, MD
Paul Lim, MD
Dean Mann, MD
Warren Schubert, MD
Sue Mi Tuttle, MD
Christina Ward, MD

Ned Bruce, PA-C
JoAnne Eller, PA-C
Tara Olson, PA-C
Naomi Zeiss, RN
AnnMarie Fox, NP
Sarah Jorgensen, PA-C
LuAnn Zeilinger, admin
Val Rousseau, admin
Jesi Woodford, admin

University of Minnesota Medical Center, Fairview

Matthew D. Putnam, MD
Ann VanHeest, MD
Julie Adams, MD
James H. House, MD (emeritus)

Hennepin County Medical Center

Thomas F. Varecka, MD

Gillette Children's Specialty Healthcare

Deb Bohn, MD
Ann VanHeest, MD

Tria Orthopaedic Center

Deb Bohn, MD
Yvonne Grierson, MD

DESCRIPTION OF DEPARTMENT/SERVICE

The Hand Surgery Fellowship Program began in 1991 as a collaboration between Dr. James H. House at the University of Minnesota, Dr. Edward C. McElfresh at the Veterans Affairs Medical Center, and Dr. Matthew D. Putnam at Park Nicollet Medical Center and the University of Minnesota. Dr. Loree K. Kalliainen assumed the role of Program Director in 2009 as Dr. Putnam pursued other challenges at the University. In 2010, the program funding lines were moved to the HealthPartners Institute for Medical Education at Regions Hospital. The fellowship is ACGME certified, and fellows enter through the NRMP match program.

The primary faculty within the Hand Surgery Fellowship Program are from both orthopaedic and plastic surgery backgrounds. Points of pride of the faculty are the Twin Cities-wide breadth of the fellowship and the collegiality between surgeons. All forms of practice are encountered by our fellows, allowing them to choose the optimal career path for themselves. The hand surgery fellows take night call at Regions Hospital, a Level I Adult and Pediatric Trauma Center. They work with all Plastic and Hand faculty and participate in the education of Plastic Surgery residents and of interns rotating on the Plastic and Hand service. The surgical and clinical experiences cover the spectrum of hand and microsurgery, and the interested fellow also has the opportunity to participate in the care of patients with elbow and shoulder disease. Orthopaedic oncology exposure is available at the University. Acute and subacute trauma are primarily seen at Regions and HCMC. Elective surgery is performed at Regions and Tria. Pediatric cases are seen at Gillette, Tria, and Regions.

Our Hand Fellowship Program has been highly competitive since its inception, and our fellows have gone on to practice hand surgery in academic and private-practice settings in the United States and in England and Lebanon.

Regions Hand Conference is on the second & fourth Wednesdays of the month. At 7:00 am on the first and third Thursdays of the month, there is a Hand Conference at the University. Both conferences cover selected patient cases, didactics, and journal club. Fellows are expected to work with Dr. Julie Adams at the University and Dr. James Fletcher at Regions to coordinate conferences. Anatomic dissections take place at the University on an approximately quarterly basis. Didactics relevant to the upper extremity are also offered at Tria. The hand fellows participate in the Department of Orthopaedic Surgery's annual Competency Assessment and James House Visiting Lectureship Day.

Each fellow must perform a QI and/or a research project each year. Limited funds are available for research support. Fellows are funded to attend a national meeting and an instructional course. Most fellows have chosen a week-long microsurgery course, but if the fellow has had adequate exposure to and experience in microsurgery, another course may be requested.

The Plastic & Hand Surgery and Orthopaedic offices at Regions Hospital are located on the 2nd floor of the North Building N273 off of the North Building elevator. The specific daily schedules of the attendings, clinics and OR schedules can be obtained from LuAnn Zeilinger (651-254-3792) for Drs. Schubert and Tuttle, Valery Rousseau (651-254-0883) for Drs. Mann, Lacey and Heinrich; Jesi Woodford (651-254-4870) for Drs. Fletcher and Kalliainen; Kathy Cherry (651-254-1513) for Dr. Ward.

AFFILIATE TRAINING LOCATION CONTACTS

University of Minnesota - Betsy Wehrwein
Education Coordinator/Program Assoc
Department of Orthopaedic Surgery
2450 Riverside Ave S R200
Minneapolis, MN 55454
Phone: 612.273.8043

TRIA Orthopaedics - Erica J. Maas
Education & Orthopaedic Sports Medicine Fellowship Coordinator
TRIA Research & Education Institute
8100 Northland Drive, Bloomington, MN 55431
Main Phone: 952-831-8742 **Direct Line:** 952-806-5362 **Fax:** 952-806-5469

Hennepin County Medical Center – Claudia Miller
Department of Orthopaedics
701 Park Avenue
Mail Stop G2
Minneapolis, MN 55415
Phone: 612-873-4220 **Fax:** 612-904-4280

HEALTH INFORMATION MANAGEMENT

LOCATION 1st Floor of the North Building

DEPT PHONE 651-254-2468
INCOMPLETE CHART ROOM 651-254-2433

CONTACTS

Beth Burns, Director	651-254-2825
Jaclyn Falkenstein, Manager File Room and Release of Info	651-254-3827
Kathy Nielsen, Manager, Transcription	651-254-3026
Gina Hale, Manager, Coding	651-254-2457
Michelle Ballentine, Supervisor, Chart Processing	651-254-2823

HOURS **24 Hours Per Day, Seven Days Per Week**

WHAT DO I NEED TO KNOW ABOUT HEALTH INFORMATION MANAGEMENT?

1. **Chart completion requirements and timeframes**. All chart completion (a.k.a. chart deficiencies, incomplete charts) is performed electronically through your Epic In-basket folders. If you have not received Epic training, please sign up. You are expected to complete your charts before you leave for another rotation. Chart completion timeframes are also found in the Medical Staff Rules and Regulations, as well as this section of your manual:

   H&P – within 24 hours of admission
   Operative Report – immediately following surgery (timeframe currently under discussion)
   Discharge Summary – day of discharge, particularly when patient is going to another facility
   Verbal orders – within 24 hours of being placed

2. **Dictation instructions**. You are expected to identify the staff you are dictating for, as well as the date of service, your name, and other details. Please read the dictation guidelines found in this section.

3. **Required elements of reports (H&P, Discharge Summary, etc.)** Whether you are using dictation, Dragon, or Epic templates, you are required to capture certain elements depending on the document type. The elements/templates are included in this section.

4. **Viewing charts for research/studies**. You **must** have approval from the IRB to perform a study, even if the information is electronic. Patients are counting on us as an organization to protect their information. If you are viewing their information without IRB approval, you are breaching their information. If the information you need is in hard copy, we will need your list at least 48 hours in advance along with IRB approval.

5. **Patient Lists.** We do not have a listing of the patients you have seen. This is something you need to keep track of.

6. **Care Everywhere.** Everyone who uses Care Everywhere is responsible for obtaining patient consent. If no consent is obtained, it is considered a breach, which can result in disciplinary measures up to, and including, termination.

USE OF MEDICAL RECORDS

Medical records are to be used within the department except in the areas of direct patient care, ancillary patient care and conferences. When a record is checked out, it must be returned by 8pm on the day requested. Arrangements may be made with the Health Information Management Department staff to reserve a record for use for the following day.

COMPLETION OF MEDICAL RECORDS

The paper record portions of discharged patients are brought directly to the Health Information Management Department on the evening of discharge for scanning into the electronic medical record (Epic)

The Medical Staff Rules and Regulations state the following chart completion schedule:

1. All entries into the medical record must be dated, authenticated, and preferably timed.
2. An admitting note will be documented at once. History and Physical Examination completed within 24 hours of admission.
3. Progress notes should be documented at least:
   a. Daily on all patients in the intensive cardiac and special care units.
   b. Five days weekly in acute care areas.
   c. Approximately every other day for areas such as rehab, alcohol/drug abuse or psychiatry.
4. Operative reports must be documented immediately.
5. Verbal orders must be signed within 24 hours
6. Discharge summary following approved format including principal diagnosis should be completed at time of discharge. Do not use abbreviations or symbols in the discharge summary. A final diagnosis must be listed.
7. All portions of the record including any required signatures must be completed within 30 days.

Chart Deficiencies are tracked in Epic. You will receive and complete chart deficiencies through your Epic in-basket folders. Our Incomplete Chart Room staff is available at 651-254-2433 during the day if you need assistance.

MEDICAL RECORD DOCUMENTATION REQUIREMENTS

As required by:

REGIONS HOSPITAL MEDICAL STAFF BYLAWS
THE JOINT COMMISSION REQUIREMENTS
UNIVERSAL HOSPITAL DISCHARGE DATA SET (UHDDS) REQUIREMENTS
MEDICARE CONDITIONS OF PARTICIPATION
APPLICABLE MN STATUTES OR RULES

The hospital shall maintain medical records that are documented accurately and in a timely manner, that are readily accessible, and that permit prompt retrieval of information, including statistical data.

An adequate medical record shall be maintained for every individual who is evaluated or treated as an inpatient, observation status, same day surgery, ambulatory care patient, or emergency patient, or who receives patient services in a hospital-administered home core program.

The medical record shall contain sufficient information to identify the patient, to support the diagnosis, to justify the treatment and to document the results accurately.

All records should contain:

- identification data
- medical history and physical examination
- diagnostic and therapeutic orders
- evidence of appropriate informed consent
- clinical observations, including results of therapy reports of procedures, tests, and the results
- conclusions at termination of hospitalization or evaluation/treatment

The medical records shall be confidential, secure, current, authenticated, legible, and complete.

The attending physician to whom a case is assigned is responsible for the completion of the medical record. The attending physician may delegate portions of the work to those supervised by the attending physician.

The Medical Records Committee will determine when a record is complete for filing of the case.

All records of all kinds are the property of Regions Hospital and may not be removed from the premises without permission of the Medical Director and then only by court order, subpoena or statute.

MEDICAL RECORD CONTENT

1. Identification data shall contain:
   - Patient's name
   - Address
   - Date of birth
   - Next of kin
   - Patient medical record number

2. History and physical examination

   An admitting note with a working diagnosis will be written at once and a history and physical examination (dictated or written) will be completed within twenty four (24) hours of admission. When dictating a history and physical, please follow the approved format.

   Except in an emergency, no surgery will be performed on a patient without a signed history, physical examination and indicated laboratory tests.

   If a complete history has been obtained and a complete physical examination performed within 30 days prior to admission, a durable, legible copy of this report may be used in the patient's medical record, provided there has been no change subsequent to the original examination or the changes have been recorded at the time of admission.

   When a patient is readmitted within seven (7) days for the same or related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record.

   Obstetrical records should include all prenatal information. A durable, legible original or reproduction of an office or clinic prenatal record is acceptable with any updates since the last examination noted if greater than 1 week prior the admission.

3. Diagnostic and Therapeutic Orders

   Orders by physicians will be entered plainly and legibly in the manner approved by the Executive Committee.

   Verbal orders will be signed by the person to whom dictated. with the letters V/O, the name of the physician, and the slash symbol (“/”) and the name of the person to whom dictated.

   Telephone orders will be signed by the person to whom dictated. with the letters T/O, the name of the physician and the symbol per and the name of the person to whom dictated. At the next visit, the physician or resident will sign the order.

   Abbreviations and symbols approved by the Patient Care Committee may be used in orders. DO NOT utilize abbreviations when documenting the final diagnosis(es) and procedure(s). There is also a list of "Do Not Use" abbreviations which must be strictly followed for patient safety.

4. Appropriate Informed Consent

   No surgical operations will be performed without the written consent of the patient or the patient's legally qualified representative if the patient is a minor, incompetent or otherwise unable to act. This informed consent must provide at least the following information: who specifically will perform the procedure; what the procedure is: the possibility of risks and complications; provisions for anesthesia as required; and disposal of any tissue removed in the course of the procedure.

5. Clinical Observations

   Progress notes should give a pertinent chronological report of the patient's course in the hospital and should reflect any change in the condition and the results of treatment.

   - any change in patient's condition in specific terms
   - test results
   - therapy results

- procedures done
- complications
- consultants' assessment and recommendations
- assessment of treatment results
- any change in plan

Progress notes should be documented immediately on admission and according to Medical Staff Bylaws thereafter.

A satisfactory consultation includes examination of the patient and the record, followed by a signed report including diagnosis and recommendations that becomes a part of the permanent record. When dictating a consultation, please follow the approved format.

6. Reports of Procedures, Tests and the Results

All diagnostic and therapeutic procedures should have an order entered and authenticated in the electronic record. This may also include any reports from facilities outside of the hospital, in which case the source facility shall be identified on the report.

Reports of pathology and clinical laboratory examinations, radiology, and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedure should be promptly completed and filed in the record within twenty four (24) hours of report generation.
The responsible practitioner should record and authenticate a preoperative diagnosis prior to surgery.

Operative reports should contain:

- Preoperative diagnosis
- Postoperative diagnosis
- Complete title of surgery
- Name of primary surgeon and assistants (spell name of assistants & their title:
  (e.g. PA, M.D., etc)
- Indication for procedure
- Technical procedures used
- Specimens removed
- Intraoperative complications
- Description of findings
- Date of surgery

A postoperative **progress note** should be entered in the medical record immediately and should include: name of primary surgeon and assistants, findings, procedure, estimated blood loss, specimens removed, and postoperative diagnosis.

All **operative reports** will be documented by the attending surgeon or an assistant immediately following surgery. The dictation of the operative report should follow the approved format.

7. Discharge Requirements:

Conclusions at termination of hospitalization should include the diagnosis or reasons(s) for admission, the principal and additional or associated diagnosis; significant findings; procedures performed; care, treatment and services provided; condition on discharge; and information provided to the patient and family, as appropriate. When dictating the discharge summary, please follow the approved format.

All relevant diagnoses established by the time of discharge should be recorded within the discharge summary without abbreviations or symbols.

The discharge summary should concisely recapitulate:

- The reason for hospitalization. This should include a brief description and short history of the patient's illness and pertinent findings or the physical examination.
- The patient's response to any medical or surgical treatment; any complications, as well as visits by consultants.
- Pertinent laboratory and x-ray findings. It is important that all laboratory reports be specific and described in quantitative rather than qualitative terms.
- The condition of the patient on discharge. This information should be stated in terms that permit a specific measurable comparison with the condition on admission.
- Any specific instructions given to the patient, and/or family as pertinent.
- Consideration should be given to physical activity, medication, diet and follow-up.
- Completed within the time frame specified by staff bylaws, rules and regulations.

To improve the accuracy of reports as well as facilitate turn-around time, please note the following guidelines when dictating:

- **If you are a resident, medical student, nurse clinician, physician assistant, nurse practitioner, etc., please identify staff you are dictating for at the beginning of your dictation.**
- **Always dictate the Date of Service.**
- Enter the correct patient identification number and report type. This information allows Transcription to quickly identify a specific report when necessary (and ensures proper placement in the electronic record).
- State and spell your name at the beginning of your dictation.
- Spell patient names.
- If dictating on a patient who has not yet been admitted, please identify the admit or surgery date. Please dictate preoperative history and physicals 24 hours prior to patient's admission whenever possible.
- Speak clearly and slowly.
- Give the surgery date when dictating an operative report and admission and discharge dates for discharge summaries.
- Dictating discharge summaries at the time of discharge helps facilitate continuity of care and assures timely, accurate reimbursement.
- Give date patient seen in ER reports.
- If a correction or deletion needs to be made on a report, please follow the guidance provided in the Edits and Addenda hospital policy.

- **Dictating Edits or Addenda in the Regions Dictaphone Text System** For dictated/transcribed reports, edits can be made at the time of electronic signature. Dictated edits/addenda will be transcribed as separate notes.

History and physicals are transcribed within three hours, consultations and inpatient operative reports within six hours, and Discharge Summaries within 24 hours. Please do not hesitate to contact Kathy Nielsen at 651-254-3026, if you have any questions or concerns regarding the dictation system.

RESEARCH

Records are pulled upon request for research studies. Approval must be received from the IRB and provided to the Department Manager prior to requesting the records to be pulled for review. The request should be in writing stating topic, number of years to be studied, requester's name, service and extension. Requests should be submitted a minimum of 48 hours in advance of starting date of the review. All studies/research should be completed within the Health Information Management Department. All study records not used within a 14-day period will be automatically re-filed. A list of records re-filed will be returned to you. Charges for pulling medical records will be billed back to the study.

UNIFORM HOSPITAL DISCHARGE DATA SET (U H D D S DEFINITIONS):

Diagnosis: All diagnoses that affect the current hospital stay.

Principal Diagnosis: is designated and defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

Other Diagnoses: are designated and defined as all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

Procedure and Date: All significant procedures are to be reported. A significant procedure is one that is: surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or requires specialized training. For significant procedures, the identity of the person performing the procedure and the date must be reported.

Principal Procedure: is one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there are two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure.

Surgery: includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture and manipulation.

Procedural Risk: This term refers to professionally recognized risk that a procedure may induce some functional impairment, injury, morbidity, or even death. This risk may arise from indirect trauma, physiologic disturbances, interference with natural defense mechanisms, or exposure of the body to infection or other harmful agents.

Traumatic Procedures: are those that are invasive, including non-surgical procedures that utilize cut downs, that cause tissue damage (e.g. irradiation) or introduce some toxic or noxious substance (e.g. caustic test).

Physiologic Risk: is associated with the use of virtually any pharmacological or physical agent that can affect homeostasis (e.g. those that alter fluid distribution, electrolyte balance, blood pressure levels, and stress or tolerance tests).

Any procedure in which it is obligatory (or usual) to utilize pre-or post-medications that are associated with physiologic or pharmacological risk should be considered as having a "procedural risk", for example, those that require heavy sedation or drugs selected for systemic effects used as alteration of metabolism, blood pressure or cardiac function.

Some of the procedures include harmful exposure risk to other persons as well as to the patient, thus, these requiring special precautionary measures.
Anesthetic Risk: Any procedure that either requires or is regularly performed under general anesthesia carries anesthetic risk, as do procedures under local, regional, or other forms of anesthesia that induce sufficient functional impairment necessitating special precautions to protect the patient from harm.

Specialized Training: This criterion is important for procedures that are exclusively or appropriately performed by specialized professionals, qualified technicians, or clinical teams that are either specifically trained for this purpose or whose services are principally dedicated to carrying them out. Whenever specially trained staff resources are necessary or any customarily employed in the performance of a procedure, it is considered significant.

BYLAWS: Time schedule of record completion:

- All medical records must be completed within 29 days of discharge.
- All final diagnoses and procedures shall be completed using UHDDS definitions.

Progress Notes:

- Progress notes must be documented at least daily on all patients in the intensive, cardiac and special care units.
- All acute care areas should have progress notes documented at least five (5) times weekly.
- Areas such as Rehabilitation, Alcohol & Drug Abuse, or Psychiatry approximately every other day.

DICTAPHONE DICTATION GUIDE

HEALTHPARTNERS FAMILY OF CARE
HEALTHPARTNERS
REGIONS HOSPITAL
HUDSON HOSPITAL
WESTFIELDS HOSPITAL
AMERY REGIONAL MEDICAL CENTER
LAKEVIEW HOSPITAL

DICTATION INSTRUCTIONS:

1. Dial 952-253-2525 (715-531-6240 for Hudson, 715-243-2605 for Westfields, 715-268-0101 for Amery/Luck)
2. Enter 5 digit Epic user ID, followed by the # key
3. Enter 1 digit facility ID where the patient was seen, 1 Regions, 2 Hudson, 3 Westfields, 4 HealthPartners, 5 St Cloud, 6 Amery, 7 Lakeview, 8 Luck.
4. Enter worktype, followed by the # key
5. Enter patient 8 digit MRN # followed by the # key (8 digit HPMG# for Regions – found at the top of the Epic screen)
6. Press 2 to begin dictation

WORKTYPES

2	History and Physical Inpatient	**28**	Dr. Helm Letters - Hudson	**69**	Luck Letter
3	Consultation Inpatient	**36**	Peer Review	**70**	Hospice Care – St. Cloud
4	Operative Report Inpatient	**37**	Care Plan	**71**	BH Clinic Note
5	Discharge Summary Inpatient	**40**	Colonoscopy - Amery	**72**	Neuropsychological Test
6	Emergency Medicine Note	**42**	Cardiac Cath	**73**	Psychological Test
7	Interim Summary/Progress Note Inpatient	**43**	Electrophysiology	**74**	Lakeview Letter
8	Radiology - Amery	**44**	Cardioversion - Amery	**75**	Chart Note
9	Referral Discharge Summary Inpatient	**45**	Cardiac Devices	**76**	Therapy Note
10	Critical Care Note ER	**46**	Holter Monitor - Hudson	**80**	Hospice Care - HealthPartners
11	Operative Report Outpatient	**47**	Transitional Care - HealthPartners	**84**	Neonatology/Newborn - Inpatient
12	Delivery Summary Inpatient	**54**	Third Party	**88**	Lakeview Clinic Note
13	Wound Clinic	**56**	Luck Clinic Note	**89**	Amery Clinic Note
15	Phone Message	**57**	Social Services - Luck	**90**	EEG/Evoked Potential Inpatient
16	Contracted Specialist Report - Westfields	**58**	BH Psych Eval - Amery	**91**	EEG Outpatient
17	Research - Regions	**59**	BH Discharge Summary - Amery	**92**	Bariatric Assessment
18	Radiology	**60**	Joint Injection - Hudson	**93**	Pulmonary Function Test
19	Inpatient Procedure – Hudson/Amery/Lakeview	**61**	Amery Letter	**94**	Long Term Care - HealthPartners
20	Outpatient Procedure	**62**	Regions Letter	**95**	Urodynamics - HealthPartners
21	Cardiology - Hudson	**63**	Hudson Letter	**96**	Cystoscopy - HealthPartners
22	External Cardiac Consultation	**64**	Westfields Letter	**97**	St. Cloud Clinic Note
23	GI Procedure Inpatient	**65**	HealthPartners Letter	**98**	Clinic Note – Regions/HealthPartners
25	GI Procedure Outpatient	**66**	St. Cloud Letter	**99**	Specialty Clinic Note - Westfields/Hudson
26	Anesthesia Note – Hudson/Amery	**67**	Hysterosalpingogram		
27	Stress Note	**68**	MMPI		

DICTATE KEYPAD FUNCTIONS:

2 Start/Stop recording
3 Rewind and automatic playback. Press 2 to start recording.
4 Fast forward, Press 3 to stop fast forward and play back
44 Fast forward to end of report. Press 2 to begin recording
5 Disconnect (to end dictation session)
6 STAT (mark current dictation as STAT). Press 2 to continue recording
7 Rewind. Press 3 to stop rewind and playback. Press 2 to start recording
77 Go to beginning of current dictation. Automatic playback
8 End report. Prompts for additional dictation
* Clear ID entry if a mistake is made when entering ID
Please state your name and patient's name at beginning of dictation. Give admission, discharge and surgery dates as well as date of service. If you are a resident, please identify the staff you are dictating for.

For assistance or if you need a listen access ID, please call the support center at 952-967-6600 and open a ticket for the Transcription team.

REGIONS HOSPITAL

Consultation

NAME:

MRN#:

PATIENT SERVICE:

CONSULT SERVICE:

STAFF:

REVIEW:

EXAMINATION AND FINDINGS:

RECOMMENDATIONS:

REGIONS HOSPITAL

Discharge (Death, Transfer) Summary

NAME:

MRN#:

ADMISSION DATE:

DISCHARGE DATE:

SERVICE:

STAFF:

ADMISSION DIAGNOSIS:

OPERATIONS/PROCEDURES:
COMPLICATIONS:

DISCHARGE DIAGNOSIS:

BRIEF HISTORY AND PERTINENT OBJECTIVE FINDINGS:

HOSPITAL COURSE:

DISCHARGE DISPOSITION:

DIET:

ACTIVITY:

DISCHARGE MEDICATIONS:

FOLLOWUP:

REGIONS HOSPITAL

History and Physical Examination

NAME:
MRN#:
ADMISSION DATE:
SERVICE:
STAFF:
UNIT:

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

PAST MEDICAL HISTORY: (Include allergies here or list separately)

FAMILY HISTORY:

SOCIAL HISTORY:

REVIEW OF SYSTEMS:
HEENT:
Cardiorespiratory:
Cardiopulmonary:
Genitourinary:
Gastrointestinal:
Neurological:

PHYSICAL EXAMINATION:
General:
Vital signs:
HEENT:
Neck:
Heart:
Lungs:
Breasts:
Abdomen:
Genitalia:
Pelvic:
Rectal:
Extremities:
Neurological:
IMPRESSION:

PLAN:

REGIONS HOSPITAL

Operative Report

NAME:

MRN#:
PROCEDURE DATE:
SERVICE:
UNIT:

STAFF SURGEON:

ASSISTANTS:

PREOPERATIVE DIAGNOSIS:

POSTOPERATIVE DIAGNOSIS:

PROCEDURE:

ESTIMATED BLOOD LOSS:

SPECIMENS REMOVED:

INDICATIONS AND DESCRIPTION OF PROCEDURE:

REGIONS HOSPITAL
Emergency Medicine

NAME:

DATE OF SERVICE:
SERVICE:
SUPERVISING STAFF:
RESIDENT:
LOG#:
UNIT:

BRIEF SUMMARY OF PREHOSPITAL

CARE: HISTORY:

PHYSICAL EXAM:

DATA (lab, x-ray, EKG, ultrasound, etc):

DIAGNOSIS:

INTERVENTION AND MANAGEMENT:

PROCEDURE NOTE:

COURSE IN THE EMD:

CONSULTATIONS:

PATIENT CONDITION:

DISCUSSION WITH FAMILY/RELATIVES:

FINAL DIAGNOSIS:

Regions Hospital

"DO NOT USE" ABBREVIATIONS, ACRONYMS AND SYMBOLS LIST

"DO NOT USE"	APPROVED PRACTICE
1. U instead of Units	Unit written out. Ex: Regular insulin **5 units**
2. IU instead of International Unit	International Unit written out. Ex: Vitamin E 400 **international units**
3. A. Q.D. B. Q.O.D.	Write out the abbreviation. A. Ex: "**daily**", "**q day**" B. Ex: "**every other day**", "**q48h**"
4. A. Trailing zero (1.0) B. Lack of leading zero	Trailing zero eliminated. A. Ex: Ativan **1 mg** IV x1 Add leading zero in order. B. Ex: Hydromorphone **0.5 mg** IV
5. An abbreviation or symbol used instead of medication name. These three are: A. MSO4 B. MgSO4 C. MS	Write out the medication name. A. **Morphine** B. **Magnesium Sulfate** or **Mag Sulfate** C. **Morphine**
6. Greek letter "ų" used to indicate "micro"	Eliminate "ų", write "mcg". Ex: Digoxin **125 mcg** PO today
7. Chemotherapy medication abbreviations	**SPELL OUT ALL** Chemotherapy medication names.
8. Routes. These six are: A. ad B. as C. au D. od E. os F. ou	SPELL OUT THE WORDS: "**eye**", "**ear**", "**left**", "**right**", "**both**"

Policy No. 50:05:15

"Do Not Use" Abbreviations, Acronyms, and Symbols List

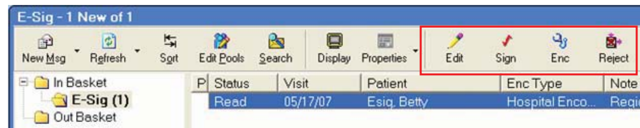
Reviewed / Revised / Approved by Health Records Committee – June 2011

E-Sig

Signing dictations/transcriptions electronically in Epic's In Basket

E-Sig Activities

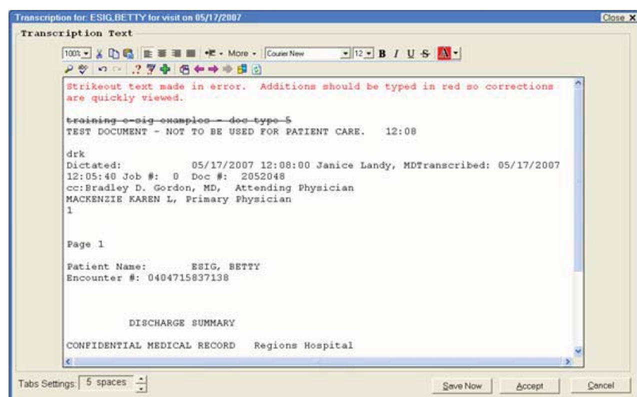
Edit: Creates an Addendum to an original note.
Sign: Authenticates (or authorizes) the note with the signer's signature.
Encounter: Opens the patient chart associated with the note.
Reject: Forwards the note to transcription for reassignment. A rejected note will remain in the Chart Deficiency folder until transcription reassigns the note. Do not "Decline" the Deficiency.



Edit a Transcribed Note

Note: All addendums (edits) are now done in Epic – not dictated. If you dictate an addendum it will appear as a separate note in the chart.

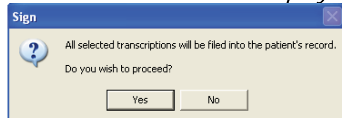
1. Click **Edit.**
2. Strikeout unwanted text and type new text in red. *This allows quick recognition of what changes have been made in the addended transcription.*



3. *Optional*: Click **Save Now** to save any changes; this creates a new addendum each time you click Save Now. This will not close the activity.

4. Click **Accept** to save changes and close the activity.

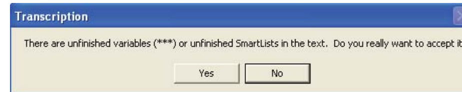
A confirmation window displays



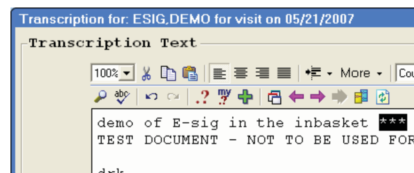
5. Click **Yes** to accept and file the edit changes made. *The In Basket status will change to Pend.*

Note: Transcription may add a **wildcard (***)** if unable to complete a transcription note. Incomplete variables must be completed to **Accept** a note.

A Transcription prompt displays if there are incomplete variables



6. Click **No** to close prompt, return to the note and complete variables.



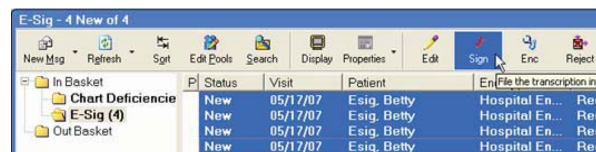
7. Click **F2** to complete unknown variables.

Sign (E-Sign) Transcription

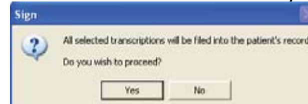
1. Click **Sign** to authorize the transcription. *The In Basket status will change to Done.*

Note: Signing multiple notes at one time is an option *after* reviewing each note. Signing more than 50 notes at a time may cause system performance problems during business hours. It is recommended that the E-Sig In Basket is checked and addressed daily.

2. Highlight the notes to Sign.
3. Click **Sign**.

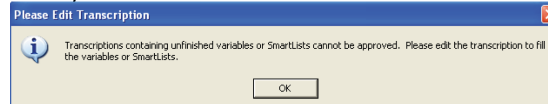


A confirmation window displays



4. Click **Yes** to sign the selected notes.

A Please Edit Transcription window displays for notes with incomplete variables



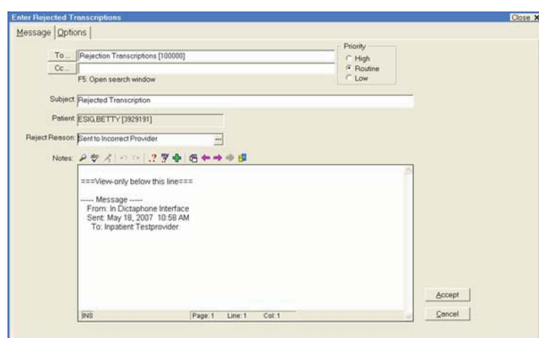
5. Click **OK**, and then edit notes.

Encounter

1. Click **Enc** to open the chart for review.

Reject a Transaction

1. Click **Reject** to reject a transcription. Do not change the value in the "To" field.



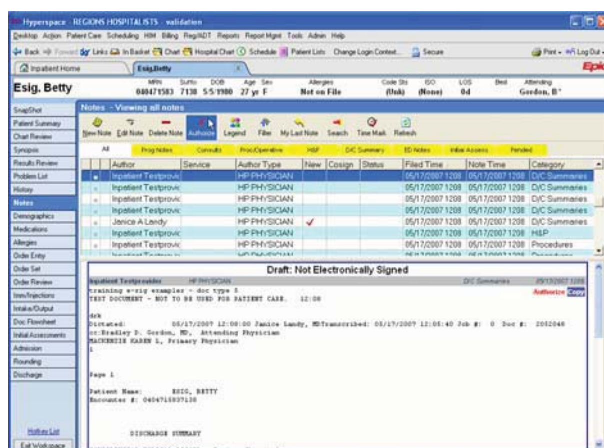
2. Click the **Reject Reason** field selection button to enter the reason for rejection (required).
3. Click **Accept**.

Note: A rejected note remains in the Chart Deficiency folder until transcription reassigns the note. Do not "Decline" the Deficiency.

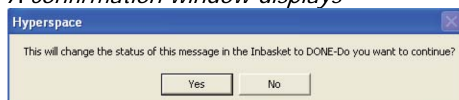
Sign in Notes Activity

Signing transcription notes from the **Notes** activity is an option.

1. Click **Notes** on the activity menu.
2. Select the note to sign.
3. Click the **Authorize** activity button.



A confirmation window displays



4. Click **Yes** to authorize.

Review E-Sig Notes in Chart Review

E-Sig notes can be reviewed in the Notes and Chart Review activities.

1. Click **Chart Review** on the activity menu.
2. Click desired note that has a status of *Available*.

Chart Review - filtered (records loaded: 22 (more records to load), records satisfying filter: 22)

Filters | Clear All Filters | Exclude | Select All | Deselect All | Start Review | Route

Encounters | Lab/EKG | Diag. Test/Proc | Other Orders | Medications | Episodes | Letters | Notes/Trans

Filing Date	Enc Date	Enc Type	Category	Status	Provide
05/21/2007 2:0...	05/17/2007	Hospital Encounter	Regions Consultation	Available	TESTP
05/21/2007 2:0...	05/17/2007	Hospital Encounter	Regions Consultation	Obsolete	TESTP
05/21/2007 2:0...	05/17/2007	Hospital Encounter	Regions Consultation	Obsolete	TESTP
05/18/2007 11:3...	05/17/2007	Hospital Encounter	Regions Consultation	Available	TESTP
05/18/2007 11:3...	05/17/2007	Hospital Encounter	Regions Consultation	Obsolete	TESTP
05/17/2007 12:0...	05/17/2007	Hospital Encounter	Regions Consultation	Available	TESTP
05/17/2007 12:0...	05/17/2007	Hospital Encounter	Regions Consultation	Available	TESTP
05/17/2007 12:0...	05/17/2007	Hospital Encounter	Regions Consultation	Available	TESTP
05/17/2007 12:0...	05/17/2007	Hospital Encounter	Regions Consultation	Unavailable	TESTP

The transcription note displays

Status Definitions:

Available: Transcription has been E-Signed and is available for patient care.

Obsolete: Transcription has been revised (addended) and is outdated.

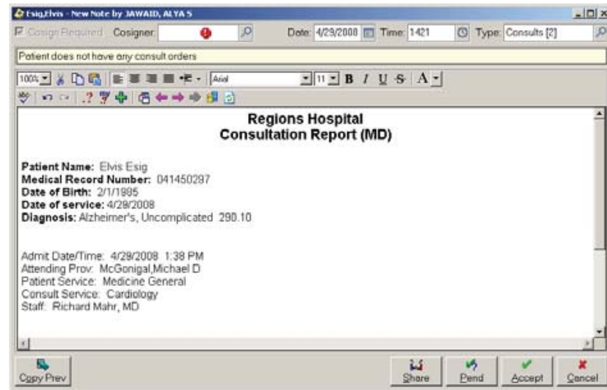
Unavailable: Transcription has not yet been E-Signed.

Composing a Note in Epic

Resident Consult, H&P, Operative, and Discharge Summary notes require a staff provider co-signature.

Resident

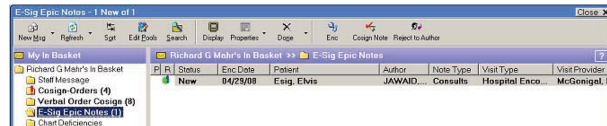
1. Enter a staff provider name in the **Cosigner** field.



Staff Provider

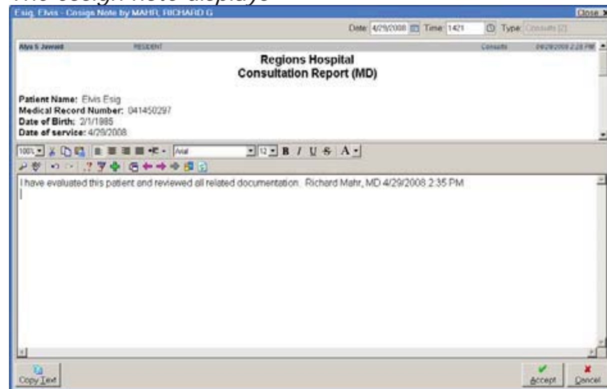
The designated cosigner will receive a new message in the In Basket **E-Sig Epic Notes** folder. A chart deficiency will be updated if appropriate; this will be resolved when the note is cosigned.

1. Select the note for review.



2. Click **Cosign Note**.

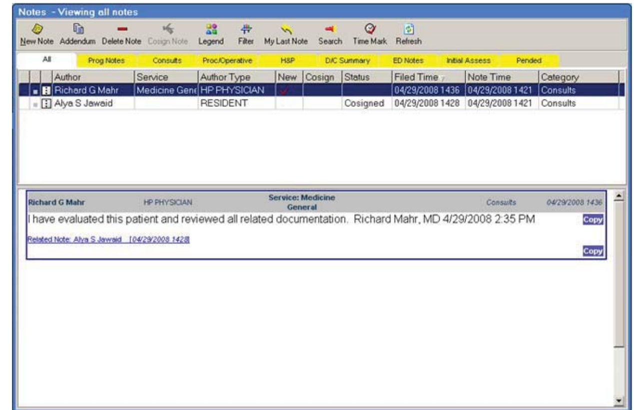
The cosign note displays



Note: the *Copy Text* button selects and copies all text in a note; this text can be pasted into a new note (i.e.; paste copied text after a .cosign DotPhrase).

3. Type the appropriate **.cosign** DotPhrase to validate the cosign note.
4. Click **Accept**.

Both notes will display in the Notes activity; each note presents with a collapse the note icon ⊟. The original and cosigned notes are linked via a hyperlink at the bottom of each note. **Cosigned** will appear in the Status Column of the original resident note after it has been cosigned. Clicking the hyperlink at the bottom of the cosigned note will open the associated staff provider cosign note.

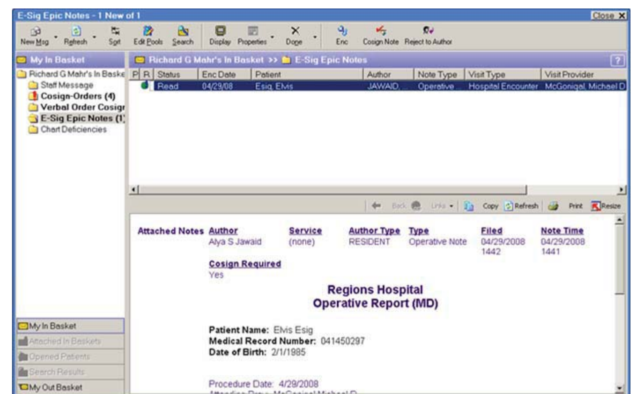


Rejecting a Cosign Required Note

Providers can reject cosign notes that are inadvertently assigned to the incorrect provider. Rejected notes are sent back to the resident author so they can change the designated cosigner.

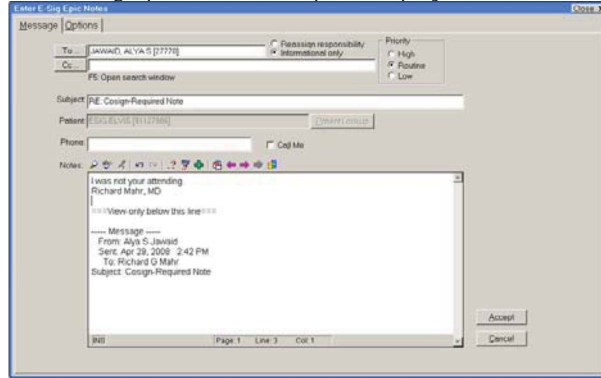
Staff Provider

1. Select the incorrect cosign note.



2. Click **Reject to Author**.

Enter E-Sig Epic Notes workspace displays



3. **Optional**: compose a rejection message (i.e.; "sent to incorrect provider") to send back to the resident.
4. Click **Accept**.

Note: *Retract* will remain in the status column until the resident reassigns the note to a new cosigner.

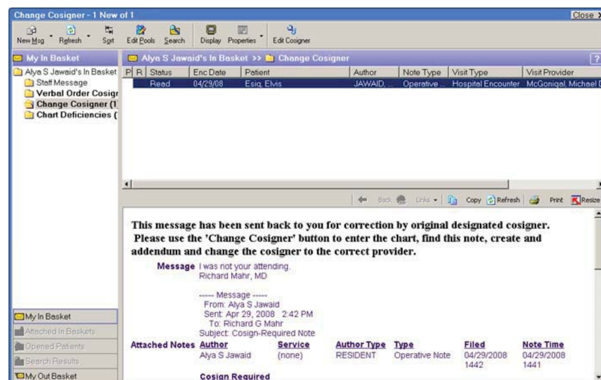
Reassigning the Rejected Note

Rejected notes will appear in the residents In Basket **Change Cosigner** folder.

Note: Select the rejected cosign note to display instructions on how to change the cosigner. The rejected note can be addended; this allows the resident to reassign the cosigning provider.

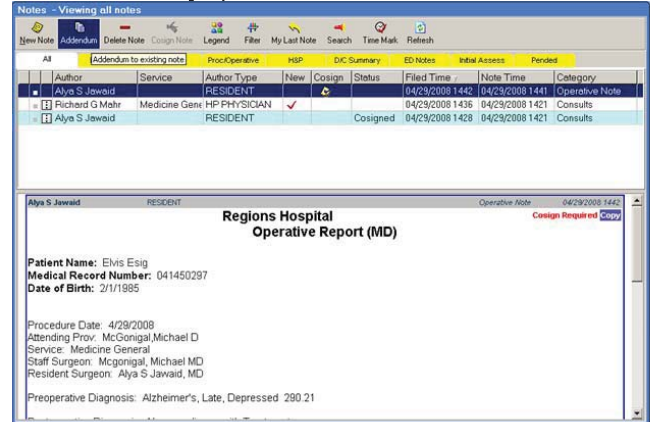
Resident

1. Select the rejected cosign note.

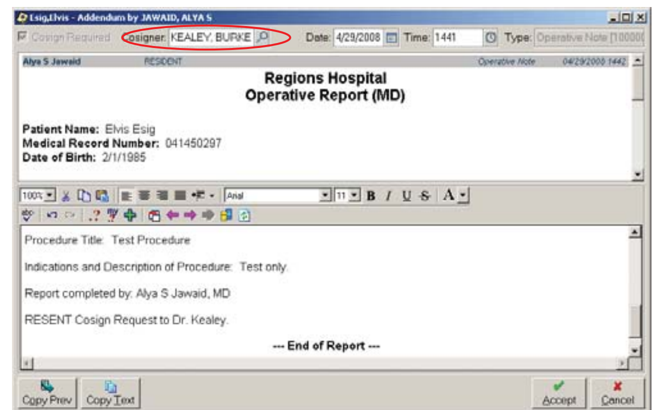


2. Click **Edit Cosigner**.

The Notes activity opens

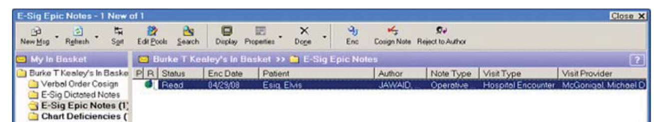


3. Click **Addendum** to reassign the cosign note.
4. Reenter the designated cosigner.



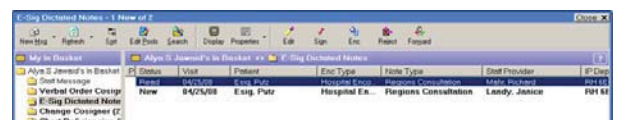
5. Document a reason for the addendum.
6. Click **Accept**.

The cosign note is rerouted to the correct provider to allow for the required co-signature.



E-Sig for Resident Dictated Notes

Residents continue to dictate the name of the cosigning provider when dictating a note. The transcription will appear in the resident's In Basket **E-Sig Dictated Notes** folder; an associated chart deficiency will be assigned to the designated cosigning provider.

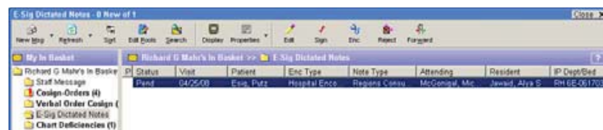


The *resident* E-Sig Dictated Notes folder has a **Staff Provider** column that displays the name of the provider responsible for the cosign note. If this staff provider is incorrect, reject the note immediately before editing. Transcription staff will then correct the note and resend it back to the resident with the correct provider.

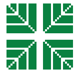
Click here to review directions on how to Edit/Sign an E-Sig note

The following confirmation prompt will display when a resident edits/signs a dictation; the note will be forwarded to the designated provider to be cosigned.

New: The *provider* E-Sig folder has been renamed the **E-Sig Dictated Notes** folder and now has a **Resident** column that displays the name of the resident who composed the original cosign note.



Note: Rejected dictations alert a Dictaphone transcriptionist; they will reroute the dictation to the correct staff provider.



Regions Hospital

Subject Edits and Addenda to Dictated/Transcribed Clinical Information	**Attachments** ☐ Yes ☒ No
Key words Edit, Addenda	**Number**
Category Management of Information (MI)	**Effective Date** 02/01/2003
Manual	**Last Review Date** 03/2008
Issued By Health Information Management	**Next Review Date** 03/2011
Applicable	**Origination Date**
	Retired Date
Review Responsibility Medical Record Committee	**Contact** HIM Department

I. PURPOSE

To ensure accurate clinical documentation in all clinical information systems (paper or electronic)

II. POLICY

In order to ensure accurate clinical documentation in all clinical information systems (paper or electronic), any revisions to dictated clinical documentation must be captured in the electronic systems. Whenever possible, revisions are made in the electronic system in which the document originated (i.e., Dictaphone Text, Co-Path, Chartscript, IDX, etc). Revisions to transcribed documents should be made at the time of electronic signature in Epic. If the original document is no longer retained in that system, then a new addendum document must be created. If the originating system does not provide a mechanism for revisions, the revisions will be made in the receiving system(s). A copy of the revised documentation must be interfaced to or scanned by all receiving electronic systems and/or filed in the paper-based medical record (per established protocols). The original, unaltered document must remain as part of the electronic patient record, and the patient record must permit access to the original document on demand.

Revisions are made in the format of either edits within the original document or addenda to the original document, and must change the content of the documentation. Revisions of documents for non-substantive changes (e.g. typos) is costly, and considered unnecessary rework.

III. PROCEDURE(S)

Dictating Edits or Addenda in the Regions Dictaphone Text System: Edits are used to correct unsigned documents <=30 days from date of service or discharge; addenda are used to correct signed documents and documents >30 days from date of service or discharge. Addenda are done as separate reports because of electronic signature in Epic.

Dial dictation system (254-5454)
Enter 4-digit dictator ID, 2-digit worktype, and 13-digit encounter number, as prompted.

Begin dictating as follows: "The following dictation is an (edit or addendum) to document ID # (found at bottom of transcribed report), patient name and patient MRN"

Dictating Corrections to Administrative Errors: Dictate an addendum to correct an erroneously placed document in the patient's chart.

Dial dictation system (254.5454)
Enter 4-digit dictator ID, 2-digit worktype, and 13-digit encounter number, as prompted.

Begin dictating as follows: "The following dictation is an addendum to document ID # (found at bottom of transcribed report), patient name and patient MRN. This document was erroneously placed in the patient's chart (due to dictation, interface, transcription error, if known), and should no longer be used for patient care." If known, provide the transcriptionist with the correct date of service, patient name and patient MRN for the document.

IV. DEFINITIONS

V. COMPLIANCE

VI. ATTACHMENTS

VII. OTHER RESOURCES

Internal:

Other:

VIII. APPROVALS

NAME:	NAME:
TITLE:	TITLE:

IX. ENDORSEMENT

Revised 12.22.11

REGIONS HOSPITAL
ABBREVIATION LIST

Issued by: Health Information Management Department

The following is a list of the only accepted and approved abbreviations that may be used within the medical record at Regions Hospital. Regions Hospital accepts international abbreviations and combinations of abbreviations that are recognized by the U.S. Government, e.g. weights and measures and the Periodic Table of Elements. In addition, Regions Hospital also accepts the nationally recognized licensures and accreditations, e.g. MD, RN, PA etc.

For weights and measures please refer to the U.S. Government web site:
http://ts.nist.gov/weightsandmeasures/publications/appxc.cfm

5-HIAA	5-hydroxyindoleacetic acid
A_2	Aortic second sound
A1C	hemoglobin A1C
AA	amino acids
AAA	abdominal aortic aneurysm
AAROM	Active assistive range of motion
A&B	apnea / bradycardia
Ab	antibody
AB	abortion
abd	abdomen
ABD Hyst	Abdominal Hysterectomy
ABG	arterial blood gas
abi	ankle brachial index (Radiant Radiology)
ABP	arterial blood pressure
ABX	antibiotics
ac	Before Meals
AC	acromioclavicular
A/C	Assist Control
ACD	Active Compression - Decompression
ACh	acetylcholine
ACDF	anterior cervical disc fusion
ACEI	angiotensin converting enzyme inhibitor
ACH	Adrenocortical hormone
ACJ	acromioclavicular joint
ACL	Anterior cruciate ligament
ACLS	Advanced Cardiac Life Support
ACS	Acute Coronary Syndrome
ACTH	Adrenocorticotrophic hormone
ACT	activated clotting time
ad	to; up to
ad lib	as much as needed; as desired
ADA	American Diabetes Association
ADAP	Alcohol and Drug Abuse Program
ADAT	advance diet as tolerated
ADC	Adult Detention Center
add	adduction
addl	additional (Radiant Radiology)
ADH	Anti-diuretic hormone
Adj IBW	Adjusted ideal body weight
ADL	Activities of daily living
adm	Admission

AE — above elbow
AEA — above elbow amputation
AFB — Acid fast bacilli
AFib — Atrial fibrillation
AFlut — Atrial Flutter
AFO — Ankle foot orthosis
AFP — alpha-fetoprotein
Ag — antigen
AGA — Appropriate for gestational age
A/G ratio — albumin-globulin ratio
AI — aortic insufficiency
AICD — Automatic implantable cardioverter defibrillator
AJs — ankle jerks
AK — above the knee
AKA — above the knee amputation
ALA — aminolevulinic acid
alb — albumin
ALIF — anterior lumbar interbody fusion
alk phos — alkaline phosphatase
ALL — acute lymphocytic leukemia
ALS — Advanced Life Support
ALS — amyotrophic lateral sclerosis
ALT — alanine aminotransferase (formerly SGPT)
AM — morning
AMA — against medical advice
Amb — ambulance
AMI — Acute myocardial infarction
AML — acute myeloid leukemia
Amp — amputation
amt — amount
ANA — antinuclear antibody (FANA)
anat — anatomy; anatomical
ANC — absolute neutrophil count
Anes — anesthesia
angio — angiography (Radiant Radiology)
ANNA — anti-neuronal nuclear antibody
ant — anterior
ante — before
Anti-factor Xa — a heparin test
A&P — auscultation and percussion
AP — anterior posterior (Radiant Radiology only)
A/P — anterior / posterior
APAP — acetaminophen
APL — acute promyelocytic Leukemia
APP — Advanced Practice Provider
append — appendix (Radiant Radiology)
appt — appointment
APT — Ante partum Testing
aPTT — activated partial thromboplastin time
aq — aqueous; water
ARB — Angiotensive-receptor blocker
ARC — AIDS related complex
ARDS — adult respiratory distress syndrome
ARF — acute renal failure
AROM — active range of motion
Art — arterial line
art — artery (Radiant Radiology)
AS — aortic stenosis
ASA — aspirin
ASAP — as soon as possible
ASCUS — atypical squamous cell of undetermined significance
ASCVD — atherosclerotic cardiovascular disease
ASD — atrial septal defect
ASHD — aterioscleroti c heart disease
asmt — absorptiometry (Radiant Radiology)
ASO — antistreptolysin O
AST — aspartate aminotransferase (formerly SGOT)
ATFL — anterior tibial-fibular ligament

AUC	area under the curve (carboplatin dosing)
A-V	arteriovenous
AV	arterioventricular
AVB	Atrial-Ventricular Block
Avg	average
AVM	Arteriovenous Malformation
AVN	avascular necrosis
AVR	aortic valve replacement
axil	axillary (Radiant Radiology only)

B12	vitamin B 12
BAD	bipolar affective disorder
BAERs	brain stem auditory evoked responses
BAL	bronchial alveolar lavage
Barb	barbiturates
BART	banana, apples, rice, toast
BAT	brightness acuity test
BB	backward bend
BBFF	both bone forearm fracture
BC	base curve
B&C	board and care
BCA	**Bureau of Criminal Apprehension**
BCG	vaccine for TB
BE	Barium enema
BEE	Basal energy expenditure
b/el	below elbow
BEA	below elbow amputation
BFB	Biofeedback
BG	blood glucose
BH	Behavioral Health
BHCG	beta human chorionic gonadotropin
bib	drink
Bicarb	Bicarbonate
bid	twice a day
bif	bifurcate (Radiant Radiology)
bil	biliary (Radiant Radiology)
bilat	bilateral (Radiant Radiology)
Bili	bilirubin
BIPAP	Bi-level Positive Airway Pressure
BK	below the knee (amputee)
BKA	below the knee amputation
BLS	Basic Life Support
BM	bowel movement
BMI	body mass index
BMP	Basic metabolic profile
BMR	basal metabolic rate
BMS	bare metal stent
BNO	bladder neck obstruction
BNP	B-type natriuretic peptide
BP	blood pressure
BPD	bronchopulmonary dysplasia (newborn)
BPH	benign prostatic hypertrophy
bpm	breaths per minute
Brady	Bradycardia
BRBPR	bright red blood per rectum
BRP	bathroom privileges
BS	bowel sounds
BSA	body surface area
BSF	basilar skull fracture
BSO	bilateral salpingo-oophorectomy
BST	backward sacral torsion
BTB	bone-tendon-bone
BTE	Baltimore Therapeutic Equipment
BUC	Buccal
BUN	blood urea nitrogen
BVM	bag valve mask
Bx	biopsy
bx	biopsy (Radiant Radiology)

$\bar{c}$ (with a line over the c)	with
C	centigrade
C diff	clostridium difficile

ca	cancer; carcinoma
CA	cancer (Radiant Radiology)
CAB	coronary artery bypass
CABG	coronary artery bypass graft
CAD	coronary artery disease
cal	calcium (Radiant Radiology)
CAM	Controlled Ankle Motion
cap	capsule
CAPD	continuous ambulatory peritoneal dialysis
card	cardiac (Radiant Radiology)
cath	catheter; catheterization
CBC	complete blood count
CBE	Clinical breast exam
CC	chief complaint
CCI	Continuous cardiac index
CCJ	calcaneocuboid joint
CCO	Continuous cardiac output
CCU	Cardiac Care Unit
CD	chemically dependent
CD#	cluster designation (always followed by a number ex. CD4)
CDT	complete decongestive therapy
CE	complete exam
CEA	carcino-embryonic antigen
cent	central (Radiant Radiology)
cerv	cervical
CF	cystic fibrosis
CFJ	coxa femoral joint
CFL	calcaneal fibular ligament
CGA	contact guard assist
cholangio	cholangiogram (Radiant Radiology)
CH50	total functional hemolytic complement
Chem 8	basic metabolic panel
Chemo	Chemotherapy
CHF	congestive heart failure
CHI	closed head injury
CHIRRP	Cardiac High Intensity Risk Reduction Program diet
Chol	cholesterol
chole	cholecystectomy
CICU	Coronary Intensive Care Unit
CI	Cardiac index
CIVI	Continuous intravenous infusion
CIWA-Ar	Clinical Institute Withdrawal Assessment for Alcohol
CK	creatine kinase
CKMB	creatine kinase muscle Brain
CL	contact lens
CLD	Clear liquid diet
CLIU	Cath Lab Intervention Unit
CLL	chronic lymphocytic leukemia
CMC	carpal metacarpal
CMG	cystometrogram
CMS	capillary filling, movement and sensation
CMV	cytomegalovirus
CN (II-XII)	cranial nerves (2-12)
CNCJ	cuboid-navicular-cuneiform joint
CNS	central nervous system
c/o	complains of
CO	Cardiac output
CO2	Carbon Dioxide
COG	center of gravity
Conc CHO	Consistent Carbohydrate Diet
comp	complete (Radiant Radiology)
compr	compression (Radiant Radiology)
cont	continue / continuous
cont	contrast (Radiant Radiology)
COP	critical outcome pathway
COPD	chronic obstructive pulmonary disease
COW	Circle of Willis

CP	cerebral palsy
CPAP	continuous positive airway pressure
CPC	comprehensive psychiatric clinic
CPD	cephalopelvic disproportion
CPK	creatine phosphokinase
CPM	Continuous Passive Motion
CPOE	Computer-based Provider Order Entry
CPP	Cerebral perfusion pressure
CPR	cardiopulmonary resuscitation
CPT	Chest Percussion Therapy
CR	cycloplegic refraction
CrCl	creatinine clearance
Creat	creatinine
CRF	chronic renal failure
crnl	coronal (Radiant Radiology)
CRP	C-reactive protein
CRRT	Continuous Renal Replacement Therapy
Cryo	cryoprecipiate
CS	C-Section
CSF	cerebrospinal fluid
C-spine	cervical spine
C-Spine	cervical spine (Radiant Radiology only)
C-T	cervical thoracic spine (Radiant Radiology)
CT	computerized axial tomography
CTA	Coronary CT Angiogram
CTAB	Clear to auscultation bilaterally
CTJ	cervicothoracic junction
CTL	Clinical Team Leader
CTR	carpal tunnel release
CTS	carpal tunnel syndrome
cu	Cubic
CUG	cystourethrogram
CV	cardiovascular
CVA	cerebrovascular accident
CVAT	Costovertebral angle tenderness
CVC	Central Venous Catheter
CVP	central venous pressure
CVVH	Continuous Veno-venous Hemofiltration
CVVHF	Continuous Veno-venous Hemodiafiltration
CVVHD	Continuous Veno-venous Hemodialysis
CW	consistent with
cx	cervix
Cx	Culture
CXR	chest x-ray
Cysto	cystoscopy
D	diopters
D5W	5% Dextrose in water
D5 NS	Dextrose 5% Normal Saline
D5 ½ NS	Dextrose 5% ½ Normal Saline
D5 1/3 NS	Dextrose 5% 1/3 Normal Saline
D5 ¼ NS	Dextrose 5% ¼ Normal Saline
D Bili	direct bilirubin
D/C	discharge
D & C	dilatation and curettage
DASH	Dietary Approaches to Stop Hypertension
DAT	direct antiglobulin test
DAW	dispense as written
DB	diaphragmatic breathing
DBP	diastolic blood pressure
DBT	Dialetical Behavior Therapy
DCR	dacryocystorrhinostomy
DDAVP	Desmopressin Acetate
DDD	degenerative disc disease
decub	decubitus
deg	degrees (Radiant Radiology)
degen	degenerative
demo	demonstrate

Dep	Dependent
DES	Drug eluting stent
DF	dorsiflexion
DFA	diet for age
DHEA	dehydroepiandrosterone
DHEA-S	dehydoepiandrosterone sulfate
diagn	diagnostic (Radiant Radiology)
DIC	disseminated intravascular coagulation
diff	differential of white blood count
dil	diluted
DIP	distal interphalangeal
disc	discontinue
DJD	degenerative joint disease
DKA	diabetic ketoacidosis
DKTC	double knee to chest
DL	direct laryngoscopy
DLIF	direct lateral interbody fusion
DM	diabetes mellitus
DME	durable medical equipment
DMSA	dimercaptosuccinic acid (Radiant Radiology)
Dnase	deoxyribonuclease
DNA	deoxyribonucleic acid
DNAR	Do Not Attempt Resuscitation
DNR / DNI	Do not resuscitate / Do not intubate
DOA	dead on arrival
DOB	date of birth
doe	dyspnea on exertion
DOI	date of injury
dop	doppler (Radiant Radiology)
DOS	date of surgery
DOT	directly-observed therapy
DPI	Dry Powder Inhaler
DPL	diagnostic peritoneal lavage
D&PLB	diaphragmatic & pursed-lip breathing
drn	drain (Radiant Radiology)
DRSG	dressing
DRUJ	distal radioulnar joint
DRVVT	dilute Russell's viper venom time
d/t	due to
DT	diphtheria tetanus
dtpa	Pentetate (Radiant Radiology)
DTs	delirium tremens
DTR	deep tendon reflexes
DVT	deep vein thrombosis
Dx	diagnosis
ea	each (Radiant Radiology)
EBD	**Emotional / Behavioral Disorder**
EBL	estimated blood loss
EBV	Epstein-Barr virus
EC	eyes closed
E-c	Enteric-coated
E Coli	Escherichia coli
ECCE	extracapsular cataract extraction
ECG	electrocardiogram
ECRB	extensor carpi radialis brevus
ECRL	extensor carpi radialis longus
ECT	electroconvulsive therapy
ECU	extensor carpi ulnaris
ED	emergency department
EDC	estimated date of confinement
EDD	estimated date of delivery
EDH	epidural hemorrhage
EDP	End Diastolic Pressure
EEG	electroencephalogram
EENT	eye, ear, nose and throat
EF	Ejection fraction
EFM	external fetal monitor
EFW	estimated fetal weight
eg	for example
EGA	Estimated Gestational Age
EGD	esophageal dilatation (Radiant Radiology only)
EHL	extensor hallicis longus

EKG	electrocardiogram
ELC	extended-length catheter
ELOS	estimated length of stay
ELP	electrophoretic pattern
embo	embolization (Radiant Radiology)
EMD	electromechanical disassociation
EMG	electromyogram
EMR	electronic medical record
EMS	emergency medical service
ENA	extractable nuclear antigens
Endo	endocrine
endo	endoscopy (Radiant Radiology)
ENG	electronystagmogram
ENT	ear, nose and throat
EO	eyes opened
EOB	edge of bed
EOD	end of day
EOL	end of life
EOM	extra-ocular movement
EP	Electrophysiology
EPAP	Expiratory Positive Airway Pressure
EPB	extensor pollicis brevis
EPL	extensor pollicis longus
EPO	erythropoietin
EPSE	extra pyramidal side effects
equip	equipment
ER	emergency room
ERCP	endoscopic retrograde cannulation of pancreatic duct
ER/PR	estrogen receptor/progesterone receptor
ERS	extended, rotated, side bent
ERT	Emergency Room Technician
ES	Extra-strength
ESI	Emergency Severity Index
ESOPH	esophogram (Radiant Radiology)
esp	especially
ESR	erythrocyte sedimentation rate
Est	Estimated
EST	electroshock therapy
ESWL	Extra-corporeal Shock Wave Lithotripsy
ETCO2	End Tidal Carbon Dioxide
ETOH	ethyl alcohol; ethanol
e-stim	electric stimulation
ETT	endotracheal tube
EUA	exam under anesthesia
ev	eversion
eval	evaluation
EVD	external ventricular drainage
ex	exercise
exam	examination
exchang	exchange (Radiant Radiology)
EX FIX	external fixator
exist	existing (Radiant Radiology)
exp	expiration (Radiant Radiology only)
exp	exploratory
ext	external (Radiant Radiology only)
ext	extremities
ext	extremity (Radiant Radiology only)
Ext	extension (Radiant Radiology only)
ext rot	external rotation
F	Fahrenheit
F	Female (Epic system only)
FIO2	Fraction of Inspired Oxygen
FA	forearm
FANA	florescent antinuclear antibody
fb	foreign body (Radiant Radiology)
FB	foreign body
FBS	fasting blood sugar
FCR	flexor carpi radialis
FCU	flexor carpi ulnaris
FDIU	fetal death in utero
FDP	flexor digitorum profundus

FDS	flexor digitorum sublimis
FEF	Forced Expiratory Flow
FENA	Fractional Excretion of Sodium
FESS	functional endoscopic sinus surgery
FEV1	Forced expiratory volume in 1 second
FF	forward flexion
FFP	fresh frozen plasma
FH	family history
FHT	fetal heart tones
fib	fibula
fibro	fibromyalgia
FlE	flexional extension
FIM	functional independent measure
FISH	fluorescence in situ hybridization
FL	fluor-I-strip
FL	fluoroscopy (Radiant Radiology)
FLA	fluorescein angiogram
FLD	Full liquid diet
flex	flexion
Flex	flexion (Radiant Radiology only)
FNA	fine needle aspirate
FO	Fiber optic
FOOSH	fall on out-stretched hand
FPB	flexor pollicis brevis
FPL	flexor pollicis longus
FRS	flexed, rotated, side bent
FSG	Finger stick glucose
FSH	follicle-stimulating hormone
FST	forward sacral torsion
FT	feeding tube
FTA	fluorescent treponemal antibody
FTT	failure to thrive
f/u	follow-up
FUO	fever of undetermined origin
FVC	Forced vital capacity
FWB	full weight bearing
FWW	front-wheeled walker
Fx	fracture

g	gram
G-1	First Year Resident
G-2	Second Year Resident
G-3	Third Year Resident
G-6-PD	glucose-6-phosphate dehydrogenase
G	gravida
GA	general anesthesia
GAF	Global Assessment of Functioning
GAGS	glycosaminoglycans (formerly mucopolysaccharides)
gastroc	gastrocnemius
GB	gallbladder
GBS	Group B Strep
GC	Gonococcus, gonorrhea
GCS	Glasgow coma score
GE	gastroesophageal
gen	general
GERD	gastroesophageal reflux disease
GETA	general endotracheal anesthesia
GFR	glomerular filtration rate
GGT	gamma glutamyl transferase
GH	growth hormone
GHJ	glenohumeral joint
GI	gastrointestinal
GJ	gastric jejunostomy (Radiant Radiology)
GJT	gastrojejunostomy tube
Gluc	glucose
glut	gluteus
GMS	Gomori methenamine silver stain
GP	general practitioner

GPC	giant papillary conjunctivitis
gr troch	greater trochanter
GSW	gunshot wound
GT	gastric tube / gastrostomy
gtt	drops
GTT	glucose tolerance test
G Tube	gastric tube (Radiant Radiology)
GU	genitourinary
GVF	Goldman visual field
Gyn	Gynecology
h	hour
H&E	hematoxylin & eosin stain
H&P	history and physical
H pylori	Helicobacter pylori
H2CO3	Carbonic Acid
HA	headache
HAA	Hepatitis antigen A
HAAb	Hepatitis A antibody
HBcAb	Hepatitis B core antibody
HBeAb	Hepatitis Be antibody
HBeAg	Hepatitis Be antigen
HBIG	Hepatitis B Immunoglobin
HBsAb	Hepatitis B surface antibody
HBsAg	Hepatitis B surface antigen
HBV	Hepatitis B virus
HC	hydrocortisone
HCG	human chorionic gonadotropin
HCM	health care maintenance
HCsAb	Hepatitis C surface antibody
HCT	hematocrit
HCV	Hepatitis C virus
HCVD	hypertensive cardiovascular disease
HDL	high-density lipoprotein
HDN	hemolytic disease of the newborn
HEENT	head, eyes, ears, nose and throat
Hem	Hematology
Hemi	hemiplegic
HENT	head, eyes, nose, and throat
HEP	home exercise program
Hep A	Hepatitis A
Hep B	Hepatitis B
Hep C	Hepatitis C
HF	Heart Failure
Hgb	hemoglobin
HHA	hand-held assist
HHC	Home Health Care
HIT/HITTS	Heparin-induced Thrombocytopenia / Thrombosis Syndrome
HIV	human immunodeficiency virus
HLA	human leukocyte antigen
HME	Heat & Moisture Exchanger
HMS	Heparin Management System
HO	House Officer
H/O	history of
HOB	head of bed
HOH	hard of hearing
HP	hot pack
HPI	history of present illness
HPV	human papillomavirus
HR	heart rate
HRJ	humeroradial joint
hrs	hours (Radiant Radiology)
hs	at bedtime, hour of sleep
HSG	Hysterosalpingography
HSV	herpes simplex virus
HT	height
HTN	hypertension
HTX	hemothorax
HUC	Health Unit Coordinator
HUJ	humeroulnar joint
HUS	hemolytic uremic syndrome
HVF	Humphrey visual field
HVGS	High Voltage Galvanic Stimulation
Hx	History

I&O	intake & output
IASD	intra-atrial septal defect
IBW	Ideal body weight
ICD	intracardiac defibrillator
ICH	intracranial hemorrhage
ICP	intracranial pressure
ICS	intercostal space
ICU	intensive care unit
I&D	incision and drainage
ID	identification
IDM	infant of diabetic mother
i.e.	that is
I:E	inspiration:exhalation
IFC	interferential current
IFE	immunofixation Electrophoresis
IFSE	internal fetal scalp electrode
IgA	immunoglobulin A
IgD	immunoglobulin D
IgE	immunoglobulin E
IGF	insulin-like growth factor
IgG	immunoglobulin G
IgM	immunoglobulin M
IHSS	idiopathic hypertrophic subaortic stenosis
ILI	Influenza-like illness
ILR	Independent living room
IM	intramuscular
IMF	infra-mammary fold
img	imaging (Radiant Radiology)
IMR	Illness Management and Recovery
INC	including (Radiant Radiology)
Indep	Independent
inf	inferior
Info	Information
inguin	inguinal (Radiant Radiology)
init	initial (Radiant Radiology)
init eval	initial evaluation
inj / asp	injury / aspiration (Radiant Radiology)
INR	international normalized Ratio
INS	insertion (Radiant Radiology)
insp	inspiration (Radiant Radiology only)
Insp	Inspiratory
inst	instructed / instructions
int	internal (Radiant Radiology only)
intra-op	intra-operatively
intravasc	intravascular (Radiant Radiology)
inv	inversion
IOL	intra-ocular lens
ionto	iontophoresis
IOP	intraocular pressure
IP	interphalangeal
IPAP	Inspiratory positive airway pressure
IPPB	intermittent positive pressure breathing
IQ	intelligence quotient
IR	internal rotation
IR	interventional radiology (Radiant Radiology)
IS	infraspinatous
iso	isometric
IT band	iliotibial band
ITB	intrathecal baclofen
ITN	intrathecal narcotic
ITP	idiopathic thrombocytopenia purpura
IUD	intrauterine device
IUGR	intrauterine growth retardation
IUP	intrauterine pregnancy
IUPC	intrauterine pressure catheter
IV	intravenous

IVC	inferior vena cava
IVCD	Intra-ventricular conduction delay
IVGTT	intravenous glucose tolerance test
IVP	intravenous pyelogram
IVPB	intravenous piggy-back
J tube	Jejunostomy tube
J Tube	jejunostomy tube (Radiant Radiology)
jt	joint
JT	joint (Radiant Radiology)
JVP	jugular venous pressure
K cal	kilocalories
Kd	pharmocokinetic rate constant
KE	knee extension
KJs	knee jerks
KOH	Potassium hydroxide
KPE	Kellerman phaco-emulsification
KUB	kidney, ureters, bladder
KVO	keep vein open
L	lumbar
L&A	light and accommodation
L&D	labor & delivery
LA	lupus anticoagulant
lab	laboratory
Lac	Laceration
lap	laparotomy / laparoscopy
LAP	leukocyte alkaline phosphatase
LAQ	long arc quads
lat	lateral
LAVH	laparoscopic assisted vaginal hysterectomy
LB	low back
LBP	low back pain
lbs	pounds
LBW	low birth weight
LCL	lateral collateral ligament
LD	learning disability
LDH	lactic dehydrogenase
LDL	low density lipoprotein
LE	lower extremity
Leuk	leukocytes
LFT	Liver Function Test
LG	lacrimal gland
LGA	large for gestational age
LH	lutinizing hormone
LHB	long head of biceps
LHD	left hand dominant
Lig	ligament
LIP	Licensed Independent Practitioner
liq	liquid solution
LIS	Lissinamine green
LMA	laryngeal mesh airway
LMP	last menstrual period
LMWH	Low Molecular Weight Heparin
LNMP	last normal menstrual period
LO	lateral oblique (Radiant Radiology only)
LOB	loss of balance
LOC	localization (Radiant Radiology)
LOC	loss of consciousness
lord	lordotic (Radiant Radiology only)
LOS	length of stay
low	lower (Radiant Radiology)
LP	lumbar puncture
lpf	low power field
lpm	liters per minute
LR	lactated ringers
L-S	lumbosacral spine (Radiant Radiology)
LS	lumbosacral
L/S ratio	lecithin-to-sphingomyelin ratio

LSD	lysergic acid diethylamide
L-spine	lumbar spine
L-Spine	lumbar spine (Radiant Radiology only)
LST	low segment transverse
LT	left (Radiant Radiology)
LTB	laryngotracheobronchitis
LTC	long-term care
ltd	limited (Radiant Radiology)
LTG	long-term goal
LTR	lower trunk rotation
LUQ	left upper quadrant
LV	Left ventricle
LVF	left ventricular function
LVSD	Left ventricular systolic dysfunction
LWBF	left without being finished
LWBS	left without being seen
LWE	local wound exploration
lymph	lymph node (Radiant Radiology)
lytes	electrolytes (Na, K, C02, and Cl)
M	Male (Epic system only)
MA	mental age
MAC	monitored anesthesia care
MAE	moves all extremities
Mag Sulfate	Magnesium Sulfate
mam	mammography (Radiant Radiology)
man	mandible (Radiant Radiology)
MAP	mean arterial pressure
MAR	Medication Administration Record
MAS	Modified Aldrete Score
MAT	multi-focal atrial tachycardia
Max	Maximum
max	maximum
maxfac	maxillofacial (Radiant Radiology)
MCA	motorcycle accident
MCC	motorcycle collision
mcg	microgram (Joint Commission recommendation)
MCH	mean corpuscular hemoglobin
MCHC	mean corpuscular hemoglobin concentration
MCL	medial collateral ligament
MCP	metacarpophalangeal
MCV	mean corpuscular volume
MDD	major depressive disorder
MDI	metered dose inhaler
ME	Medical Examiner
Mech soft diet	Mechanical soft diet
Mech Vent	Mechanical ventilation
meds	medications
mEq	milliequivalent
MET	muscle energy
MF	meniscofemoral
MFR	myofascial release
MGD	meibomian gland disease
mgmt	management
MI	myocardial infarction
MIBG	metaiodobenzylguanidine (Radiant Radiology)
MIC	minimum inhibitory concentration
MI-CD	mentally ill & chemically dependent
micro	microscopic
MICU	medical intensive care unit
MI&D	mentally ill & dangerous
Min	minute(s) - Epic use only
min	minute(s) – Epic use only
min	minimum (Radiant Radiology)
MIP	Maximum inspiratory pressure
Misc	Miscellaneous
MLC	Multileaf Collimator
MLD	manual lymph drainage

MMF	maxillary mandibular fixation
MMR	measles, mumps, rubella
MMSE	mini-mental status exam
MMT	manual muscle test
mo	month
mobs	mobilizations
mod	moderate
mod	modified (Radiant Radiology)
MO	medial oblique (Radiant Radiology only)
MOI	mode / mechanism of injury
MOM	milk of magnesia
mono	mononucleosis
morph	morphology (Radiant Radiology)
MPC	Mallampatis class
MPH	miles per hour
MR	magnetic resonance (Radiant Radiology)
MR	mentally retarded
MR#	medical record number
MRA	magnetic resonance angiography
MRE	manual resistive exercises
MRSA	methicillin resistant staphylococcus aureus
MRI	magnetic resonance imaging
ms	milliseconds
MS	multiple sclerosis
MSE	mental status exam
MSK	musculoskeletal (Radiant Radiology)
MS/MI	mitral valve stenosis / mitral valve insufficiency
MSPN	Medical Student Progress Note
MT	metatarsal
MTP	metatarsophalangeal
MTS	marginal tear strip
MU	Monitor Unit
muga	multiple uptake gated acquisition (Radiant Radiology)
multi	multiple (Radiant Radiology)
mV	millivolts
MV	minute volume
MVA	motor vehicle accident
MVC	motor vehicle collision
MVI	multivitamin injection
mvmt	movement
MVR	mitral valve regurgitation
MWM	mobilization with movement
myocard	myocardial (Radiant Radiology)
N/A	not applicable
NAPA	N-acetyl procainamide
NAS	no added salt
NB	newborn
NC	nasal cannula
NCF	Neuroleptic Consent Form
NDD#	National Dysphagia Diet #
ndl	needle (Radiant Radiology)
NDT	neurodevelopmental treatment
Neb	Nebulizer
neg	negative
Neuro	Neurology
NG	nasogastric
NGT	nasogastric tube
NH	Nursing Home
NHL	non-Hodgkin's lymphoma
NIBP	Non-invasive blood pressure
NIH-SS	National Institute of Health Stroke Scale
NJ	nasojejunal (Radiant Radiology)
nip	nipple (Radiant Radiology only)
NIPS	Non-invasive Programmed Stimulation
NJT	nasal jejunal tube (Radiant Radiology)
NKA	no known allergies
NKDA	no known drug allergies
NL	normal

NMES neuromuscular electric stimulation
NMR Neuro-Muscular Re-education
NM nuclear medicine (Radiant Radiology)
NMS neuroleptic malignant syndrome
nn nerve
noc night
non rep do not repeat
NOS No other symptoms
NPA near point of accommodation
NPC near point of convergence
NPH normopressure hydrocephalus
NPH Neutral Protamine Hagedorn (isophane insulin)
NPO nothing by mouth
NRB non re-breather mask
NS normal saline
NSAID Non-steroidal anti-inflammatory drug
NSR normal sinus rhythm
NST non-stress test
NSVD normal spontaneous vaginal delivery
NT not tested
NTG Nitroglycerin
NT / ND Non-tender, non-distended
NWB non-weight bearing

O 2 oxygen
OA osteoarthritis
OAE otocustic auditory emissions
OAJ occipital-atlanto joint
OB obstetrics
OBGYN obstetrics gynecology (Radiant Radiology)
Obls obliques (Radiant Radiology only)
OBS organic brain syndrome
occas occasionally
OCT oxytocin challenge test
OD overdose
ODD Oppositional Defiant Disorder
OFC occipitofrontal circumference
OGT orogastric tube
OGTT oral glucose tolerance test
OM otitis media
OOB out of bed
O & P ova and parasites
OPCU Outpatient Care Unit
OPD Outpatient Department
Ophth ophthalmology
OPV oral polio vaccine
OR operating room
ORIF open reduction, internal fixation
ORSE Over-Refraction Spherical Equivalent
Orth orthopedics
os by mouth

OT occupational therapy
OTC over the counter
oto otology

_
p (with a line over the p) after
P pulse
pCO2 Carbon dioxide concentration / partial pressure
p flex plantar flexion
p2 pulmonic second sound
P/A posterior/anterior
PA pernicious anemia
PA posterior anterior (Radiant Radiology only)
PA Pressure Pulmonary Artery Pressure
P & A percussion and auscultation

PAC	Premature atrial contractions
PACH	pachemeter test
PACU	Post Anesthesia Care Unit
PAD	Peripheral arterial disease
PADP	pulmonary artery diastolic pressure
Palb	prealbumin
palp	palpate / palpation
PAM	potential acuity meter
Pap	Papanicolaou test
PAS	Periodic Acid-Schiff stain
PASP	pulmonary artery systolic pressure
PAT	paroxysmal atrial tachycardia
Path	pathology
path	pathology (Radiant Radiology)
PBI	protein bound iodine
pc	after meals
PC	Pressure control
PCA	patient controlled analgesia
PCB	paracervical block
PCH	probate court hold
PCI	percutaneous coronary intervention revascularization
pcl	posterior chamber lens
PCL	posterior cruciate ligament
PCN	penicillin
PCO	posterior capsular opacity
PCP	phencyclidine hydrochloride
PCP	Primary Care Physician
PCR	polymerase chain reaction
PCT	proprioceptive training
PCV	packed cell volume
PCWP	pulmonary capillary wedge pressure
PD	peritoneal dialysis
PDA	patent ductus arteriosus
PE	physical examination
PE	pulmonary embolus
PEA	pulse-less electrical activity
peds	pediatric (Radiant Radiology only)
Ped	Pediatrics
PEEP	Positive end expiratory pressure
PEG tube	Percutaneous Endoscopic Gastrostomy tube
pel	pelvis (Radiant Radiology)
per	by
perc	percutaneous (Radiant Radiology)
PERRL	Pupils Equal Round & Reactive to Light
PERRLA	Pupils Equal Round Reactive to Light & Accommodation
PET	Positron Emission Tomography
PF	patellofemoral
PFC	Patient Flow Coordinator
PFSH	Past, family and / or social history
PFT	Pulmonary function test
PG	phosphatidylglyserol
pH	potential of Hydrogen of Carbon Dioxide alkalinity / acidity
PH	past history
Phos	phosphorus
PHQ9	Patient Health Questionnaire
PICC	peripherally inserted central catheter
PICU	pediatric intensive care unit
PID	pelvic inflammatory disease
PIH	pregnancy induced hypertension
PIP	Peak Inspiratory Pressure
PIP	Proximal interphalangeal
pirif	piriformis
PIV	Peripheral IV
PIVM	passive intervertebral motion
PJC	Premature junctional contractions

PKU	phenylketonuria
PLB	pursed-lip breathing
plcmt	placement (Radiant Radiology)
Plt	platelet
Plts	platelets
PM	Afternoon / evening
PMH	past medical history
PMNs	polymorphonuclear lymphocytes
PM&R	physical medicine and rehabilitation
PMS	premenstrual syndrome
PN	progress note
PND	paroxysmal nocturnal dyspnea
PNF	proprioceptive neuromuscular facilitation
PNH	paroxysmal nocturnal hemoglobinuria
PNS	Peripheral Nerve Stimulator
PO	by mouth
pO2	Partial Pressure of Oxygen
POBA	plain old balloon angioplasty
POC	products of conception
POCT	Point of Care Testing
POD	post-operative day
POE	prone on elbows
PORP	partial ossicular reconstruction prosthesis
Port	Portable (Radiant Radiology)
post	posterior (Radiant Radiology)
post-op	post-operative
Post Tib	Posterior Tibial
PP	packaged platelets
PPD	purified protein derivative
PPH	postpartum hemorrhage
PPI	Protein Pump Inhibitor
PPM	Permanent pacemaker
PPN	Peripheral parenteral nutrition
PPTL	post partum tubal ligation
PR	per rectum
PRBCs	packed red blood cells
PRE	progressive resistive exercises
Preg	pregnancy
pre-op	pre-operative
prep	preparation
pres	pressure (Radiant Radiology)
prev	previous (Radiant Radiology)
PRIND	partially reversed ischemic neurologic deficit
PRN	as needed, as necessary
pro	protein
proc	procedure (Radiant Radiology)
pron	pronation
PROG	prognosis
PROM	premature rupture of membranes
prosth	prosthesis (Radiant Radiology)
Protime	Prothrombin time
PRUJ	proximal radioulnar joint
PS	Pressure support
P/S	Procedural Sedation
PSA	prostate specific antigen
PSBO	Partial small bowel obstruction
PSC	posterior sclerotic cataract
PSI	Pneumonia Severity Index
PSS	Psychotic Severity Scale
Psy	psychiatry
pt	patient
PT	physical therapy
PTA	percutaneous transluminal angioplasty (Radiant Radiology)
PTA	prior to admission
PTCA	percutaneous transvenous coronary angioplasty
PTFL	posterior tibial-fibular ligament
PTH	parathyroid hormone
PT/INR	Prothrombin time plus INR
PTSD	post-traumatic stress disorder
Pulm	Pulmonary
punc	puncture (Radiant Radiology)

PUW	pickup walker
PV	per vagina
PVCs	premature ventricular contractions
PVD	Peripheral vascular disease
PWB	partial weight bearing
PXF	pseudo exfoliation
q	every
q # h	q2 h - every two hours q4 h - every four hours, etc.
q24h	every day, daily
q48h	every other day
qam	every morning
QC	Quality Control
qh	every hour
qhs	every night
qid	four times a day
qns	quantity not sufficient
qpm	every evening
qs	quantity sufficient
Quad	quadriplegic
quads	quadriceps
qual	qualitative
quant	quantitative
R	respiration
RA	rheumatoid arthritis
RA	Right atrium
RA	room air
rad	radiologist (Radiant Radiology)
RAF	rheumatoid arthritis factor
RAI	radioactive iodine
RASS	Richmond Agitation Sedation Scale
RAST	radioallergosorbent test
RBC	red blood cells
RC	rotator cuff
RCL	radial collateral ligament
RCT	rotator cuff tear
RD	radial deviation
RDS	respiratory distress syndrome
recip	reciprocal
recon	reconstruction (Radiant Radiology)
REE	Resting energy expenditure
re-ed	re-education
Rehab	rehabilitation
rep	let it be repeated
Resp	Respiratory
retic	reticulocyte
rev	revision (Radiant Radiology)
rev'd	reviewed
RF	Rheumatic fever
Rh	rhesus
RHD	Rheumatic Heart Disease
RIBA	recombinant immunoblot assay
right HD	right hand dominant
RJ Traction	Robert Jones traction
RLF	retrolental fibroplasia
RNA	ribonucleic acid
r/o	rule out (Radiant Radiology only)
R/O	rule out
ROM	range of motion
ROS	Review of Systems
rot	rotation
RPD	Rate of perceived dyspnea
RPE	Rate of perceived exertion
RPMI	Roswell Park Memorial Institute media
RPR	rapid plasma reagin syphilis (replaces VDRL)
RR	respiratory rate
RRA	radio receptor assay
RRT	Rapid Response Team
RSI	rapid sequence induction
RSV	respiratory syncytial virus
RT	right (Radiant Radiology)
RTC	return to clinic
RTS	revised trauma score
RTW	return to work

RUJ	radioulnar joint
RUQ	Right upper quadrant
RV	Right ventricle
RW	rolling walker
Rx	treatment

_
s (with a line over the s) without

S	sacral
S & R	Seclusion and Restraint
SAH	subarachnoid hemorrhage
SAO2	pulse oximetry O2 saturation
SAQ	short arc quads
sats	saturations
SB	side bending
SB	small bowel (Radiant Radiology)
SBA	stand-by assist
SBE	sub-acute bacterial endocarditis
SBO	small bowel obstruction
SBP	systolic blood pressure
S Brad	Sinus bradycardia
SBS	short bowel syndrome
SC	subcutaneous
scap	scapula
SCD(s)	Sequential Compression Device(s)
SCI	spinal cord injury
SCJ	sternoclavicular joint
SCM	sternocleidomastoid
SCO	sequential compression device
scrn	screening (Radiant Radiology)
SCUF	Slow Continuous Ultrafiltration
SDH	subdural hematoma
SDS	same day surgery
SE	spherical equivalent
SEA diet	Southeast Asian diet
SEC	single end cane
seg	segmental (Radiant Radiology)
sent	sentinel (Radiant Radiology)
SGA	small for gestational age
SGOT	serum glutamic oxalacetic transaminase (See AST)
SGPT	serum glutamic pyruvic transaminase (See ALT)
SGW	shotgun wound
SH	social history
shldr	shoulder
SI	sacroiliac
SIADH	syndrome of inappropriate anti-diuretic hormone
SICU	surgical intensive care unit
SIDS	sudden infant death syndrome
SIMV	Synchronized intermittent mandatory ventilation
SIRS	Systemic Inflammatory Response Syndrome
SKTC	single knee to chest
sl	slight
SL	Sublingual
SLE	systemic lupus erythematosus
SLP	Speech language pathologist
SLR	straight leg-raising
SLS	single leg stance
SMA	superior mesenteric artery syndrome
SMAb	smooth muscle antibodies
SNAG	sustained natural apophyseal glide
SNF	Skilled Nursing Facility
sngl	single (Radiant Radiology)
S/O	sign out
SOAP	Subjective, Objective, Assessment, Plan
SOAR	Survivors Offering Assistance In Recovery
SOB	shortness of breath
SOC	stayed order of commitment
sol	solution
SOMI	Sternal Occipital Mandibular Immobilization (collar)

S/P	status post
sp gr	specific gravity
SP02 (%)	oxygen saturation via pulse oximeter
spec	specimen
Spont	Spontaneous
SPT	serum pregnancy test
spv	supervised
S&R	seclude and restrain
SROM	spontaneous rupture of membranes
SS	supraspinatous
SSD	Source to Surface Distance
SSS	sick sinus syndrome
ST	sore throat
S Tach	Sinus tachycardia
Staph	staphylococcus
STAT	at once, immediately
STD	sexually transmitted disease
STG	short-term goal
STI	sexually transmitted infection
STJ	subtalar joint
STM	soft tissue mobilization
Strep	streptococcus
STS	Society of Thoracic Surgeons
STSG	split thickness skin graft
subclav	subclavian (Radiant Radiology)
sun	sunrise (Radiant Radiology only)
sup	superior
supin	supination
Surg	surgery
SUX	succinylcholine
SVC	Superior vena cava
SVO2	saturation of venous oxygen
SVR	systemic vascular resistance
SVRI	systemic vascular resistance index
SVT	Supra-ventricular tachycardia
sx	symptoms
syr	syrup
T	temperature
t ½	half-life (pharmacokinetic parameter)
T3	tri-iodothyronine
T4	thyroxine
T & A	tonsillectomy and adenoidectomy
T-band	theraband
T bili	total billirubin
T protein	total protein
TA	Applanation tonometer
tab	tablet
Tachy	Tachycardia
TACS	trauma acute care surgery service
TAH	total abdominal hysterectomy
TB	tuberculosis
TBA	to be assessed
TBG	thyroid binding globulin
TBI	traumatic brain injury
TBSA	total body surface area
TBUT	tear break-up time
TCD	transcranial Doppler (Radiant Radiology)
TCF	transitional care facility
TCJ	talocrural joint
TCN	tetracycline
TCU	transitional care unit
TD	transdermal
TDM	treadmill
TDWB	touch down weight bearing
TE	tangential excision
TEDS	thrombo-embolitic stockings
TEE	trans-esophageal echocardiogram
TENS	transcutaneous electric nerve stimulation
TF	tube feeding

t/f	to follow
TFJ	tibiofemoral joint
TFM	trans-friction massage
THA	total hip arthroplasty
THC	tetrahydrocannabinol
ther ex	therapeutic exercise
Ther Rec	Therapeutic Recreation
thor	thoracic (Radiant Radiology)
thorspine	thoracic spine (Radiant Radiology)
THR	Target heart rate
throm	thrombosis (Radiant Radiology)
TIA	transient ischemic attack
tib/fib	tibia fibula (Radiant Radiology only)
Tib	tibia
TIBC	total iron binding capacity
tid	three times a day
TIPS	Trans-jugular intrahepatic portosystemic shunt
Ti/Tot %	Inspiratory time / Total cycle time
TKA	total knee arthroplasty
TKE	terminal knee extension
TKO	to keep open
TLIF	Transforaminal Lumbar Interbody fusion
TLSO	thoracic lumbar sacral orthotic
TM	tympanic membrane
TMD	temporomandibular disorder
TMJ	temporomandibular joint
TMJs	temporomandibular joint (Radiant Radiology only)
TNJ	talonavicular joint
TOF	train of four
tol	tolerate
TONO	tonopen
TOP	termination of pregnancy
TOPO	topography
TORB	Telephone Order Read Back
TORCH	toxoplasmosis, rubella, cytomegalovirus, herpes simplex
TORCHS	toxoplasmosis , rubella, cytomegalovirus, herpes simplex, syphilis
TORP	total ossicular reconstruction prosthesis
tors	torsion (Radiant Radiology)
TOS	thoracic outlet syndrome
TP	transverse process
TPA	tissue plasminogen activator
TPN	total parenteral nutrition
TPR	temperature, pulse, respiration
TR	time request
Trach	Tracheotomy
trans	trans scapular (Radiant Radiology only)
transhep	transhepatic (Radiant Radiology)
transthora	transthoracic (Radiant Radiology)
transvag	transvaginal (Radiant Radiology)
Trig	triglycerides
tst	test (Radiant Radiology)
T-spine	thoracic spine
T-Spine	thoracic spine (Radiant Radiology only)
TSH	thyroid stimulating hormone
TTA	trauma team activation
TTE	Trans-thoracic cardiac echo
TTF-1	thyroid transcription factor 1
TTN	transitory tachypnea of newborn
TTP	thrombotic thrombocytopenia purpura
TTWB	toe touch weight bearing
TTY	Teletype
TUR	transurethral resection
TURP	transurethral resection of prostate
TV	Tidal volume

TX	treatment (Radiant Radiology)
Tx	treatment
txn	traction
Type 1 DM	insulin dependent diabetes mellitus
Type 2 DM	non-insulin dependent diabetes mellitus
U (circled)	unilateral
UA	urinalysis
UAC	umbilical artery catheter
UB	upper back
UBE	upper body ergometer
UBW	Usual body weight
UC	urine culture
UCD	usual childhood diseases
UCL	ulnar collateral ligament
UD	ulnar deviation
UE	upper extremity
UFH	Unfractionated heparin
UGI	upper gastrointestinal (Radiant Radiology only)
Unilat	unilateral (Radiant Radiology only)
U/O	Urine output
up	upper (Radiant Radiology)
UPJ	ureteropelvic junction
UPT	urine pregnancy test
URI	upper respiratory infection
Uric	uric acid
Urol	Urology
US	ultrasound (Radiant Radiology)
U/S	ultrasound
UT	upper trapezius
UTD	up to date (vaccinations)
UTI	urinary tract infection
UUN	Urinary Urea Nitrogen
UVC	umbilical vein catheter
UVJ	uncovertebral joint
V	volts
VA	visual acuity
vac	vacuum assisted delivery
VAC	vacuum assisted closure
vag	vagina
Vasc	Vascular
VATS	video assisted thoracic surgery
VBAC	vaginal birth after cesarean
VBG	venous blood gas
VC	verbal cues
VCG	vectorcardiogram
VCUG	voiding cystourethrogram
VD	venereal disease
VDRL	Venereal Disease Research Laboratories (test)
VE	exhaled minute ventilation
Vent	Ventilator
VERs	visual evoked responses
vessl	vessel (Radiant Radiology)
VHD	valvular heart disease
VL	vastus lateralis
VLDL	very low-density lipoprotein
VMA	vanillylmandelic acid
VMO	vastus medialis obliques
VNS	Vagus Nerve Stimulator
vol.%	volume percent
VORB	Verbal Order Read Back
VQ	ventilation quantitation (Radiant Radiology)
V/Q scan	ventilation perfusion lung scan
VRE	vancomycin resistant enterococcus
VS	vital signs
VSD	ventriculoseptal defect
Vt	Tidal volume
VT	Ventricular tachycardia
VW	view (Radiant Radiology)
VWS	views (Radiant Radiology)
VZV	varicella zoster virus
W	with (Radiant Radiology
W4D	Worth 4-dot test (strabismus)

WB	weight bearing
WBAT	weight bearing as tolerated
WBC	white blood count
w/c	wheelchair
WD	well developed
WFL	within functional limits
wk	week
WN	well nourished
WNL	within normal limits
wo	without (Radiant Radiology)
WOCN	wound, ostomy and continence Nurse
WP	WATSU practitioner
WT	weight
w/v	weight by volume
W/WO	with / without (Radiant Radiology only)
XC	cross clamp
XR	x-ray (Radiant Radiology only)
Y/O	year old
yr	year
yrs	years (Radiant Radiology only)
ZAJ	zygophyseal joint

SYMBOL DEFINITIONS

Symbol	Definition
♀	Female
♂	Male
>	Greater than
<	Less than
<->	to - from
↑	Increase
↓	Decrease
→	going to
2x, 3x	2 times, 3 times, etc
√	Flexion
/	Extension
~~	approximately
Ψ	Psychiatric
Ø	no/none
Three dots within a triangle	therefore
Δ	Change
ā	before
A (circled)	assist
@	at
B (circled)	bilateral
I (circled)	independent
L (circled)	Left
N (circled)	normal
R (circled)	Right
#	Number
+	Positive
-	Negative
1°	First degree
2°	Second degree
3°	Third degree

APPENDIX A – EPIC

These abbreviations may only be used in Epic and may not be used for documentation or paper forms.

A	unable to palpate, Doppler only
BUE	bilateral upper extremities
D	unable to palpate, no Doppler pulse
Hi	High
LAP	left atrial pressure
LBBB	Left Bundle Branch Block
LLE	left lower extremity
LLQ	Left Lower Quadrant
Lo	Low
LUE	left upper extremity
LUQ	Left Upper Quadrant
PAP	pulmonary artery pressure
RBBB	Right Bundle Branch Block
Resp	Respirations
RLE	right lower extremity
RLQ	Right Lower Quadrant
RUE	right upper extremity
RUQ	Right Upper Quadrant
Temp	Temperature
Temp Src	Temperature Source
w/	with
w/o	without
Wt	Weight
1D	First Degree
2D	Second Degree
3D	Third Degree
3D	three dimensional (Radiant Radiology)

APPENDIX B – Machine Settings

These abbreviations are machine settings and may not be used for documentation or paper forms.

Exp	Expiratory
Esen	Expiratory sensitivity
Est Min Ventilation	Estimated Minute Ventilation
Est Vt	Estimated Tidal Volume
EtCO2	End Tidal CO2
F set	Frequency set
Fset	Frequency of set respirations
Ftotal	Frequency of total respirations
I/E Ratio	Inspiratory/Expiratory Ratio
I/E Ratio	Inspiratory to Expiratory Ratio
O2	Oxygen
O2 Cal	Oxygen Calibration
VC	Vital Capacity
VG	Volume Guarantee
Vt Exp (lpm)	Tidal Volume expiratory
Vt Insp	Tidal Volume inspiratory

Chart Completion in Epic 2009

New In Basket workflow for Inpatient providers

With the Epic 2009 upgrade the Chart Deficiency folder is changing to the Chart Completion folder. This change provides a streamlined workflow for signing In Basket inpatient-related messages. Previously, providers had to sign verbal orders from the Verbal Order Cosign folder, dictation from the E-sig Dictated notes folder, then go to the Chart Deficiency folder and complete any deficiencies. The recommended workflow in Epic 2009 is for providers to take actions on messages in the **Chart Completion** folder first. This completes the messages plus any related deficiencies from one folder, reducing work for the provider (fewer clicks).

In Basket

New Msg | Sec Pt Msg | Refresh | Edit Pools | Settings | Search | Out | Display | Properties | ? | Close X

Staff Message
E-Sig Dictated Notes (3)
Open Charts (1)
Overdue Result (1)
Results (77)
Rx Authorization
Rx Response
Verbal Order Cosign (2)
Chart Completion
Incomplete Notes (5)
Letters-Unsent

Chart Completion 0 unread, 9 total — Sort & Filter | Resize

Chart Completion | Jump To | Sign | Edit | Decline | Already Done | Ignore | Reassign

Due Date	P.	Deficiency	Status	Encounter ...	Discharge ...
11/09/10	S.	Verbal Orders	E-Signature Needed-...	11/01/10	12/01/10
11/20/10	C...	Verbal Orders	E-Signature Needed-...	07/28/10	
11/20/10	C...	Verbal Orders	E-Signature Needed-...	07/28/10	
11/23/10	W..	Verbal Orders	E-Signature Needed-...	08/03/10	
01/11/11	D...	Consultation	E-Signature Needed-...	01/06/11	01/13/11
01/18/11	D...	Consultation	E-Signature Needed-...	01/13/11	
01/18/11	D...	History & Physical	E-Signature Needed-...	01/13/11	
01/18/11	D...	Discharge Summary	E-Signature Needed-...	01/13/11	
01/28/11	D...	Consultation	Cosign Needed	01/13/11	

Red text indicates the message is overdue.

Epic 2008 – Tool Bar Buttons	Epic 2009 Tool Bar Buttons
Sign	Sign – signs the message.
Edit	Edit – allows providers to make an addendum for changes to dictated notes.
Reject	Decline – rejects or defers the message, depending on the message type.
Defer	Decline – rejects or defers the message, depending on the message type.
Done	Already Done – the message has been completed.
Reassign	Reassign – send the message to the correct provider, if known.
	Jump to – Enabled on Cosign Needed messages to go to the specific item in the patient's chart.

Additional Details:

- If a provider has not signed all their dictation prior to the Epic Upgrade on Feb 12, 2011, they will temporarily see two E-sig Dictated Notes folders. This is a conversion issue for Epic 2009. Once the existing notes are signed, the older E-sig folder will be removed. All new messages appear in the new **E-sig** folder and in the **Chart Completion** folder.
- All Verbal Order and Co-sign Order messages per patient come into the **Chart Completion** folder as one collapsed message. Providers can expand the message to view all the associated verbal orders or co-sign orders to sign. They can sign the complete list from the single message or sign or act on each individual order specifically.
- The workflow of deferring notes or verbal orders (now decline) does not change. Any deferred verbal orders are routed to the nursing unit where the patient was at the time the order was placed. Any declined transcriptions (notes) are routed back to the dictation pool.
- Bulk signing is not allowed across patients for dictation. Bulk signing applies to one patient only. If a provider tries to bulk sign by selecting messages that apply to more than one patient, the toolbar buttons are disabled.
- Ambulatory Providers – Only those ambulatory providers who also work at a hospital will see the **Chart Completion** folder. There is no change to Ambulatory workflows for signing dictation when done from an ambulatory encounter. Ambulatory providers can continue to sign dictation from the E-sig Dictated Notes folder because there are no chart deficiencies associated with these notes. Bulk signing is still possible for dictation done on an ambulatory encounter.

Created by HealthPartners Care Systems Learning & Performance
Confidential and Privileged

Updated January 26, 2011
Page 1 of 1

LOCATION Regions Hospital 1st Floor, North Building, Suite 1020

Dept. Phone 651 254-3489
Clinical Pager 651 629-0556

DESCRIPTION OF DEPARTMENT/SERVICE

The Infection Prevention & Control Department has responsibility for Regions Hospital as well as its affiliated clinics and programs. Additionally, consultative services are provided for other health care facilities, home care agencies,
EMS providers, local corporations, state and local government agencies and community organizations.

The Infection Prevention & Control program is a multidisciplinary, systematic approach to quality patient care that emphasizes risk reduction of infectious disease transmission in a health care environment by using sound epidemiological principles and evidence-based methodologies. The IP&C program for staff and patients is supported by Employee Health and Wellness, Performance Improvement, Data and Measurement, Risk Management, and Safety departments at Regions Hospital.

Objectives:

- Prevent infectious disease transmission within Regions Hospital as well as the public health community.
- Recommend methods for early identification and appropriate therapy of infectious agents
- Analyze practices that have potential to affect rates of healthcare associated infections
- Provide Infection Control education and training to employees, medical staff, and professional staff
- Comply with reporting requirements to local, state and federal public health agencies.
- Facilitate compliance with accrediting organization standards and guidelines.

Goal:
To provide health care workers with the knowledge and support to minimize occupational hazards and prevent the transmission of infectious organisms; and to continue to measure, assess and reduce the infectious complications of patients and staff

Resident Role and Responsibilities

A. Know and Comply with Infection Prevention Bundles. A bundle is a group of evidence based interventions that have been shown to reduce infection rates. Bundles are part of a monthly audit and reported publically to the Minnesota Hospital Association.

Prevent Methicillin Resistant Staphylococcus Aureus (MRSA) infections
1. Active screening of MRSA on admission to the ICU's
2. Contact Isolation and use of dedicated equipment
3. Hand Hygiene compliance
4. Decontamination of the environment and equipment
5. Decolonization of carriers

Catheter Related Blood Stream Infection (CLABSI) Bundle
1. Hand hygiene before insertion, entering line, or dressing changes
2. Maximal barrier precautions during insertion
3. Chlorhexidine skin antisepsis for site prep and care
4. Appropriate catheter site* and administration care
5. No routine replacement
*NOTE: Select the catheter, insertion technique, and insertion site with the lowest risk for complications. Subclavian site is preferred unless medically contraindicated.

Ventilator Associated Pneumonia (VAP) Bundle
1. Elevate head of bed to at least 30 degrees
2. Daily sedation "vacations." (Reduction of sedation acceptable)
3. Daily assessment of readiness to extubate.
4. Peptic ulcer disease prophylaxis.
5. Deep vein thrombosis prophylaxis.

Surgical Site Infection (SSI) Bundle

1. Appropriate prophylactic antibiotic within 30-60 minutes of incision; discontinued 24 hours post surgery
2. Appropriate hair removal via clipping (No shaving)
3. Peri-operative glucose control
4. Urinary catheter removed within 48 hours

B. Hand Hygiene before and after all patient care contacts.

C. Culturing guidelines

- Order cultures when a new healthcare acquired infection is suspected
- Order cultures prior to starting antibiotics
- Follow culture results to compare antibiotic sensitivity to current antibiotics prescribed
- Consult with infection preventionists on questions about isolation precautions or exposures
- Consult with ID physicians as needed; i.e., for patients with infections caused by multi-drug resistant organisms, highly contagious or unusual infectious diseases.

D. **It is mandatory to order an Infectious Disease physician consultation when a patient:**

1. Is going home on IV antibiotic therapy
2. Has fungemia (a positive blood culture caused by a fungal agent)
3. Is receiving four (4) or more antibiotics

Multi-Drug Resistant Organism (MDRO) Isolation Protocol

Patients with a known history of MRSA, VRE, C. diff, ESBL, Acinetobacter baumanii, Stenotrophomonas Maltophilia, and CRE are identified in the electronic medical record (EPIC). Infection Control makes entries based on the current patient surveillance cultures and removes a patient from this system if they are no longer colonized with these specific antibiotic resistant organisms.

Upon admission patients with a history of MRSA are placed in contact isolation. In order to remove a patient from isolation they must have NONE of the following risk factors; Reside in a Nursing Home or LTAC, open draining wounds, long term lines and tubes, receive dialysis, or on antibiotics to treat MRSA. They will then need two sets of negative surveillance cultures obtained at least one week apart. Patients with a history of VRE are kept in contact isolation for the duration of hospitalization. Patients with Clostridium difficile diarrhea are placed in Enteric isolation **until the patient no longer has diarrhea.** Rooms are cleaned with Bleach at discharge.

See Regions Hospital Infection Control policies:

50:14 Contact Isolation Precautions
50:46 Methicillin Resistant Staphylococcus aureus
50:49 Multi Drug Resistant Organisms
50:08 Clostridium difficile
50:96 Vancomycin Resistant Enterococcus
20:15 TB Exposure Control Plan

Regions Hospital uses the Centers for Disease Control/Healthcare Infection Control Policy Advisory Committee (CDC/HICPAC) guidelines for isolation. See *Guidelines to Isolation Precautions for Communicable Diseases* IC Policy IC: 60:01.

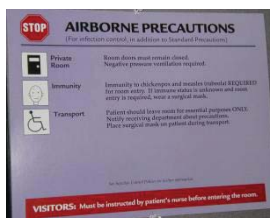
STANDARD PRECAUTIONS (SP)

Standard Precautions are the primary strategy to reduce hospital acquired infections (HAI). SP are to be used for all patients and every procedure regardless of diagnosis, known or presumed infection status. This includes Hand Hygiene before and after patient contact. Perform Hand Hygiene after removing gloves.

Standard Precautions incorporate the applications of both Universal Precautions (designed to reduce the risk of transmission of bloodborne pathogens) and Universal Body Substance Isolation (designed to reduce the transmission of pathogens from moist body substances and non-intact skin).

TRANSMISSION-BASED ISOLATION PRECAUTIONS

- Airborne
- Contact
- Droplet
- Enteric
- Neutropenic
- Special Respiratory



AIRBORNE
IMMUNITY TO THE SPECIFIC DISEASE IS REQUIRED WHEN ENTERING THE AIRBORNE ISOLATION ROOM I.E. MEASLES and CHICKENPOX

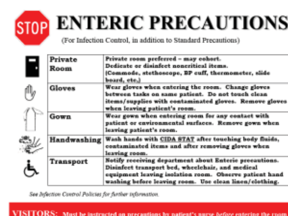
Use Airborne Precautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small-particle residue [5 um or smaller in size] of evaporated droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance). Examples: Measles, Chickenpox. **HAND HYGIENE IS REQUIRED AFTER LEAVING ROOM.**

CONTACT
GLOVES AND A GOWN ARE <u>REQUIRED</u> WHEN ENTERING A PATIENT'S ROOM

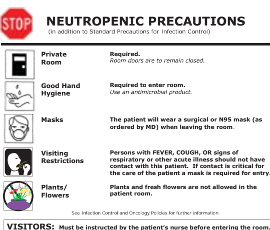
Use Contact Precautions for specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient or indirect contact by touching the surfaces or patient-care items in the patient's environment. Examples: Lice, Respiratory Syncytial Virus, Methicillin-resistant Staph Aureus (MRSA). **HAND HYGIENE IS REQUIRED AFTER LEAVING THE PATIENT'S ROOM AFTER REMOVING GLOVES.**

DROPLET
WEAR A BLUE SURGICAL MASK WITH EYE PROTECTION WITHIN 5 FEET OF A PATIENT.

Use Droplet Precautions for a patient known or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets larger than 5 um in size. Transmission requires close contact since large droplets do not remain suspended in the air and generally travel only short distances (3-5 feet). Examples: Pertussis, Mumps, Meningitis. **HAND HYGIENE IS REQUIRED AFTER LEAVING THE ROOM.**

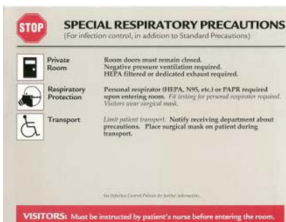


ENTERIC
Post for patients with Clostridium difficile diarrhea. USE CIDASTAT ANTIMICROBIAL HANDWASHING SOAP, RATHER THAN ALCOHOL-BASED HAND RUBS, AFTER DIRECT PATIENT CARE OR CONTACT WITH PATIENT CARE ENVIRONMENT TO REMOVE FECAL CONTAMINATION AND THESE SPORE-FORMING BACTERIA.



NEUTROPENIC
POSITIVE AIRFLOW ROOM REQUIRED.

Protective measures are used to heighten awareness for patients determined to have a more severe and longer duration of immuno-suppression, which places them at greater risk for infection from both endogenous and exogenous sources. Oncology staff determines which patients require Neutropenic precautions and the duration they are to remain in effect. **HAND HYGIENE IS REQUIRED <u>BEFORE</u> ENTERING**



SPECIAL RESPIRATORY
NEGATIVE AIRFLOW ROOM REQUIRED; STAFF ENTERING ROOM MUST BE FIT-TESTED FOR AND WEAR AN N95 MASK by Employee Health if needed

Use Evaluation of Pulmonary TB (100144) or Management of Pulmonary TB Order Sets to evaluate and manage patients with pulmonary tuberculosis.

Coordinate discharge planning with the Ramsey county or MN departments of health for directly observed therapy, medication supply, contact tracing and control of patient's with active pulmonary TB.

Use Special Respiratory Precautions for patients known or suspected to be infected with Severe Acute Respiratory Syndrome (SARS) or *Mycobacterium tuberculosis,* transmitted by airborne droplet nuclei (small-particle residue [5 um or smaller in size] of evaporated droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance). **HAND HYGIENE IS REQUIRED AFTER LEAVING THE ROOM.**

BLOOD/BODY FLUID EXPOSURE PROTOCOL: Please report your exposures/injuries/splashes to Employee Health and Wellness via the Care Line (952) 883-5484. Care is available 24/7.

1. Care for the exposure site
    a. EYES: Flush eyes with water.
    b. SKIN: Wash with soap and water.
2. Seek the assistance of the nursing supervisor or designee. Fill out the Injury/Illness/Exposure Report Form.
3. Call the Care Line: (952) 883-5484 (24 hrs/day, 7 days/week). The Care Line will triage you to EHW or the Emergency Center.
4. Take your exposure form with you. If you are sent to the Emergency Center, ask for the Charge Nurse when you register.
5. Initial follow-up coordinated through Employee Health and Wellness (651) 254-3301.

NOTE

- **Consistently Use Safety and Needleless Devices TO PREVENT EXPOSURE.**
- **Don Personal Protective Equipment *BEFORE p*erforming exposure prone procedures.**
- **Be mindful and stay in the moment if you are doing a procedure requiring a needle or sharp instrument.**

INFORMATION RESOURCES

I. Web based Employee Resource and Information Center “ERIC” for Infection Prevention & Control and Patient Care policies

    A. Infection Control/Employee Health and Wellness Policies on ERIC 360 Compliance ERIC/Work Tools/Policy Manuals/Regions Hospital Policy Manuals/Infection Control/Type subject in “keyword” search window
    B. HealthPartners Online Training Regions Hospital Infection Control

II. EPIC TB Standing Order Sets. 1) Evaluation and 2) Management of Pulmonary TB

III. Health Education Resources. Web based patient and family information.

ERIC/in Quick Links Search Window select Health Education Resources/Infectious Diseases/select desired topic master – Chlamydia, hepatitis, influenza, MRSA, etc.

IV. Regions Hospital Medical & Nursing Library

INTEGRATED HOME CARE

LOCATION	475 Etna Street, Suite 3 St. Paul, MN 5510	**DEPT PHONE** **CENTRAL INTAKE** **CENTRAL INTAKE FAX**	651-415-4663 X54000 952-883-6875 952-883-7288

CONTACT Denise Edgett, Homecare Manager
651-415-4005 x 54000

HOURS Office Staffed 8:00am to 4:30pm, Monday through Friday
Service Provided Seven Days per Week
On Call Nurse 24 Hours per Day, 7 Days per Week

DESCRIPTION OF DEPARTMENT/SERVICE

Integrated Home Care is a Medicare-certified and state-licensed agency providing comprehensive services to a varied adult population in the seven county metro areas. Using a customized and personalized care plan, this team helps patients and their families move safely, efficiently and comfortable from hospital or transitional care to home. Services include: Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Social Services, Chaplain, Music Therapy and Home Health Aides.

Common services offered:

- Management of conditions such as congestive heart failure, chronic obstructive pulmonary disease, diabetes and cancer
- Care for surgical wounds, burns and ulcers
- Rehabilitative care for strokes, fractures and neuromuscular disease
- Assistance with personal care and activities to support independent living
- Medical social work services
- Interpreters available

The agency utilizes Certified Wound, Ostomy and Continence Nurses to promote effective management of complex wounds and ostomies.

The Palliative Care Program is for Home Care eligible clients, facing serious and life limiting medical conditions.

Home Safety/Falls Prevention Program available.

Interpreter services provided to non-English speaking and hearing impaired clients.

For more information, http://www.healthpartners.com/public/care/family-of-care/home-care/

INTERNAL MEDICINE

LOCATION Room C7379, 7th Floor, Central Building, Regions Hospital

DEPT PHONE 651-254-1886

CONTACT Karen Lee, Residency Coordinator

HOURS 7:30 am to 4:00 pm, Monday through Friday

STAFF Elie Gertner, M.D. – Department Head, Internal Medicine/Medical Education
Kelly Frisch, M.D. – Associate Program Director, Internal Medicine Postgraduate Training Program
Nate Bahr, M.D. – Internal Medicine Chief Resident
Benji Mathews, M.D. – Internal Medicine Chief Resident

Description of Department/Service

The Department of Internal Medicine is the largest medical department in the hospital. It is composed of over 100 full time staff physicians under the chairmanship of Dr. Elie Gertner. Many staff physicians also hold faculty appointments at the University of Minnesota. All Subspecialties in Internal Medicine are represented by board-certified Internists and many of the staff physicians attend on the inpatient medical service. Offices of the Chair of Academics and Residency Program are located on the seventh floor of the main hospital building. Cardiology offices are located on the second floor of the Main Building, and the remaining staff physicians' offices are dispersed. In addition to faculty physicians, there are approximately 40 residents and fellows, and 15 medical students at any given time participating in departmental activities. The Internal Medicine Department has two chief medical residents per year. The chief resident's responsibility involves coordinating the inpatient services, teaching residents and students as well as functioning as liaison for the faculty and house staff.

Consultations: Consultations are available from General Internal Medicine and from all subspecialties of Internal Medicine. Consultations requested from 7:30 am to 4:00 pm, Monday through Friday, may be obtained by entering an order in EPIC. All STAT consults, as well as consults to be done after hours and on weekends, should be called to the respective service by the requesting physician. The name and beeper number can be obtained from the operator, on AMION or by calling the Medicine Office at extension 4-1886. Consultation is encouraged for educational and patient care purposes.

Conferences: The Department has approximately 10 conferences scheduled throughout the week and all are intended for house staff participation. Conference schedules are available through department offices or by calling extension 4-1886. They are also posted on a bulletin board outside the Medicine Office on the seventh floor of the tower hospital building.

Outpatient: The Department of Internal Medicine practices at multiple primary care clinics, including HealthPartners Specialty Center, Midway Clinic, and Center for International Health.

HealthPartners Midway Clinic: General internists are the core of our adult care team. This team specializes in the care of all adults. With focus on preventive health care – thorough periodic physicals, health screenings and education – the team aims to involve patients in their own health care. The clinic, located off campus, features patient-friendly clinic space and automated medical records.

HealthPartners Adult and Seniors Clinic: General Internists and nurse practitioners provide comprehensive services for adults with a wide range of medical illnesses. Staff works closely with providers from multiple specialties to provide care of the patients. This clinic is located at the HealthPartners Specialty Center. Geriatricians specialize in the care of individuals 55 and older. Our physicians and other health care providers have special training and expertise in the area of geriatrics and general medicine. Senior patients receive senior health care literature and full access to a complete range of nursing home services should the need develop. The clinic is located at The HealthPartners Specialty Center.

International Care Team: Our International Care Team features highly skilled medical professionals – doctors, nurse practitioners, nurses, counselors, and interpreters – all specially trained to understand and respect the health needs of different cultures. Our team has a combined total of more than 100 years of experiences working with refugees and new Americans.

We have professionally trained medical interpreters on staff available in nine languages, and access to interpreters for any language. In addition, some of our health care staff are bilingual and have spent considerable time working and living abroad.

Subspecialty Clinics: Subspecialty clinics are available for patients with special problems requiring specialty expertise.

DEPARTMENT STAFF

Cardiology

Timinder Biring, M.D.
Johannes Brechtken, M.D.
Cynthia Brenden, M.D.
Ranjan Dahiya, M.D.
Thom Dahle, M.D.
Katie Moriarty, MD
Marco Guerrero, M.D.
Sheetal Kaul, M.D.
Antoine Khoury, M.D
Thomas Kottke, M.D.
James Morrison, M.D.
William Nelson, M.D. Section Chief
Glen Nickele, M.D.
Joseph Browning, MD
Kiran Pandey, M.D.
Stephen Riendl, M.D.
Danish Rizvi, M.D.
Stephen Smalley, M.D.
Michael Thurmes, M.D.
Dennis Zhu, M.D.
Benjamin Williams, MD

Endocrinology and Metabolism

Anders Carlson, M.D.
Chhavi Chadha, M.D.
Dionysia (Tenia) Kalogeropoulou, M.D.
Chris Kodl, M.D.
John MacIndoe, M.D. Section Chief
Kevin Sheridan, M.D.
Greg Mucha, M.D.

Gastroenterology

Ahmad Abdulkarim, M.D.
Sandeep Bahadur, M.D.
Nadeem Chaudhary, M.D.
Paul Dambowy, MD
Roger Gebhard, M.D.
Karin Hagen, M.D.
Irshad Jafri, M.D. Section Chief
Rebecca Li, M.D.
Christopher Shepela, M.D.
Daniel Virnig, M.D.

General Internal Medicine

Brenda Abraham, M.D.
Paul Bloomberg, M.D.
Kim Swain de Pop, M.D.
Jaclyn Chaffee, M.D.
Heather Cichanowski, M.D.
Sarah D'Heilly, M.D.
Brian Flagstad, M.D.
Shary Vang, MD
Elaine Francis, M.D.
Kelly Frisch, M.D.
Jennifer Hines, M.D.
Teresa Kovarik, M.D.
Terrence Maag, M.D.
Angela Medina, M.D.
Mikhail Perelman, M.D.
Michael Westerhaus, MD
Kimberly Rathmann, M.D.
Anne Settgast, M.D.
Paula Skarda, M.D.
Patricia Walker, M.D.
J. Bryan Warren, M.D.
Leann West, M.D.
Khoula Sikander, MD

Geriatrics

Lissa Chipeco, M.D.
Kenneth Engberg, M.D
Franklin Fleming, M.D.
Floyd Knight, M.D.
Lee Rock, M.D.
Michael Spilane, M.D. Section Chief

Hematology/Oncology

Daniel Anderson, M.D.
Kurt Demel, M.D.
Gretchen Ibele, MD
Gary Shapiro, MD
Randy Hurley, M.D., Section Chief
Jeffery Jaffe, M.D.
Daniel Schneider, MD
Balkrishna Jahagirdar, M.D.
Colleen Morton, M.D.
Steven McCormack, MD

Hospitalists

Rachel Burton, M.D
Demeka Campbell, M.D..
Rachel Darling, MD
Brian Flagstad, M.D.
Ashwin George, M.D
Daniel Goldblatt, M.D.
Mohamed HagiAden, M.D.
Tarek Hamieh, M.D.
Brett Hendel-Paterson, M.D.
Rick Hilger, M.D.
Michael Holth, M.D.
Megan Iverson, M.D.
Jawali Jaranilla, M.D.
Hans Jeppesen, M.D
Rebecca Jones, M.D.
Gautam Kale, M.D.
Burke Kealey, M.D.
Stephanie Kim, M.D.
Richard Mahr, M.D.
Ankit Mehta, MBBS
Salma Mohsin, D.O.
Stacey Mollis, M.D.
Matthew Mundy, M.D.
Karla Nockleby, M.d.
Pawan Patel, M.D.
Patrick Pederson, M.D.
Ghaziuddin Qadri, M.D
Rosemary Quirk, M.D.
Kreegan Reierson, MD
Daniel Ries, M.D.
James Risser, M.D.
Jason Robertson, M.D., Section Chief
Miguel Ruiz, M.D.
Manish Saha, M.D.
Jerome Siy, M.D.
Chrisanne Timpe-Dupuis, MD
Deepti Torri, M.D.
M. Colin Turner, M.D.
Kate Venable, MD.
Khuong Vuong, M.D
Jon White, M.D.
Karen Williams, M.D.
Thomas Yacovella, M.D.
Shone Zhao, M.D.

Infectious Disease

Omobosola Akinsete, M.D.
Laurel Cushing, M.D.
Noe Mateo, M.D.
Jonathan Sellman, M.D., Section Chief
Greg Siwek, M.D.
William Stauffer, M.D.

Nephrology

Paul Abraham, M.D. Section Chief
Chokchai Chareandee, M.D.
Eric Chen, M.D.
Randa El-Husseini, MD
Nayan Gowda, M.D.
Christine Johns, M.D.
Prasun Ray, M.D.
Ann Rinehart, M.D
Vishal Sagar, M.D.

.

Pulmonary and Critical Care

Michael Alter, M.D.
Petr Bachan, M.D.
Jagdeep Bijwadia, M.D.,Section Chief
Krista Graven, M.D.
Jannica Groom, M.D.
Melissa King-Biggs, M.D.
Eric Korbach, M.D.
Kealy Ham, MD
John Marini, M.D.
Charlene McEvoy, M.D.
Avi Nahum, M.D.

Rheumatology

Elie Gertner, M.D.
Tom Harkcom, M.D., Section Chief
Ellen Shammash, M.D.
SouPan Wu, M.D.
Paul Sufka, MD

MEDICAL TOXICOLOGY FELLOWSHIP PROGRAM

LOCATION Central Section, 2nd Floor
Regions Hospital

CONTACT Kristi Lamb, Coordinator **PHONE** 651-254-5298

CORE FACULTY

Regions Hospital

Sam Stellpflug, MD, Program Director, Medical Toxicology
Andrew Topliff, MD, FACMT, Associate Program Director
Carson Harris, MD, FACEP, FAEEM, Associate Program Director
Joel Holger, MD, FAEEM, Research Preceptor, Emergency Medicine Department
Matt Morgan, MD, Toxicologist, Emergency Medicine
Kristin Engebretsen, Pharm D, DABAT, Clinical Toxicologist

Hennepin Regional Poison Center

Jon Cole, MD, Medical Director
Stacey Bangh, Pharm D, DABAT, Site Education Director, Toxicology Fellowship
Dave Roberts, MD, FABMT, Sr. Associate Medical Director, Hennepin Regional Poison Center
Deb Anderson, Pharm D, Director, Hennepin Regional Poison Center
Elisabeth Bilden, MD, Assistant Medical Director, Hennepin Regional Poison Center
Louis Ling, MD, FACEP, FABMT, Sr. Associate Medical Director, Hennepin County Medical Center

Fellows Heather Ellsworth, MD, 2nd Year Fellow
Ben Orozco, MD, 1st Year Fellow

DESCRIPTION OF PROGRAM/SERVICE

Medical Toxicology is a unique and dynamic specialty that combines components of emergency medicine, occupational and environmental medicine, pediatrics, and public health practice. The American Board of Emergency Medicine, American Board of Pediatrics and American Board of Preventive Medicine sponsor the specialty of medical toxicology. The American Board of Medical Specialists (ABMS) formally recognized Medical Toxicology in September of 1992. Medical Toxicologists have the expertise to identify and treat chemically induced diseases, environmental and hazardous material exposures, and other toxicological emergencies. Medical Toxicology's scope of practice includes acute poisoning, adverse drug reactions, substance abuse, envenomation, workplace chemical exposure, and mass chemical exposure to industrial chemicals and chemical weapons.

The fellowship is based at Regions Hospital. This training program is a collaborative effort between HealthPartners/Regions Hospital, Hennepin County Medical Center (HCMC) and the Hennepin Regional Poison Center (HRPC).

Purpose/Goals

The medical toxicology fellowship program will prepare graduates for leadership positions in clinical toxicology, Poison Centers, public health, academic, governmental, industry and other practice settings.

The training program will provide fellows with opportunities to achieve proficiencies in technical skills, core competencies necessary for the practice of medical toxicology as follows:

1. Provide extensive experience in medical toxicology inpatient, outpatient, and poison center practice so fellows will gain the appropriate clinical knowledge and skills to assess clinical manifestations, differential diagnosis and manage poisonings in children and adults.

2. Insure fellows have a strong foundation in the basic science of toxicology, including pharmacokinetics teratogenesis, toxicity, and interaction of therapeutic drugs. Fellows will understand the biochemistry of toxins, kinetics, metabolism, mechanisms of acute and chronic injury and carcinogenesis.
3. Provide a rich opportunity to gain familiarity with investigative activities and critical appraisal of scientific literature. Fellows will be required to complete one research project and submit this project for publication. They will become familiar with experimental design, statistical analysis of data and epidemiology research.
4. Provide opportunities for fellows to evaluate and treat acute and chronic workplace and environmental exposures.
5. Fellows will become familiar with laboratory techniques in toxicology
6. Acquire an understanding of the operation of the Minnesota Poison Control System, including educational, service and administrative aspects.
7. Acquire effective teaching techniques and skills for oral and written communication.

Procedures and Methods

1. Fellows will evaluate and treat patients on the toxicology consulting service, MICU, PICU, Emergency Department, Poison Center and Occupational and Environmental Medicine (OEM) clinic. Additional clinical experiences may be desired or required based upon the fellow's prior experience and interests. Weekly case conference presentations will complement the clinical experience.
2. Fellows will attend core lectures and pharmacology lectures throughout the program and discuss basic toxicology concepts in the clinical settings
3. A monthly research conference and weekly journal club will introduce and review research methodology and train fellows to critically analyze the available medical literature.
4. Fellows will evaluate environmental exposure issues and learn to identify hazardous materials and manage environmental exposures and contaminations rotations in the OEM clinic and Minnesota Occupational Safety and Health Administration.
5. The Program provides opportunities for fellows to become familiar with intervention techniques to prevent poisoning both in the community and in occupational settings.
6. Fellows will become familiar with laboratory techniques in toxicology during their clinical rotations and during an optional one-month Forensic Toxicology/ Medical Examiner rotation
7. Fellows will provide medical back up for Poison Center calls throughout their fellowship and spend 3 months at the Poison Center. Fellows will become familiar with administrative skills as necessary for directorship of a regional poison control center and the role of regulation and legislation in poison prevention.
8. The Program provides a rich opportunity for fellows to learn and apply effective teaching techniques, and effective skills for oral and written communication and effective teaching techniques through presenting case conferences, lectures, ground rounds

Supervision
Fellows will be supervised by the Toxicology Faculty in conjunction with designated rotation attendings.

Other Resources
Consultation from specialty consultants related to toxicology (mycology, herpetology, botany, HazMat, etc.) is available and is obtained when appropriate, and provides immediate feedback on patient problems. Follow-up of admitted patients is at the discretion of each fellow physician and provides valuable information on clinical course and outcomes. A quality improvement program is in place and, when appropriate, the fellow is included in this process.

Evaluation
Fellows are informally evaluated during their rotations. A written evaluation is completed at the conclusion of the rotation by several faculty members or supervisors. An evaluation of the rotation by the fellow is encouraged.

NEUROLOGY

CONTACT PERSON JoAnn Niemi **PHONE** 651-254-3705

LOCATION 2 North, Room N2135
Regions Hospital

STAFF
Bret Haake, MD, Department Chair
Geoffrey Alt, MD
Raluca Banica-Wolters, MD
Paula Cotruta, MD
Vivian Fink, MD
Patricio Reyes, MD
Mike Rosenbloom, MD, Program Site Director
Melissa Samuelsson, MD
Bruce Snyder, MD

David Tullar, PA
Amy Larson, NP

DESCRIPTION OF DEPARTMENT/SERVICE

Neurology is composed of full time board certified adult neurologists and advanced practice providers. General neurology clinics are held five days a week at the Health Specialty Center and at HealthPartners Riverside Clinic.

The inpatient consultation service is covered from 8 a.m. to 5 p.m., Monday through Friday by an assigned neurologist. After hours and on weekends, the service is covered by phone by the assigned neurologist.

The Neurodiagnostics Laboratories include EEG, EMG and all modalities of evoked potential. Several first year neurology residents and psychiatry residents rotate on the Neurology service at Regions Hospital. Third and fourth year medical students rotate in the outpatient neurology clinics. Medical student elective rotations are available by request in both the outpatient and inpatient settings.

NEUROSURGERY

LOCATION

Neuroscience Administrative Offices and
Neurosurgery Physician Offices
North Building, 2nd Floor N2135

Clinic:
Neurosurgery Department, 4th Floor
HealthPartners Specialty Center
401 Phalen Boulevard
St. Paul, MN 55130

CONTACTS

Denis McCarren, Director of Neuroscience and Program Manager - Spine	**651.254.3349**
Linda Moses, Specialty Operations Manager (HSC 401)	651-254-7031
Neurosurgery	
Melinda Cortez, Administrative Assistant Scheduling	651-254-3490
Cheryl Sarno, RN/Jill Goring, RN/Danielle Wilson, RN	
1st Call Pager (Neurosurgery Nurse Clinicians)	651-629-0185
JoAnn Niemi, Senior Administrative Assistant	651-254-3705
Neuroscience Service Line	

STAFF

Jon McIver, MD Section Head
Alex Mendez, MD
Mathew Kang, MD
Anje Kim, MD

DESCRIPTION OF DEPARTMENT/SERVICE

The Department of Neurosurgery provides neurosurgical consultation and care for Regions Hospital inpatients and HealthPartners Medical Group outpatients. Referrals are welcome. Referral sources are both internal (hospital and clinic departments) and external. Neurosurgeons provide outpatient consultation and follow-up care at the HealthPartners Specialty Center, 401 Phalen Boulevard, St. Paul. Elective surgeries are arranged through outpatient clinic visits.

Regions Hospital is a Level 1 Trauma center and the neurosurgeons provide coverage for trauma care on a 24-hour basis.

NURSING SERVICES

Description of Nursing Organization

The Vice President for Patient Care Services is Chris Boese RN MS at 254-3286. The Vice President for Patient Care Services is accountable for all nursing practice within the Regions organization.

Inpatient Care Units: The Inpatient nursing leadership team consists of Directors of Nursing, Nurse Managers, Inpatient Clinical Supervisors, and Patient Flow Coordinators.

Inpatient Nursing Leadership

Directors of Nursing/Other Directors	***Name***	***Phone #***
Director of Nursing Birth Center	Julie Thompson Larson	651-254-3581
Director of Nursing Critical Care	Beth Heinly-Munk	651-254-3130
Director of Nursing Medical/Surgical	Julie Weegman	651-254-3350
Director of Cardiovascular Clinical Services	Mike Cannon	651-254-5184
Director of Behavioral Health	Wendy Waddell	651-254.1457
Director of Rehab Institute	Donna Jensen	651-254-1697
Director of Nursing Practice and Education	Julibeth Petter	651-254-0966
Director of Clinical Informatics (EPIC)	Karen Jones	651-254.2797
Director of **Corporate** Risk Management	Jeremy Sundheim	651-254.0789
Director of Patient Safety	Stephanie Doty	651-254-0760
Director of Emergency Center	Richelle Jader	651-254-5097
Director of Surgical Services	Greg Mellesmoen	651-254-0071

Patient Care Units		***Nurse Manager***	***Office Phone #***
South 11	Opening November, 2012	SriWan (Lek) Kremer RN	
South 10	NeuroScience	Patsy Reed RN Jenny Prochnow RN	651-254-0838 651-254-0941
South 9	Orthopedics	Karen Lane RN	651-254-3360
C9300	Rehabilitation	Deb Spotts DON	651-254-3290
C9100	Medicine	Susan Becht RN	651-254-1540
South 8	CLIU/Tele/Renal	Sarah Cassell RN Mary Costello RN	651-254-1398 651-254-5055
South 7	CV Surgery/CICU/Cardiac Tele	Emilienne Anderson RN Deb Martchev RN	651-254-1708 651-254-3190
South 6	MICU/ProgressiveCare/Oncology/Med	Pam/Peine RN & Bonnie Sweeney RN	651-254-3673 651-254-3398
C5100 (S11)	Trauma	SriWan (Lek) Kremer RN	651-254-1378
C5200 (S11)	Surgery	SriWan (Lek) Kremer RN	651-254-1378
C6200	Dialysis Contracted Services DaVita	Mike Cannon RN, DON (Regions' liaison) Maxwell Larson (Davita)	651-254-3350
C6300	Surgery	Cheryl Laine RN	651-254-0941
C5400	Burn Center	Candyce Kuehn RN	651-254-3596
W3	SICU	Hannah Grace RN	651-254-1554
W2	Post Partum/Newborn Nursery	Kathy Kuzelka RN	651-254-1673
W1	Labor & Delivery	Cheryl K. Patterson RN	651-254-3825
Special Care Nursery	Level II SCN	Sue Claseman, RN (supervisor)	651-254-3353
E7	Behavioral Health	Gayle Godfrey RN	651-254-1896
E6	Behavioral Health	Marie Mortek RN	651-254-1588
E5	Behavioral Health	Vicki Mortensen RN	651-254-3104
E4	Behavioral Health	Mary Roberts RN	651-254-3341
E3	Behavioral Health	Charles Aluko RN	651-254-4164
Patient Flow Coordinator		Patient Bed Placement, handles bed placement for all admissions & patient transfers	Pager 651-629-2002 or 651-254-BEDS
Inpatient Clinical Supervisors: Critical Care / Med/Surg		Monday – Friday day hours, direct inpatient care issues to Nurse Manager. After hours, contact Inpatient Clinical Supervisors.	Pager 651-629-0123

Surgical Services: The Director for Surgical Services (Operating Rooms, Same Day Surgery, Post Anesthesia Care Unit, Anesthesia and Reprocessing) is Greg Mellesmoen at 651-254-0071. Greg is also responsible for HealthPartners Specialty Center Same Day Surgery.

Emergency Center: The Nursing Administrative Director for the Emergency Center is Richelle Jader RN at 651-254-5097. The Nurse Manager is Mary Healy at 254-1554.

Ambulatory Care:

Clinics: Each ambulatory clinic is managed by a manager or supervisor, collaborating with the Lead Physician and Clinic Administrator regarding the overall management of the primary and specialty clinics.

Cardiology: The Manager for Heart Center is Terri Carter at 254-0873.

Digestive Care Center: The manager for the Digestive Care Center is Terri Meister (interim) at 254-8603. Gastrointestinal or endoscopic procedures are completed for both inpatients (Regions site) and outpatients (Health Specialty Center site). Patients are prescheduled for procedures during day hours. These services are also provided urgently or emergently during evening, night and weekend hours through the use of on call scheduling.

Chemotherapy Infusion Nursing Services: The Manager of Cancer Care Center is Diana Christensen-Johnston at 651-254-3978. In this location, patients receive outpatient chemotherapy and other selected non-chemotherapy infusions (e.g. blood transfusion) during the day hours, Mon-Friday.

Adult Drug and Alcohol Program: This program is an outpatient day program with some boarding capabilities. It is located at 445 Etna Street, Suite 55, St Paul MN 55106. The program manager is Charlie Mishek at 651-254-9443.

Inpatient Care Units:

- Seventeen inpatient care units are roughly organized by medical specialty. Patients may be admitted to another unit if a unit is at capacity, a patient needs isolation, or there is some other clinical situation..
- Remote telemetry access is managed by South 8 and is available to all med/surg units. A physician may order remote telemetry via EPIC through Order Entry function.
- Dialysis Unit is located adjacent to C6200 for patients undergoing acute hemodialysis. ICU patients who need dialysis receive dialysis in the patient ICU room. Dialysis Nursing Services are provided by contract from DaVita.

Operations:

Patient Logistics (bed placement) – Patient Flow Coordinator on duty 24/7/365 to be reached by pager 651-629-2002.

DIRECT ADMISSIONS

All admissions from referring locations must be communicated to the Patient Flow Coordinator prior to directing the patient to Regions. REGIONS DIRECT (physician support phone line) will facilitate the admission process. REGIONS DIRECT is 24/7 coverage at 651-254-2000. The Patient Flow Coordinator will subsequently be contacted by Regions Direct to coordinate appropriate patient placement. Upon securing a staffed hospital bed, the Patient Flow Coordinator will provide Regions Direct with the hospital destination. Regions Direct staff will then communicate the plan to the referring physician/referring facility. Communication through Regions Direct for direct admissions is essential to ensure a smooth admission for the patient including assurance that a staffed hospital bed will be available and ready upon the patient arrival

IN-HOUSE TRANSFERS

Request for in-house patients requiring a change in level of care should be communicated through EPIC. Communication from EPIC system to Tele-Tracking system is essential to ensure timely and appropriate transfers are coordinated by the Patient Flow Coordinator.

The Patient Flow Coordinator acts as an administrative liaison with delegated authority to carry out the administrative policies and practices of the hospital. They also have notary public authorization. The Patient Flow Coordinator is available 24/7 on pager 612-629-2002. The Patient Flow Coordinators directly report to the Manager of Access/Flow, Jeanette Hofmeister at 651-254-5087.

Patient Care Issues/Nursing Staffing Coverage – Inpatient Clinical Supervisors
The Inpatient Clinical Supervisors are available to assist resident physicians with policy interpretations, patient/family complaints and concerns, obtaining legal consultation and other patient care issues during the 1500–2300 hours. During the night shift (2300 – 0700), the functions are covered by the Patient Flow Coordinator and can be reached at pager 651-629-2002. During the daytime hours, please work through the nursing unit manager. The Inpatient Clinical Supervisors report to the Director of Critical Care, Beth Heinly-Munk, at 651-254-3130.

Patient Care
All communication regarding patient care should be directed to the patient's registered nurse. This includes the medical plan, anticipated discharge date and anticipated needs after discharge. This will ensure that the necessary referrals are coordinated in a timely fashion. It is also very helpful to include this information in your progress notes. Case managers and other nurse clinicians will also support you in caring for patients. Interdisciplinary care planning rounds occur on each patient care unit 2-3x/week.

Medical Orders
Medical orders are entered into the EPIC electronic health record and require a physician name to enter into the system. In the event of emergency downtime, please write orders legibly. A printed/stamped name and pager number is required under your signature. Medication orders are entered by pharmacists into a medication system and also require a legible signature to enter orders into the system.

Preparing patients for discharge
- Communicate anticipated discharge date as soon as possible in the patient course. Write discharge or transfer orders before the day of discharge/transfer so that medications/home needs/supplies/ equipment/transportation can be arranged in advance. On the day of discharge, discharge orders should be written by 0900. Our goal is to discharge medically ready patients by 1200.
- All narcotic orders require a valid DEA number or the prescription will not be filled. Patients will be given the completed discharge medication form and may fill these prescriptions at Regions or at the outside pharmacy of their choice.
- An order to "discharge the patient" is done by completing EPIC.

OBSTETRICS & GYNECOLOGY

LOCATION North Building, First Floor, Room N1060 **DEPT PHONE** 651-293-8191
CONTACT Jo-Ellyn Pilarski, Residency Program Coordinator **PHONE** 651-254-3725

STAFF

Chi Chi Ayika, M.D.
David Baram, M.D., Section Head, OB/GYN, Regions Hospital, Medical Student Site Director
Tess Barrett, M.D.
Kamalini Das, M.D, Residency Site Director
Clarice Decker, M.D.
Lisa Fall, M.D.
Myriah Hanno, M.D.
Lawrence Harms, M.D.
Gerald Hautman, MD.
John Hering, M.D.
Diane Horvath-Cosper, M.D.
LeeAnn Hubbard, M.D.
Barbara Hyer, M.D., Medical Director, OB/GYN
Curtis Keller, M.D.
Becky Kleager, M.D.
Richard Kopher, M.D.
Joan Kreider, M.D.
Katie Krumwiede, M.D.
Charles Lais, Department Head, OB/GYN HealthPartners Medical Group
Javed Malik, M.D.
Michael Maurice, M.D.
Laura Mayer, M.D.
Ruth Merid, M.D.
Seth Myles, M.D.
Soumathy Prosper, M.D.
Rose Ramirez, M.D.
Buvana Reddy, M.D.
Adrienne Richardson, M.D.
James Shold, M.D.
Christopher Thiel, M.D.
Eric Trygstad, M.D.
John Vickers, M.D
Amina Warfa, M.D.

CERTIFIED NURSE MIDWIVES

Debrah Albert, CNM
Sheila Billstein, CNM
Ann Bruce, CNM
Lois Cannon, CNM
Georgeanne Croft, CNM
Catherine Crowly, CNM
Jeri Dentz, CNM
Ann Dohrmann, CNM
Jody Ford, CNM
Lori Geller, CNM
Lorene Gilliksen, CNM, MSN
Deborah Haqq, CNM
Karin Larson, CNM
Karin Marshall, CNM
Cherida McCall, CNM
Monica McCleary, CNM
Lisa Miles, CNM
Marie Pederson, CNM, MS Midwife Director
Colleen Rusch, CNM
Nasrid Sanei, CNM
Nahid Shokohi, CNM
Mary Skorczeski, CNM, MS
Michelle Stegeman, CNM
Margaret Szondy, CNM
Susan Tighe, CNM
Marsha Travis, CNM
Kristine Tromiczak, CNM
Eileen Turner, CNM
Tori Washington, CNM
Patricia Wilson, CNM
Maria Wolff, CNM
Mary Wood, CNM
Edie Ziegler, CNM, MS

DESCRIPTION OF DEPARTMENT/SERVICE

The Department of Obstetrics and Gynecology is a major primary care department with diversified programs and extensive community involvement. The department also provides high risk and complicated gynecologic and obstetric care and has a Level 2 NICU. Its main function is to provide comprehensive and personal health care to women to meet a wide spectrum of individual patient needs while at the same time fulfilling its educational obligations. The educational obligations include teaching of Phase D medical students and Regions Emergency Department residents in addition to OB/GYN residents from the University of Minnesota.

The services within the Department include:
Obstetrics, high-risk obstetrics (perinatology), inpatient and outpatient gynecology and surgery, uro-gynecology, OB/Gyn pelvic ultrasound, colposcopy, Gyn special services, reproductive endocrine/infertility, and a large OB midwife service.

Didactics are held on Monday afternoons from 2:00 p.m. to 5:00 p.m. at the University of Minnesota. The didactics at Regions include Obstetrics Morbidity and Mortality Conferences, Fetal Monitor Strip Review Conferences, and Pre-operative Gynecology Conferences.

OCCUPATIONAL MEDICINE

LOCATION	HealthPartners St. Paul Clinic, 1st Floor	**PHONE**	651-293-8161
	HealthPartners Riverside Clinic, 3rd Floor		612-341-6876
	HealthPartners West Clinic, 1st Floor		952-541-2500
	HealthPartners Arden Hills Clinic		651-523-8542
CONTACT	Paula Geiger, Residency Coordinator	**PHONE**	651-293-8269

HOURS Clinic 8:00 a.m. to 5:00 p.m.
Office 7:00 a.m. to 3:00 p.m.

STAFF Fozia Abrar, MD, MPH, Department Head
Jon O'Neal, MD, MPH, Residency Program Director
Rita Wallace-Reed, MD, MPH
Robert Gorman, MD, MPH
David Parker, MD, MPH
Gary Johnson, MD, MPH

DESCRIPTION OF DEPARTMENT/SERVICE

HealthPartners Occupational and Environmental Medicine Clinic offers comprehensive medical services, evaluation, care and consultation regarding occupationally or environmentally related health conditions or issues. This includes evaluation and treatment of work related illness and injuries, toxicologic and environmental exposure assessments, disability prevention, and employee surveillance and toxicology screening. As a collaborator with the University of Minnesota School of Public Health, Division of Environmental and Occupational Health, we are a core component in the National Institute of Occupational Safety and Health recognized and funded University of Minnesota based Educational Resource Center. We have a strong academic and research emphasis. Our educational and training programs include an occupational medicine residency, with practicum rotations for medical students and graduate level occupational health nurses, as well as family practice and internal medicine residents.

Practice and Research Interests:

Dr. Abrar: Global health and disability management

Dr. O'Neal: Medical causation determination, independent medical evaluations, indoor air quality, and workplace exposure evaluations

Dr. Gorman: Low back pain and upper extremity disorders, injury disability prevention as well as clinical care guideline development and outcomes research

Dr. Wallace-Reed: Injury prevention, management and follow up of acute work injuries, including joint injections and orthopaedics

Dr. Parker: Worksite health and safety

Dr. Johnson: Injury care, return to work strategies, and disability prevention.

OFFICE OF INTEGRITY AND COMPLIANCE / PRIVACY

LOCATION 8170 Building **DEPT PHONE** 952-883-5124

CONTACTS

Contact	Phone	Location
Michelle Meadows, Director, Integrity and Compliance - Regions	651-254-3449	Regions
Eric Anderson, Director, Integrity and Compliance - HPMG	952-883-6241	8170 Bldg
Tobi Tanzer, Vice Pres. of Office of Integrity and Compliance, Corporate Compliance Officer and Privacy Officer	952-883-5195	8170 Bldg

HOURS 8:00 a.m. – 5:00 p.m.

DESCRIPTION OF DEPARTMENT/SERVICE Integrity and Compliance Program, including Privacy

General Description:
The mission of the Office of Integrity and Compliance is to provide the organization's employees, care providers, business units and oversight bodies with the knowledge, tools and support necessary to participate meaningfully in the Integrity and Compliance Program. The purpose of the Integrity and Compliance Program is to prevent, detect and correct violations of legal, professional and ethical standards. The Integrity and Compliance Program includes the following elements:

Hotline and Complaint Reporting:
Employees can report potential compliance issues through several channels, including an option to report information anonymously through our toll-free HOTLINE number: (866) 444-3493. If you suspect that a business practice or relationship could be illegal or unethical, our knowledgeable staff can answer your questions and provide you with guidance. You may also E-mail any compliance questions or concerns to the Office of Integrity and Compliance - IntegrityandCompliance@healthpartners.com.

Investigations:
Our staff will ensure that reports of potential concerns are documented and thoroughly investigated. We gather information by conducting thorough reviews to confirm compliance with company policies, various government regulations and laws.

Corrective Action:
As compliance issues are identified, our staff assists in developing corrective action plans to appropriately respond to the issue. Corrective actions can include, but are not be limited to: training, policy development or revision, employee discipline and refunds.

Training Support:
We provide formal and informal training support to help personnel navigate through the many laws, regulations and policies that health care organizations must comply with.

Policy Development:
We provide guidance and direction to business operations regarding with the development and consistency of company policies.

Self-Assessment:
We conduct a variety of auditing and monitoring activities to promote compliance with applicable laws, regulations and organizational policies.

Privacy Office:
The Office of Integrity and Compliance serves as the organization's Privacy Office. In this capacity, we establish privacy-related policies, conduct privacy training, investigate privacy concerns, facilitate corrective actions and monitor ongoing privacy compliance.

Learn more about the Office of Integrity and Compliance and the Integrity and Compliance Program at:
http://intranet.healthpartners.com/Intranet/Menu/0,1646,7643,00.html

OPHTHALMOLOGY 2012

LOCATION Health Partner Health Specialty Clinic (HSC)
401 Phalen Blvd, 2nd Floor

DEPT PHONE 651-254-7500

APPOINTMENTS 952-967-7911

CONTACT Patricia A Morris, Clinic Lead

PHONE 651-254-7531

HOURS 8:00 a.m. to 4:30 p.m. Monday-Friday

Ophthalmology Staff

Michael Floyd, MD, Pediatric Ophthalmology
Dave Johnson, M.D., Comprehensive
John Knapp, MD, Comprehensive
Leslie A. Kopietz, M.D. – Comprehensive
Jerry Kobrin, M.D., Comprehensive
Jill Melicher, MD, Oculoplastics/Orbital Disease
J. Daniel Nelson, M.D., Cornea Dry Eye
Anthony J. Pfaff, M.D., Comprehensive
Paul Tani, M.D., Vitreoretinal Disease

DESCRIPTION OF DEPARTMENT/SERVICE

A wide variety of ophthalmological services are available to patients at the Health Specialty Center. We provide a full service Eye clinic that includes routine exams and contact lens fittings/evaluations done by our optometry department, medical and surgical ocular evaluations done by our ophthalmologists and a full service optical department. We provide both in-patient consultation and Emergency Department coverage at Regions Hospital. We are surgically equipped to handle most types of ocular trauma including lid lacerations, corneal lacerations, ruptured globes and traumatic cataracts. We are also capable of treating congenital, infantile, and age related cataracts. Several of our ocular surgeons perform refractive surgery, including LASIK, LASEK, and photorefractive keratectomy,

In-patients at Regions Hospitals are evaluated daily by one of our ophthalmologists on Regions Rounds, done daily (Monday through Friday from 8 – 10AM). Consults are placed via EPIC. Specifics as to why the consult is being sought will direct our evaluation of the patient. Patients needing urgent consults should have those directed to the on-call ophthalmologist outside of the 8-10 AM hours. Visit the AMION website to determine the ophthalmologist on call.

ORTHOPAEDICS

LOCATION:	APPOINTMENTS	651-254-8300
Orthopaedic Clinic	NURSE LINE	651-254-8300 Option 3
1st Floor, Main Building, Regions Hospital	MD Referral Line	651-254-8377
and	CLINIC FAX	651-254-8379
HealthPartners Specialty Center		
435 Phalen Boulevard		
St. Paul, MN 55130		
Orthopaedic Office	OFFICE PHONE	651-254-1514
Second Floor, North Building, Ste. 273N	OFFICE FAX	651-254-1519
Tricia Corbo, Education Program Director		651-254-3247

FACULTY:
Peter Cole, M.D., Chief
Thuan Ly, M.D., Residency Program Site Director

University Affiliated:
Sarah Anderson, M.D.
Peter Cole, M.D.
Mengnai Li, M.D.
Paul Lafferty, M.D.
Thuan Ly, M.D.
Scott Marston, M.D
Robert Morgan, M.D.
Julie Switzer, M.D.
Christina Ward, M.D.

HPMG: (no resident coverage)
Heather Cichanowski, M.D. — Non-operative orthopaedics and sports medicine
Michael D'Amato, M.D.
Gavin Pitmann M.D.
Randy Twito, M.D.
Jonathan Cooper, M.D.
Thomas Lange, M.D.
Drew Thomas, M.D.

DESCRIPTION OF DEPARTMENT/SERVICE:

The Department of Orthopaedics provides services for the diagnosis and treatment of diseases and injuries of the musculoskeletal system, including the cervical, thoracic and lumbar spine, pelvis, and extremities.

REFERRALS AND CONSULTATIONS

Daily coverage is provided by a "First Responder" who is an orthopaedic or emergency medicine resident, PA, or orthopaedic staff physician available for immediate consultation. A daily call schedule is published and can be obtained through the operator or the orthopaedic office. Call schedules are also posted on AMION.

To obtain consultations or to make a referral:

For Emergencies: Page the First Responder directly.

For Inpatient Consults: Page the First Responder directly.

For Outpatient Consults: Please call the Clinic Appointment Center to schedule patients (651-254-8300).

OTOLARYNGOLOGY/HEAD & NECK SURGERY

DEPARTMENT LOCATION North Bldg., 2nd Floor
DEPT PHONE 651-254-3860
FAX 651-254-0898

CLINIC LOCATION HealthPartners Specialty Center 4th Floor
401 Phalen Boulevard
St. Paul MN 55130
CLINIC PHONE 651-254-8550
FAX 651-254-8558

CONTACT
Kristin Brochman, Administrative Ass't **PHONE** 651-254-3860

Naomi McCabe, Administrative Ass't **PHONE** 651-254-8575
Willie Braziel, Manager **PHONE** 651-254-1530

STAFF
Henry Chang, M.D.
Harley S. Dresner, M.D.
Manuela Fina, M.D.
David D. Hamlar, M.D., D.D.S., FACS
Peter A. Hilger, M.D. FACS
Christopher W. Hilton, M.D.
Seth C. Janus, M.D.
Frank G. Ondrey, M.D. Ph.D.
Derek J. Schmidt, M.D., Department Head
Pao Vang, M.D.

Gina Cincinelli, PA-C, MPAS
Rachel Nippoldt, RN
Breta GulbransonHeath, RN

DESCRIPTION OF DEPARTMENT/SERVICE

Otolaryngology-Head and Neck Surgery is a medical and surgical specialty. The clinic at HealthPartners Specialty Center is staffed by the HealthPartners and University of Minnesota, Department of Otolaryngology Head and Neck physicians. As a part of our commitment to research and education, resident staff, as well as medical students, rotates through our department.

The physicians who make up our department are Board Certified in Otolaryngology Head and Neck Surgery. Many of our staff members have additional certifications that required additional training with expertise in Facial Plastic and Reconstructive Surgery, Neuro-otology, Head and Neck Oncology, Pediatric Otolaryngology, and Laryngology. Regions Hospital and HealthPartners offer a wide variety of medical and surgical services for conditions such as:

Cancers of the Face, Head, and Neck
Dizziness and Vertigo
Ear Infections/Hearing Problems
Facial Cosmetic Abnormalities - Facial Fractures
Microvascular Surgery & Head and Neck Reconstruction
Nasal Allergies, Sinusitis
Pharyngitis/Tonsillitis
Sleep Apnea
Skullbase Tumors
Temporomandibular Joint and Associated Dental Disorders
Soft Tissue Injuries of the Face and Neck
Surgery of the Thyroid and Parathyroid
Throat and Voice Problems

Many of the procedures undertaken are performed on an out-patient basis either in a small operating room for minor cases located in our clinic area, at the HealthPartners' Same Day Surgery facility located on Phalen Boulevard, or in the hospital's main operating rooms.

The Otolaryngology Clinic at HealthPartners Specialty Center has a full-time nurse specifically trained in ear, nose, and throat disorders to assist in patient care. The physicians and staff provide the specialty care necessary to serve the Metro and surrounding suburbs.

HealthPartners Geriatrics
TRANSITIONAL CARE, LONG TERM CARE & ASSISTED LIVING SERVICES

LOCATION	Mail Stop 26602G P.O. Box 1309 Minneapolis, MN 55440-1309	**PHONE**	952-833-6805, Option 3
CONTACT	Robyn Hastings, Senior Manager	**PHONE**	952-883-6801
HOURS	8:00 AM – 5:00 PM, Monday – Friday		

DESCRIPTION OF DEPARTMENT/SERVICE

HealthPartners Geriatrics provides on-site primary medical care services to residents in 11 transitional care settings, over 65 community nursing homes and over 50 assisted living sites across the metro area. Directed by the HealthPartners Division of Home Care, Hospices and Geriatrics, the program utilizes physician/nurse practitioner teams to manage the complex medical care needed by these patients. In the 11 dedicated transitional care units (TCU) (Presbyterian Homes of Roseville, Capitol View, Ambassador Good Samaritan, Edina Care Center, Southview Acres, Maplewood Care Center, Maranatha Care Center, St. Therese,Presbyterian Homes of Bloomington, Galtier Health Care Center and Lyngblomsten Care Center), medical teams are on site Monday through Friday and patients are seen by nurse practitioners and physicians a minimum of three times per week and as needed until discharged to home, assisted living or to long-term care facilities. Medical teams visit each long term care home at least monthly, with additional visits made when necessary. Medical teams visit assisted living sites at least monthly. In addition to visits, program personnel handle over 50,000 patient care phone calls each year. All patients discharged to a nursing home, assisted living facility or TCU are referred to the HealthPartners Geriatrics Program; communication with the medical team assigned to the facility is essential. The patient’s social worker or nurse case managers have lists of HealthPartners Geriatrics teams and pager numbers.

PATIENT REPRESENTATIVE DEPARTMENT

LOCATION 2nd Floor, Main Building, Room 2020 **DEPARTMENT PHONE:** 651-254-2372

CONTACTS Mary Albrecht, Patient Representative
Sarah Larsen, Patient Representative
Kathy Reeves, Patient Representative
Paula Nelson, Best Care Best Experience, Manager

HOURS 8:00 a.m. – 4:30 p.m., Monday-Friday

DESCRIPTION OF DEPARTMENT/SERVICE

Regions Hospital is committed to providing the best care and best experience for all of our patients and their families, however, sometimes things get in the way and patient satisfaction is compromised. If an issue cannot be resolved at the department level, the patient, the family, or staff may contact the patient representative.

The patient representatives are complaint management experts. Please don't hesitate to call them if you would like help with a difficult patient situation, or if you want some tips for handling a sensitive patient or family interaction.

Patients always have the option to contact an outside agency to register a complaint, including:

Minnesota Board of Medical Practice
2829 University Avenue SE – Suite 400
Minneapolis, MN 55414-3246
(612) 617-2130 or (800) 657-3709

Office of Ombudsman for Older Minnesotans
121 E. 7th Place, Suite 410
St. Paul, MN 55101
(651) 431-2555 or (800) 657-3591

Laboratory Quality/Safety Concerns
College of Accredited Pathologists
(866) 236-7212 (toll free)

Office of Health Facility Complaints
85 E. Seventh Place, P.O. Box 64970
St. Paul, MN 55164-0970
(651) 215-8702 or (800) 369-7994

Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
(800) 994-6610
complaint@jointcommission.org

This is basically what happens when a complaint is received by a patient representative:

- Complaint is documented according to the complainant perception
- Complaint is forwarded via e-mail to department manager
- If complaint is about a staff physician, the complaint is sent to the physician involved and to the Section head
- If complaint is about a resident, the complaint is sent to the director of medical education
- Person who receives the complaint investigates, reviews medical record, interviews staff, and does whatever is necessary to understand all sides of the issue
- If complaint is about a staff physician, the physician involved should respond to the patient representative; the Section head will be asked for a response if the physician involved in the complaint does not respond within the time frame
- Results from the investigation are sent to the patient representative within 20 days (the response can be verbal or in writing)
- The patient representative will recommend the most appropriate response to the patient/family
- After the response is made and the case is closed, legitimate physician complaints (both behavior and quality related) are forwarded to Medical Staff Services for their physician files.
- Closed, legitimate complaints go through the Peer Review process.
- Compliments received by the patient representatives are also sent to the physician, the Section head, and Medical Staff Services.

The patient representatives are complaint management experts. Please don't hesitate to call them if you have questions about the complaint or about how to respond, or if you want some tips for handling a sensitive patient interaction.

To reach a patient representative:

- Call 254-2372 or
- E-mail to their Outlook account: Patient Representatives – Regions

HP950025 (2/09) © 2009 HealthPartners

Regions Hospital®

HealthPartners Family of Care

Service Recovery and Patient Complaints

Patient Complaints

The purpose of this brochure is to let you, the physician, know what you can do when a patient or family member is unhappy about some aspect of their care or service. Regions Hospital is committed to providing the best care and best experience for all of our patients and their families, however, sometimes things get in the way and patient satisfaction is compromised.

Service Recovery

A complaint is often based on failure to meet a patient's realistic or unrealistic expectations. Dealing with complaints at the earliest possible moment is called service recovery, and doing service recovery is vital to patient satisfaction. Customer service experts report that someone whose problem is resolved to his satisfaction is more loyal than someone who has never had a problem at all.

The most common complaints involve delays: delay in getting a bed, delay in seeing a physician, delay in discharge and delay in receiving their medications. Complaints about delays respond very well to service recovery efforts.

The Regions Hospital and HealthPartner's process for doing service recovery is **LEAD**

- **L**isten without interrupting
- **E**xpress thanks for the feedback
- **A**pologize for the inconvenience – without blaming another department or person
- **D**o something to make the situation better

Each unit and department at Regions Hospital has service recovery tools available to allow you to "do something" on the spot. Tools available are:

- Free parking coupon
- Free coffee/soda coupon
- $5 cafeteria coupon
- $5 gift shop coupon
- Employee may spend up to $25.00 in the gift shop for a gift for a patient
- $10 Cub gift card
- $10 SuperAmerica gift card
- $10 Target gift card
- Send flowers to patient's home

The HUC or the nurse manager can help access the service recovery tools. It's amazing what a sincere apology and a free parking coupon can do to improve a poor situation.

Patient Representatives

If an issue cannot be resolved at the department level, the patient, the family, or the staff may contact the patient representative. The patient representative office handles approximately 100 complaints per month, and an estimated 25 percent of these have a physician component. Here is some information about the patient representative department:

- The patient representatives report to a Best Care Best Experience project manager
- There are three patient representatives; two representatives are in the hospital most days
- The patient representative office hours are 8:00-4:30, Monday-Friday
- The office is located on the second floor, next to the Parking Office

Regions Hospital Patient Representatives are here to serve you.

ANATOMIC AND CLINICAL PATHOLOGY LABORATORY
GENERAL INFORMATION

General Information Available On: CLIA License # 24-D0651198

- **EPIC – Home Page–Links-Regions Laboratory Guidelines**
- **EPIC – Tool Bar–Links (Icon)-Index-Regions Laboratory Guidelines**

Accreditations:

- **Joint Commission**
- **College of American Pathologists (CAP)**
- **Forensic, Urine Drug Testing**

Client Services – General Information	**651-254-4795**
Client Services Fax	651-254-1529
Pathology Administration-General Information	651-254-4796
Pathology Department Provider to Pathologist Hotline	651-254-4794
Pathology Administration Fax	651-254-2741
Manager/Charge Tech On Duty	**24 Hours/365 Days**
	Call Main Client Services 651-254-4795 and ask for "Manager On Duty" or Vocera @ 651-254-3808 "Call Lab Charge"
Pathologist-On-Call	24 hours/365 days Monday – Friday, 8:00 AM – 5:00 PM, Call 651-254-4796, Option #4 After Hours/Holiday Call – 651-254-4795 or check www.amion.com

LOCATIONS:

The Pathology Main Laboratory and Offices are located on the 3rd Floor of the Central Section

Mail Stop: 11103E
640 Jackson Street
St. Paul, MN 55101-2595

The Morgue is on the First Floor of the Education Building, Room 106.
The Outpatient Drawing Lab is on the First Floor of the Central Section, Room M1293AA.

To access pertinent Pathology & Laboratory Medicine information:

1) Click on the following link to ERIC:
http://intranet/Intranet/Menu/0,1646,38601,00.html

Or

2) From the ERIC homepage → click on "Department Sites" → click on "Regions Hospital" in the left navigation bar → click on "Laboratory" in the left navigation bar → click on "Resident Handbook Information" in the left navigation bar.

Or

3) From the MyPartner homepage, search for "Regions Lab" in the "Site Search" box → click on the link titled "Regions Hospital Laboratory" → click on "Resident Handbook Information" in the left navigation bar.

PHARMACY SERVICES

LOCATION Regions Hospital | **DEPT PHONE** 651-254-9627

CONTACT Craig Harvey, Pharmacy Director | **PHONE** 651-254-9560

LOCATIONS		HOURS
Inpatient Pharmacy	651-254-9627	24 hours a day
Sterile Products (IV Pharmacy)	651-254-5178	24 hours a day
OR Satellite Pharmacy	651-254-8897	0600-1430 Mon-Fri
Outpatient Pharmacy/Discharge Rx	651-254-9561	0700-1900 7 days/week
ED Pharmacy	651-254-4494	0900-0100 7 days/week

PHARMACY MANAGEMENT	PHONE NUMBER	PAGER
Craig Harvey, Pharmacy Director	651-254-9560	n/a
Tanya Barnhart, Manager, Compliance & Clinical Program	651-254-0869	651-629-0497
Brian Howard, Manager, Inpatient Pharmacy Services	651-254-3828	651-629-0737
Julie Vollmer, Manager, Outpatient Pharmacy Services	651-254-1447	

LOCATIONS	SERVICES
INPATIENT	Provides comprehensive unit-dose distribution services.
OR SATELLITE	Provides comprehensive unit-dose distribution services for OR.
OUTPATIENT	Provides comprehensive outpatient Rx services for Discharge and Employee prescriptions.
ED PHARMACY	Provides comprehensive outpatient Rx services for ED prescriptions.
CLINICAL	Provides drug-related information and consultation for physicians, nurses, and other health care professionals. Pharmacology and pharmacokinetic consultative services are available to assist the physician in obtaining desired therapeutic endpoints rapidly without toxicity. Some of these consult services are provided automatically and others are available upon physician request.

Contact Clinical Pharmacists on AMION

- Decentralized Clinical Pharmacists (DCP) are available seven days a week from 7am to 11pm.
- They attend multidisciplinary rounds on most floors and round with some services M-F.
- Each patient's medication list, labs, and ongoing treatment plan is reviewed daily.

Contact Pharmacy Residents on AMION

We have 2 PGY-1 pharmacy residents who rotate through a variety of medical services. They are generally available for questions regarding the service's patients 7am to 5pm Monday-Friday. They also rotate through other pharmacy service areas on weekends.

Automatic Pharmacy Consults/Services	
Vancomycin & aminoglycoside dosing	Consult orders should be placed through EPIC and provide useful information, however doses will be adjusted regardless of the presence of a consult.
Warfarin dosing	
Clozapine monitoring	Consult orders are not needed.
Methadone (for opiate withdrawal) dose verification	
Renal dosing adjustments	
Automatic Therapeutic Substitutions	

Available Pharmacy Consults/Services	
Antiepileptic dosing/monitoring	Consult orders must be placed through EPIC or by speaking to a pharmacist.
Digoxin dosing/monitoring	
Direct-thrombin inhibitor dosing/monitoring	
Heparin and Enoxaparin dosing	

Antimicrobials Requiring ID Approval Before Dispensing
Please call Infectious Diseases before ordering these agents and notify the pharmacist of approval.
Amphotericin B-Liposomal (Amphotec®)
Caspofungin
Ceftaroline
Daptomycin
Linezolid (IV & PO)
Quinupristin/Dalfopristin
Tigacycline
Voriconazole (IV & PO)

Drug Shortage Information

- Is available through your Department Chair
- Is available via a link on the pharmacy webpage

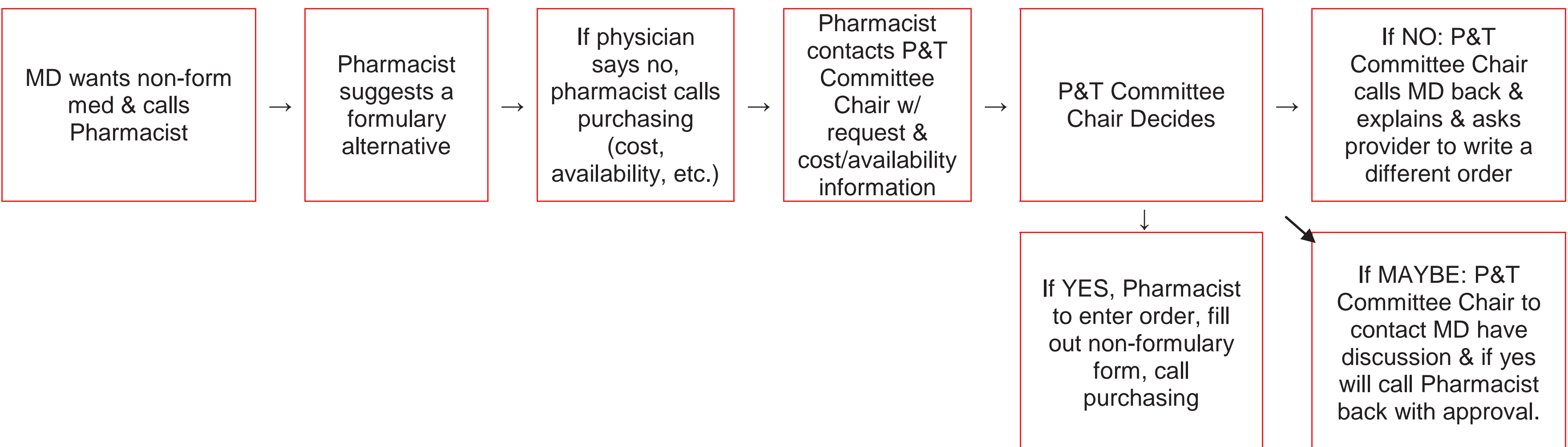
Formulary Information

- Is available via a link on the pharmacy webpage

PHARMACY DOSING PROTOCOLS –
Located on COMPLIANCE 360 website on ERIC and Pharmacy Services webpage

Renal Dosing Protocol - ADULT
Renal Dosing Protocol - PEDIATRIC
Automatic Inpatient Therapeutic Drug Substitution List
Pediatric Standardized Dosing Protocol
IV to PO Automatic Conversion Policy
Non-Formulary Alternative Options List
Restricted Antibiotics Policy
Pharmacist Management of Warfarin Therapy Protocol
Medications with Restricted Prescribing Privileges
Category X Medications
Lactation - Breastfeeding Policy for Female Patients
Nonformulary Medication Request - Special Order
Enoxaparin Guidelines
Inpatient Methadone use for Opiate Withdrawal – Maintenance
Requests for Fomulary Addition or Deletion
Clozapine Monitoring Guidelines
Once Daily Aminoglycoside
High Risk (PINCH) Medications
Recombinant Factor VIIa Guidelines
IV Administration Medication List
IV Medication Preparation Reference
Unapproved Abbreviations
Argatroban - Lepirudin
Clozapine Policy and Procedures, Inpatient
Regions Hospital Restricted Antibiotic Policy
Herbal Medications - Dietary Supplements

P&T Approved Flow Diagram- Non-formulary Medications:



Additional Information:

*Effective: Monday, August 21, 2006

*Evening/Nights: Pharmacist and physician to clinically evaluate the drug and the timeframe in which needed. If medication is critical for patient care during the evening/night shift, and plans are to acquire the medication from another facility, pharmacist should instruct physician that the ***PHYSICIAN*** must page P&T Committee Chair personally with the request. If the physician determines that the medication can wait until the morning, the pharmacist should pass the information on to the AM shift and P&T Committee Chair should be paged at that time. Pharmacist's discretion and professional judgment should be used.

*Evening/Nights: No purchasing information will be available to provide P&T Committee Chair.

*This process should also be used if a physician refuses to adhere to the automatic substitution policies approved by P&T.

Current P&T Committee Chair: Dr. Warren, Pager #: (612) 580-0528

Antibiotic Stewardship

Stewardship of our antibiotic resources is becoming increasingly important with the evolution of multiple drug resistant pathogens and a limited number of novel antibiotics available both now and in the future. Use of antibiotics in specific patients or patterns of antibiotic utilization in the medical center all have an effect on resident bacterial flora and their susceptibility to individual antibiotics or an entire chemical class of drugs.

Misuse and under-dosing of antibiotics have been shown to drive bacterial resistance; a phenomenon often termed collateral damage. At the same time a delay of appropriate initial antibiotic therapy has been shown to contribute to patient mortality.

Patient exposure to appropriate or inappropriate antibiotic therapy carries the risk of adverse drug reactions. For these reasons, antibiotic stewardship is a responsibility of all healthcare professionals and the governing structure of the Hospital. Our goal in treating bacterial infections is an optimal clinical outcome without antibiotic induced side effects.

In January of 2007 the Infectious Disease Society of America published a position paper on antibiotic stewardship which will likely in the future be incorporated into the hospital accreditation process.

For the last ten years, Regions has maintained a program that links measures of antibiotic utilization with changes in bacterial resistance patterns. These initial efforts were multidisciplinary including an infectious diseases physician, an infectious diseases trained pharmacist, and a microbiologist. This program was sanctioned by the P&T Committee with the approval of hospital administration, the pharmacy director, the patient care committee, and medical executive committee. The P&T Committee also created an antibiotic subcommittee.

Goals of Antibiotic Stewardship

1. Optimize the utilization of antibiotics within Hospital.
2. Reduce antibiotic adverse drug events, drug-drug, drug-food interactions, & promote appropriate dosing that optimize appropriate pharmacodynamic outcome parameters.
3. Limit growth in bacterial resistance or collateral damage.
4. Optimize parenteral to oral conversion of antibiotics
5. Use the optimal route and method of antibiotic administration
6. Duration of antibiotic therapy should be guided by patient response.
7. Reduce overall cost and utilization of antibiotic therapy
8. Create a seamless process for practitioners.

Tenants of Antibiotic Stewardship

1. Obtain appropriate cultures or diagnostic tests apriori
2. Direct antibiotic against intended bacterial pathogens
3. Do not delay antibiotic therapy
4. Make sure your initial antibiotic/s cover/s likely bacterial pathogens.
5. Dose your antibiotic for maximal performance.
6. Streamline your antibiotic therapy once culture and susceptibility data become available. Avoid unnecessary duplication of antibiotic therapy.
7. Limit the duration of antibiotic therapy to treat the specific problem.

Outpatient Pharmacy

To: Regions Hospital Residents

From: Julie Vollmer, Outpatient Pharmacy Manager

Date: March 2012

Re: Outpatient Pharmacy Services

Regions Outpatient Pharmacy operates under **Federal Regulation 340B** which restricts prescription service to "Regions qualified patients." Service provided to the following:

- Regions Hospital discharged patients
- Regions Hospital ED patients
- Regions Hospital owned clinic patients, and
- Regions Hospital employees. Residents are included when ID badge presented.

Access and Flow -- Discharge prescription orders:
"Access and Flow" is a Regions process improvement program to facilitate an orderly and planned discharge of the hospitalized patient. The goal is to discharge 35% of all patients prior to noon on the day of discharge. All patients being discharged will be identified and assigned an "Anticipated Discharge Date and Time". From a Pharmacy perspective, **discharge medication orders should be sent to Outpatient Pharmacy at least 2 hours prior to the "Anticipated Discharge Date and Time".** Ideally, orders can be sent the day prior to discharge and Pharmacy will deliver to the nursing unit 1 hour before the scheduled "anticipated discharge time". "Regions 1Main" pharmacy is the default pharmacy in EPIC to speed up the discharge process for providers. Controlled substance prescriptions (II-V) will print on the patient's floor and **MUST** be signed in non-black ink before being sent to pharmacy.

Can Residents have prescriptions filled at Regions OP Pharmacy?
Yes. Please bring your Regions ID badge to qualify for this Regions employee benefit. In addition, OTC products are available for purchase as an employee at 20% off regular price.

Regions Pharmacy accepts 1,000's of insurance plans. Co-pays for prescriptions are the same at Regions Pharmacy as at a typical retail pharmacy. In addition, Regions Pharmacy accepts a variety of charity care programs offered and funded by the hospital.

Questions about Regions Outpatient services, call or e-mail

- Julie Vollmer, Regions Outpatient Pharmacy Manager 651-254-1447
- OP Pharmacy 651-254-9561, option 0.

PLASTIC & HAND SURGERY

LOCATION North Building, 2nd Floor, N273
Regions Hospital

DEPT PHONE 651-254-3792

CONTACT Willie Braziel, Manager

PHONE 651-254-1530

STAFF

Warren Schubert, MD, Chair
James Fletcher, MD, Chief of Hand and Wrist
Cherie Heinrich, MD
Loree Kalliainen, MD
Martin Lacey, MD, Chief of Craniomaxillofacial
Dean Mann, MD
Sue Mi Tuttle, MD
Christina Ward, MD

Ned Bruce, PA-C
JoAnne Eller, PA-C
Tara Olson, PA-C
Sarah Jorgenson PA-C
AnnMarie Fox, NP

DESCRIPTION OF DEPARTMENT/SERVICE

Eight surgeons, four physician assistants, one nurse practitioner and RN's staff the Department of Plastic & Hand Surgery. There is a Plastic Surgery Resident, a General Surgery Intern and an Emergency Department Resident (most months). There is also an Oral & Maxillofacial Surgery Resident. There are two Hand Fellows from the University of Minnesota who participate in the call schedule, some of the operative procedures, and clinics.

The Plastic & Hand Surgery office is located on the 2nd floor of the North Building N273 off of the North Building elevator. The specific daily schedules of the attending, clinics and OR schedules can be obtained from LuAnn LaShomb (651-254-3792) for Drs. Schubert and Tuttle, Valery Rousseau (651-254-0883) for Drs. Mann, Lacey and Heinrich; Jesi Woodford (651-254-4870) for Drs. Fletcher and Kalliainen; Kathy Cherry (651-254-1513) for Dr. Ward.

Every Monday – 6:30 a.m.	Combined Rounds with ENT maxillofacial trauma cases from the previous week are reviewed.	South Conference Room 2446, 2nd Floor of the South Section
1st, 3rd & 5th Wednesdays 6:30 a.m.	Case Discussions in Plastic Surgery Complications & Conditions Conference	South Conference Room 2446, 2nd Floor of the South Section
2nd & 4th Wednesdays - 6:30 a.m.	Hand Conference	South Conference Room 2446, 2nd Floor of the South Section
1st Thursday – 5:30 p.m.	Maxillofacial Trauma Conference	Regions 3rd floor Auditorium, 3rd floor, East Building

There are additional conferences at the University, which are part of the Regions Hospital Plastic & Hand Surgery Rotation. This conference list is also posted in the Plastic & Hand Surgery Office.

Some students perform their entire rotation at Regions Hospital. Others have constructed a rotation in which they alternate between Regions, the University of Minnesota and VA hospitals. The phone number for the University office is 612-625-1188. Dr. Bruce Cunningham is the Chairman of Plastic & Reconstructive Surgery at the University and has welcomed involvement of students.

PSYCHIATRY

LOCATION Room E2921, 2nd floor, East Building, Regions Hospital

CONTACT Mary Barraclough, Residency Program Manager
PHONE 651-254-3103
E-MAIL mary.m.barraclough@healthpartners.com

STAFF Christine Stanson, M.D., Residency Program Director
Diane Dahl, M.D., Asst. Residency Director
Michael Trangle, M.D., Assoc. Medical Director, HP Med. Group, Behavioral Health
John Kuzma, M.D., Medical Director for Inpatient Behavioral Health Services
Carol Novak, M.D., Medical Director for Outpatient Behavioral Health Services

Shehla Alavi, M.D.
Onaiza Ansar, M.D.
Heather Berg-Patel, M.D.
James Black, M.D.
Elizabeth Canepa, M.D.
Lisa Capell, M.D.
Kathryn Curdue, M.D.
Bruce Field, M.D.
Zvi Frankfurt, M.D.
Christina Frazel, M.D.
Tom Gratzer, M.D.
Charlotte Guest, M.D.
Suzanne Harris, M.D.
Barclay Jones, M.D.
Amy Nygaard, M.D.
Scott Oakman, M.D.
Elizabeth Reeve, M.D.
Jeffrey Richards, M.D.
Chhabilall Sharma, M.D.
Alex Solovey, M.D.
Karen Ta, M.D.
Stefan Tchepichev, M.D.
Tracy Tomac, M.D.
In-Lin Tuan, M.D.
Janet Zander, M.D.

DESCRIPTION OF DEPARTMENT/SERVICE

The Psychiatry Department is a multi-disciplinary health care delivery system. It blends the disciplines of psychiatry and behavioral sciences in an academically focused community clinic. The house staff in Psychiatry is trained to develop the necessary skills including:

1. A working knowledge of clinical psychiatric disorders including their "natural history," diagnosis, treatment, and interface with other medical disorders.

2. Scientific habits of thought and attitudes to assess critically differential diagnosis, therapeutic alternatives, and contemporary medical literature.

3. The knowledge and skills for an academic professional while retaining a practical and relevant clinical style.

Behavioral Health has 96 adult psychiatric inpatient beds. Comprehensive outpatient services include programs in adult, child and adolescent services, substance abuse, international/cultural psychiatry, and other specialty services.

Residents at Regions have the opportunity to provide direct patient care under the supervision of staff psychiatrists. The resident physician functions within a psychiatric team composed of a supervising psychiatrist, a psychiatric social worker, an occupational therapist, and nursing staff.

Residents may elect to devote their advanced years of training to consultation-liaison, child, community psychiatry, forensics, crisis, suburban private practice, or administration, under the direction and supervision of faculty staff.

RADIOLOGY

LOCATION 1st Floor, Regions Hospital, Central Section
3rd Floor, Central Section, Regions Hospital for Interventional Radiology
Health Specialty Center 401 Phalen Boulevard for Outpatient Imaging
Breast Health Center, Regions Hospital

CONTACT **Dorothy Walden-Woodworth**, Director of Radiology **PHONE** 651-254-3777

STAFF Susan M. Truman, MD – Chief of Radiology

Azhar Ali, MD	Rick Aizpuru, MD	Martin Asis, MD
Tara Bowman, MD	Peter Bretzman, MD	Rick Castaneda, MD
George Edmonson, MD	Andrew Hartigan, MD	Edith Kang, MD
David Lee, MD	Jorge Leon, MD	Suzanne Parrino, MD
Jeff Phelan, MD	Greg Rathmann, MD	Vladimir Savcenko, MD
Thinesh Sivapatham, MD	Patrick Sullivan, MD	Angela Tai, MD
Joseph Tashjian, MD	Donald Wiese, MD	

DESCRIPTION OF DEPARTMENT/SERVICE

The Radiology Department provides a full range of modalities related to diagnostic imaging including Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Ultrasound, Nuclear Medicine, Angiography, Angioplasty (stent placement), DEXA, PET/CT, Interventional Radiology, Percutaneous Imaging Guided Biopsy, Mammography, and General Diagnostic Radiology. Coverage of the Radiology Department is provided by St. Paul Radiology who provides 24/7 subspecialty radiology interpretations and consultation, including neuroradiology, musculoskeletal radiology, emergency radiology, breast imaging, nuclear medicine, abdominal imaging, pediatric radiology, interventional radiology and neurointerventional radiology.

A. KEY PHONE NUMBERS

1. Main Radiology Department: Phone 651-254-3766; Fax 651-254-5680. To reach a Radiologist, call this number and a receptionist will answer and page one for you.
2. Angiography/Interventional Radiology: Phone 651-254-9400; Fax 651-254-2390.
3. Central Scheduling (7:30 AM to 6:00 PM): Phone 651-254-8200; Fax 651-254-2379. Fluoroscopy, DEXA, CT, MRI, Ultrasound, Nuclear Medicine.
4. File Room: Phone 651-254-3794; Fax 651-254-5705.

B. SCHEDULING OF EXAMINATIONS

1. Required Information
   - An order is required for all exams performed. Ordering is done through EPIC, the electronic medical record.
   - All orders must include: Name of exam, indication or symptoms and the ordering physician beeper number.
     Radiologic services are available 24 hours per day, seven days per week. In order to serve you better, appropriate clinical information is essential to both interpretation and performance of the correct procedure. Please do not hesitate to get in touch directly with one of the radiologists if you have a question or problem. The radiologists, in turn, may wish to directly convey a result to you, or seek your approval to proceed with further diagnostic procedures. Including your beeper number and/or telephone number where you can be reached will expedite your patient's procedure in the Radiology Department.

2. Routine Requests
   - The routine workday for examinations is 7:00 AM to 4:30 PM. We would prefer to perform non-emergent exams during this time period; however, examinations outside of these hours will also be performed without hesitation if you deem necessary. Feeding tube placements will not be performed routinely after 5:00 PM.

- CT, general diagnostic imaging (x-ray), and US are staffed 24 hours per day, seven days per week. Examinations may be scheduled at any time.

3. <u>"STAT" Requests</u>
   - Because of the nature of this Hospital, there are frequently several simultaneous requests for immediate examinations. We may ask why the examination is STAT in order to set priorities. Films to check chest tube placement and exclude pneumothorax are generally not considered emergent, but will usually be performed within 30 minutes.

4. <u>Portable Examinations</u>
   - Radiographs should be obtained portably in the patient's room when there would be difficulty transporting the patient to the Radiology Department. Such patients are those on ventilators or cardiac monitoring. They generally do not include patients with IV's, NG tubes, or multiple chest tubes, if such are attachable to transport carts. The quality of the portable exam is less, generally has more radiation, and costs more than a more definitive examination done in the Radiology Department.

5. <u>Emergency Procedures</u>
   - Radiologic consultation is available 24 hours per day. To discuss or schedule an emergency procedure, contact the Radiology Front Desk at 651-254-3766. There is a staff radiologist in the Hospital 24 hours per day. Please do not hesitate to contact us.

6. <u>Protective Measures for the Radiologic Technologist</u>
   - Because of their repeated exposure to radiation, Radiologic Technologists are not to hold the patient in position for the radiographic examination. If the patient cannot maintain the position for the examination requested by the clinician, the examination will be changed to one which the patient can tolerate or other means of support and/or restraint will be used.

C. LOCATION OF FILMS

Films are available in the PACs (Picture Archiving Computer System) and viewed through the Web Browser (a desktop icon on many computers) or EPIC Imaging Link (viewable through any computer on which you can access EPIC – the electronic medical record) There are also PACS view stations in many clinics and in the Emergency Department and several inpatient units.

D. RADIOLOGY CONSULTATION AND CONFERENCES

The Radiology Department is available for consultation 24 hours per day. In addition, participation in several specialty conferences occurs during each week and month. If you have a special request, please contact us.

E. RELEASE OF PATIENT INFORMATION

For the protection of the patient and ourselves, we must have a release of information statement signed by the patient or his or her legal guardian for all radiographs, CD's and/or reports to be sent out or taken from the Hospital. The original films are the property of Regions Hospital and are the legal responsibility of this Hospital.

If a patient is transferred from Regions Hospital to another hospital by ambulance, the images will be copied on a CD and sent with the patient if a release of information form has been signed and left with the Radiology Department. We are able to deliver films to any local hospital or doctor's office by means of the Hospital delivery service, within a few hours after receiving a request for such transfer. Such requests should be directed to the Radiology File Room. Films made here after 4:00 PM can be delivered by the following weekday morning after 8:30 AM. If there are any questions about release of films and/or reports, please call or see the Radiology File Room at 651-254-3794.

F. TELEPHONE ACCESS TO DICTATED REPORTS

The Radiology Department has a digital dictation system, which provides instant telephone access to dictated reports from any touch-tone telephone.
To listen to a report, dial 651-602-7234. A recorder will answer with a message confirming that you have accessed the radiology dictation system and guide you through the following procedure:

a) When prompted for user ID, press 7, 2,¸3, 4,#.
b) Enter the patient's 8 digit date of birth followed by the # key.
c) A copy of these instructions is available in the Radiology File Room.

You will immediately hear the most recent report dictated for that record number. To pause or play during review, touch 1; to access earlier reports on the same number, touch 6. To rewind, press 3. To fast forward, press 5. To skip to the impression, press 4. For assistance, please call Radiology File Room at 651-254-3794. Reports are accessible on the system for approximately one week.

G. ACCESS TO WRITTEN REPORTS

All reports are available in EPIC; however, if you need a copy of the written report, call 651-254-3794.

QUESTIONS/CONCERNS

If you have additional questions or concerns regarding Radiology Services, please contact/e-mail one of the following individuals:

Dorothy Walden-Woodworth, Administrative Director	651-254-3777
Eric Nelson, Clinical Operations Manager	651-254-5628
Brad Stegeman, Manager, Breast Health Center, IR, OR	651-254-3342
Susan Truman, M.D., Medical Director	651-254-3766

REHABILITATION INSTITUTE

LOCATION Health Specialty Center
401 Phalen Blvd, 4th Floor
St Paul, MN 55101

DEPT PHONE 651-254-7761

STAFF

*	Physiatry		
	Rebecca Koerner, M.D., Medical Director	**BEEPER:**	612-580-0242
	Jess Olson, MD., Staff Physiatrist	**BEEPER:**	612-580-0178
	Richard Timming, MD, Staff Physiatrist	**BEEPER:**	612-580-9679
	Keith Moench MD, Staff Physiatrist	**BEEPER**	612-580-1726
	Matt Hofkens MD, Staff Physiatrist	**BEEPER:**	651-629-4183
*	Psychology		
	Rich Young, Ph.D., L.P., Rehab Psychologist	**BEEPER:**	651-629-0609
*	Rehabilitation Admission Coordinator, Cathy Meakins, RN	**OFFICE**	651-629-1019
*	Speech and Language Pathology		651-254-2053
*	Physical Therapy		651-254-2071
*	Occupational Therapy		651-254-2060
*	Hand Occupational Therapy		651-254-2844
	Therapeutic Recreation		651-254-2060
*	Therapeutic Aquatics		651-254-4797
*	Social Work		
	-- Laura Senst	**BEEPER:**	651-629-1850
*	Acute Inpatient Rehabilitation Program on C93		651-254-0090
	RN, Nurse Manager on C93	**BEEPER:**	651-629-0850
		OFFICE	651-254-3290
	C93 Ward		651-254-0099

DESCRIPTION OF DEPARTMENT SERVICE

The Rehabilitation Institute (RI) provides comprehensive inpatient and outpatient rehabilitation services to maximize person's physical, cognitive, social, emotional, and behavioral, and vocational abilities. The emphasis is on providing high quality patient care and functional outcomes cost effectively. Services include:

Physiatry

Physiatrists are physicians who treat medical conditions that limit function or cause pain. They provide a full spectrum of care-from diagnosis to treatment and rehabilitation-to restore maximum health, function, and quality of life. They work with patients to develop a customized treatment plan which may be in an inpatient or outpatient setting, such *as* the hospital (inpatient/outpatient), nursing home, transitional care unit, or in the home. They prescribe adaptive equipment, orthoses and prostheses, wheelchairs/mobility devices, and determine therapy needs. They use several nonsurgical treatments for pain including, therapy, medications, and various injections. They also perform permanent partial disability and independent medical exams.

Psychologists evaluate and treat cognitive, emotional, and behavioral difficulties as this relates to patients' rehabilitation progress. Issues that interfere with therapeutic progress or medical treatment may be areas of therapeutic focus, including difficulty adjusting to new abilities, changes in familial roles, relationship issues, chemical use patterns, or long standing difficulties with mood. Patients can be seen while hospitalized or on an outpatient basis. Neuropsychological evaluations are used to formally evaluate cognitive and memory functioning following neurologic illness or injury, especially as this relates
to practical issues in patients' lives.

Psychology

Psychologists evaluate and treat cognitive, emotional, and behavioral difficulties as this relates to patients' rehabilitation progress. Issues that interfere with therapeutic progress or medical treatment may be areas of therapeutic focus, including difficulty adjusting to new abilities, changes in familial roles, relationship issues, chemical use patterns, or long standing difficulties with mood. Patients can be seen while hospitalized or on an outpatient basis. Neuropsychological evaluations are used to formally evaluate cognitive and memory functioning following neurologic illness or injury, especially as this relates to practical issues in patients' lives.

Rehabilitation Admissions Coordinator
This person facilitates the admission process to rehabilitation and helps decide whether or not an admission to the rehabilitation unit is the most appropriate placement.

Speech and Language Pathology
Speech and language pathologists provide diagnosis and evaluation of speech and language disorders including: developmental speech and language disorders and acquired neurogenic and cognitive disorders, learning disabilities, hearing impairment, and reading problems. Services are also provided for problems related to voice, dysphagia, laryngeal) speech, and cleft palate.

Physical Therapy
Physical therapists provide evaluation and treatment for musculoskeletal disorders, orthopedic and neurological disabilities, and physical rehabilitation of major disabilities. Services are provided at the bedside, in the physical therapy clinic on the main campus, in the therapeutic pool, and at the off-campus site at Suburban Square.

Occupational Therapy
Occupational therapists provide an extensive range of services for patients whose ability to cope with tasks of daily living is impaired by physical, cognitive and/or emotional injury or illness. Services include evaluation and treatment of limitations in: activities of daily living, upper extremity function, visual perception and cognition, as well as provision of adapted equipment and upper extremity orthoses.

Hand Occupational Therapy
Hand occupational therapists provide assessment and treatment of patients with traumatic injuries to the upper extremity (crush injuries, tendon injuries, amputations) and provide preventative and post-op management for overuse syndromes such as carpal tunnel syndrome, lateral epicondylitis, etc. The therapists provide treatment in the areas of wound and scar management, edema control, sensory re-education, range of motion exercises, strengthening, coordination training, prosthetic training and orthotic fabrication and training.

Therapeutic Aquatics
Therapeutic Aquatic staff provides physical therapy and adapted aquatics in a warm water pool, to people affected by disease or disability. Treatment emphasis is on the use of exercise, activity, or swimming to meet an individual's rehabilitative or fitness needs. Community programs are also offered and include: Arthritis exercise, fibromyalgia classes, open swim, and group adapted aquatics for special schools, group homes, and developmental achievement centers.

Social Work
The social worker evaluates the patient, family, and community resources and helps make plans for discharge from the hospital to an independent setting and as active a lifestyle as possible. Referrals may be made to various community agencies. After discharge, support is provided to the patient and family during the period of adjustment to home and community. The social worker continues to act as a resource person as needed.

Therapy Referrals
A physician referral to rehab is appropriate if the patient has had functional change from baseline, which may prevent a return to independent or assisted living. The treatment team will work with the patient to improve function and make recommendations for rehabilitation and the most appropriate discharge destination.

For changes in:

- swallowing or communication: send orders to speech therapy.
- activities of daily living: send orders to occupational therapy.
- mobility: send orders to physical therapy.
- cognition: send orders to speech and occupational therapies.
- hand function: send order to hand occupational therapy.

PM&R Referrals

If you think the patient may benefit from admission to out acute inpatient rehab unit on C93, send a consult to physical medicine & rehabilitation (PN&R) write the orders in the medical chart. You can also consult PM&R physician (whether or not the patient need inpatient rehab) for treatment recommendations for neurologic and musculoskeletal disabilities including spasticity, pain, bowel/bladder issues, tbi, equipment needs and rehab programming.

Acute Inpatient Rehabilitation

What is it?

It is an intense treatment program for adults (^16 years of age) with functional limitations in: eating, dressing, grooming, bowel and bladder management, transfers, mobility, memory, problems solving, communicating or swallowing. We specialize in treating individuals with complex rehabilitation needs. This 16-bed, DRG-exempt, inpatient rehabilitation unit on C93, is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) since 1990.

How is it different from a TCU?

Our program is for people who need daily medical and rehabilitation management by a physician, rehabilitation nursing and education, and 3 hours of daily therapy. We also offer rehabilitation psychology, recreational therapy, hand therapy, burn rehabilitation, pain management and physical therapy in a warm therapeutic pool.

Who gets admitted?

Patients who:

- are able to benefit (or work towards) 3 hours of daily therapy.
- have a primary admitting diagnosis of: stroke, brain injury, multiple trauma, spinal cord injury, amputation (with complication), femur fracture (with complications), hip or knee arthroplasty (with complications) polyarthritis, neurological disorders, burns, severe debilitation and other disability requiring intensive rehabilitation care.
- are medically stable. They can be on heparin, IV's, dialysis, tube feedings, 02, routine BIPAP, cycle TPN, restraints, isolation, safety, safety assistant, or have a tracheostomy. They cannot have chest tubes, be on a ventilator, constant infusion, or require hourly monitoring. They may be able to have a PCA pump in some situations.
- have a funding source.

How do I get a patient admitted?

- Send a PM&R consult.
- Dictate your discharge summary (include discharge orders and follow-up recommendations).
- Complete an EPIC MD admit/transfer order form.
- Any questions, page the rehabilitation admissions coordinator at 651-629-1019. On weekends, page the on-call physician.

RESPIRATORY CARE SERVICES / PULMONARY REHAB/ SLEEP HEALTH CENTER

LOCATIONS		**DEPT PHONE** 651-254-2721
Respiratory Care	3rd Floor Central Bldg. Suite C-3194, Regions Hospital	
Pulmonary Function Lab	401 Phalen Blvd HealthPartners Specialty Center	651-254-7690
Sleep Health Center	2688 Maplewood Drive	651-254-8150
CardioPulmonary Rehab	2575 University Avenue West, Suite 140	651-254-2353

CONTACTS			
	Bob Voges, Respiratory Care Mgr.	Phone: 651-254-2721	Pager: 651-629-0412
	Ted Wawryziniak, Sleep Services Mgr	Phone: 651-254-8153	
	Jon Schluck, CardioPulm Rehab Mgr	Phone: 651-254-2346	Pager: 651-629-1057

HOURS Respiratory care and hemodynamic monitoring services are available 24 hours a day.
Pulmonary Function Lab is staffed 8am to 4:30pm, Monday through Friday.

DESCRIPTION OF DEPARTMENT/SERVICE

Respiratory Therapy/ Pulmonary Function Laboratory/Hemodynamic Monitoring/ Bronchoscopy
Pulmonary Rehab (See Below)
Sleep Health Center (See Below)

Respiratory Care Services

Statement of Function
Services are provided to medical/surgical departments under the direction of the Pulmonary/Critical Care Section of the Department of Internal Medicine. Respiratory Therapists provide assistance to you in your evaluation, care, and management of patients with impaired or abnormal cardio-respiratory function. Specific expertise in the technical operation of respiratory equipment and clinical application of procedures Is offered.

Beepers
Respiratory Care staff carries beepers and Vocera communicators to enhance communication. Each unit/area will be informed as to the practitioner and corresponding beeper number assigned to their area at the beginning of each shift. For questions or problems pertaining to respiratory care/hemodynamic procedures, beep The Senior (lead) Respiratory Therapist at (651) 629-0434.

Services Offered
Mechanical Ventilator Support - Respiratory Care staff will set up, troubleshoot, and maintain ventilators. The primary adult ventilator at Regions Hospital is the Puritan-Bennett 840. Weaning/extubation protocols are used in adult ICU,s and automatically started on all ventilator patients except those with a trach. Discussion between the physician and Respiratory Care concerning the rationale for the weaning/extubation is encouraged. Non-invasive ventilation, bedside ICU, inpatient and outpatient bronchoscopy and intubation assist, as well as high frequency oscillatory ventilation with the Sensor Medics 3100B is also available as well as other critical care services .

Oxygen Therapy - Systems available include: Nasal cannula, Venturi mask, non-rebreathing mask, high flow oxygen nebulizer, and high flow humidity systems. Respiratory Care staff will monitor and document therapy. Since oxygen is a drug, please write precise orders for initiation or discontinuance of oxygen. Continuous oximetry and arterial blood gas puncture is available as per physician order.

Bronchial Hygiene and Chest Physiotherapy - A variety of procedures and combinations of procedures are available on order. Procedures include humidity, aerosol bronchodilator therapy, bronchial drainage with percussion/vibration, (manual and mechanical) flutter valve, sputum inductions, CPAP and BiPAP mask therapy.

All are included in the Respiratory Care Protocols which are automatically initiated on any general or progressive care patient with respiratory treatment orders for Respiratory Care Services. Incentive spirometry is normally a responsibility of the nursing staff.

Pulmonary Function Laboratory - Limited pulmonary function tests are available for inpatients at Regions Hospital. Bedside testing consisting of spirometry and spirometry before and after bronchodilator are available for inpatient testing. These Pulmonary Screens, which include FVC, FEV1, FEV1, and FEF 25 to 75% are generally available with minimal advanced scheduling and uninterpreted results are placed in the chart immediately to facilitate pre-surgical or discharge evaluations. The Pulmonary Function Laboratory, located in the Lung and Sleep Health Clinic at HealthPartners Specialty Center, is equipped to provide you with a variety of pulmonary function measurements including: flow/volume determinations with or without bronchodilators, CO diffusion, nitrogen washout, lung volumes, ABGs at rest, oximetry during and following exercise with or without oxygen, and methacholine challenge testing. When ordering these outpatient studies, please specify all of the tests you would like done. All final pulmonary function reports include interpretations by a pulmonary physician. Complex and simple Cardio-Pulmonary Stress testing are also available in the Pulmonary Function Laboratory.

Inpatient pulmonary function testing is limited to bedside spirometry.

Bronchoscopy – Respiratory Care Services also provides set-up and assistance with Critical Care bronchoscopies as well as general care and inpatient bronchoscopy done in the Digestive Care and Interventional Pulmonology Center located on 2nd floor of the hospital. For more information contact the department, or the Senior RCP on pager 651-629-0434.

Hemodynamic Monitoring — Respiratory Therapist will assist with arterial, CVP, ICP, and PA insertions, pressure line monitoring and maintenance (arterial, atrial, PA, wedge, and ICP), discontinuance of arterial and central lines, cardiac output measurements, 02 consumptions, and in-house transport monitoring.

Patient Education - Asthma, COPD, MDI with spacer, dry powder inhaler, peak flow meter instruction and related patient education materials are provided by respiratory care. Home nebulizer therapy and CPAP education is generally provided by the participating DME, but Respiratory Care staff are available for questions and concerns.
Smoking Cessation counseling is also provided by Respiratory Care upon receipt of an order.

Respiratory Care Protocols

Respiratory Care Protocols have been created at Regions Hospital to assist the physician with evaluating patients' respiratory care needs, determining the indications for respiratory treatments, and selecting the appropriate modalities. Respiratory Care Protocols are automatically started when the physician writes an order for a Respiratory Care treatment. Respiratory Care treatments are defined as: M.D.I instruction, Nebulizer Tx, CPAP or BiPAP Tx (used in place of IPPB), or Chest Physical Therapy. If preferred, the physician may also write a general order such as "respiratory care to evaluate." In both instances, respiratory care staff will perform a complete patient evaluation for respiratory therapy treatments within 24 hours of the initial order.

Respiratory Care Protocols will be utilized for all patients for whom respiratory care treatments are written with the exception of:
Pediatric patients under the age of 18
Patients ordered to receive short-term therapy of less than 24 hours.

Respiratory Care Staff are also a part of the Rapid Response Team for Regions Hospital.

Discussion between the physician and Respiratory Care concerning the rationale for the therapy is encouraged. If you have any questions about this service or would like more information on Respiratory Protocols, please contact the Respiratory Care Supervisor on beeper 629-0434 or call the Respiratory Care Manager at 651-254-2723. In an acute situation, any immediate physician orders will be followed until a complete RC evaluation has been made. If a physician would like to overwrite the orders for respiratory care protocols, it must be done by a staff physician and be written as an "overwrite of RC Protocols."

Verbal Orders

Verbal/telephone orders are accepted for procedures consistent with common practices for respiratory care in this institution. Subsequent documentation of the order is expected.

Priorities for Service

Priorities are established to ensure the care of critically ill patients and are listed in the medical guidelines of the department.

<u>Consultation</u>

Jagdeep Bijwadia, M.D.	Department Head, Medical Director Sleep Health Center
Avi Nahum, M.D.	Medical Director of Pulmonary Rehab
Alain Broccard, M.D.	Medical Director of Medical ICU
Krista Graven, M. D.	Pulmonary, Critical Care Medicine, Medical Director of Respiratory Care and Pulmonary Function Lab
Jannica Groom, M.D.	Pulmonary Critical Care Medicine
Missy King-Biggs, M.D.	Pulmonary Clinic
Eric Korbach, M.D.	Pulmonary Critical Care Medicine
John J. Marini, M.D.	Medical Director of Pulmonary Research
Charlene McEvoy, M.D.	Medical Director of Pulmonary Clinic

Physician members are invited to seek consultation of the Pulmonary/Critical Care Medicine Section regarding the management of patients with impaired or abnormal respiratory function and any respiratory therapy procedures. Usually, upon perusal of the medical record, the indication and objective for therapy procedures is found clearly documented. If, however, there appears to be no indication for therapy, or objectives appear unclear, or continued therapy appears unwarranted, the respiratory care practitioner will consult with the responsible physician to outline and document the objectives of therapy. If indications and objectives are not outlined, subsequently, or are inconsistent with the department's guideline for respiratory therapy procedures, the practitioner will consult the Medical Director to review the therapy. In such an instance, the respiratory care practitioner will proceed as authorized by the Medical Director of the Department.

Pulmonary Rehab

The Pulmonary Rehab Program is a six week outpatient exercise and education program. It is offered through the Cardiopulmonary Rehabilitation Department. Those with diagnosed chronic obstructive and restrictive pulmonary disease may qualify. Sessions are held twice a week at the Westgate Business Center located at Hwy #280 and University Avenue. Contact Cardiopulmonary Rehab at (651) 254-9999 for questions and/or fax referrals to (651) 254-4776. Additional information is also available by visiting the Cardiopulmonary Rehabilitation link on ERIC.

Sleep Health Center

The Sleep Health Center is an outpatient unit located on Maplewood Drive in Maplewood. The Sleep Health Center is a new state-of-the-art sleep center which provides overnight and day sleep testing, day nap testing (MSLT's), MWT's, actigraphy, mask fitting and desensitization. The Sleep Health Center does not currently perform Home Sleep Testing. All tests include interpretation by a Physician . At this time, there are no direct referrals to the Sleep Health Center and all patients must be seen by either The Lung and Sleep Health Clinic or the Neurology Clinic for referral to the Sleep Health Center. Additionally, The Sleep Health Center partners with Hudson, Westfield's, Osceola, and Lakeview Hospitals to offer sleep testing services in those locations. The Sleep Health Center does not provide inpatient testing at this time. Contact the Sleep Health Center at 651-254-8150 for questions.

HealthPartners Home Medical supplies DME for Sleep Patients and is located in Arden Hills at the Arden Woods Office Park. This is Home Medical's only full service location, however, they also maintain limited service locations at Parkway, Anoka Riverway, Hudson (Hudson Hospital), New Richmond (Westfields Hospital), HSC (401 Phalen), Osceola Medical Center, and Lakeview Hospital. Contact Home Medical at 651-523-8440 for questions.

LOCATION	Regions Hospital North Building, 2nd Floor	**DEPT PHONE**	651-254-1633
CONTACT	Willie Braziel, Manager Graduate Medical Education	**PHONE**	651-254-1530
	Deb Collier, Program Associate Graduate Medical Education		651-254-1504

STAFF

David Ahrenholz, MD
Joe Barbato, MD
Bruce Bennett, MD
Robert Bulander, MD
Ryan Carlson, ND
Gary Collins, MD, Dept Chair
David Dries, MD, Ass't Medical Director for Surgical Care
Victoria Elmer, MD
Fred Endorf, MD
Sandy Engwall, MD
Michael McGonigal, MD
William Mohr, MD
Todd Morris, MD
L.T. Nguyen, MD
Cassandra Palmer, MD
Gary Rosenthal, MD
Thamrong Suwan, MD
Seth Wolpert, MD, Site Director

DESCRIPTION OF DEPARTMENT/SERVICE

The Department of Surgery is staffed by 18 surgeons. There is one fellow (Surgical Critical Care) and 13 residents, including 5 G-1's. The Department has six surgical services: Trauma, Acute Care Surgery, General Surgery, Burn, Surgical Intensive Care, and Vascular Surgery.

The main Surgery office is located on the second floor of the North Building. The majority of the surgical patients are cared for on the Surgical Intensive Care Unit on 3 CM, C5100 and C5200. The Burn Center on the 5th floor cares for burn patients and some plastic surgery patients. The Surgical Research Unit Laboratories are located on the 1st floor of the Education Building.

Trauma patients are seen in the Emergency Room by the Trauma Service. Acute General Surgery patients are seen by the Acute Care Surgery Service either in the Emergency Room or on the inpatient Units.

The Surgery Department conducts and participates in many conferences each week including a Chief's Conference, a Multidisciplinary Trauma Conference, a Multidisciplinary Critical Care Conference, weekly case presentation, and a SICU Journal Club. One of the primary goals of the department is medical student and resident education. Information about conferences and education are available in the Surgery Office.

DEPARTMENT DESCRIPTIONS - SERVICES

CARE MANAGEMENT DEPARTMENT
INCLUDING SOCIAL WORK AND CASE MANAGER SERVICES

LOCATION East Building, Room 3876
Main Building, Room 6035
Regions Hospital

DEPT PHONE 651-254-9260

CONTACT PERSON Joshua Brewster, Director, Care Management 651-254-3780
Karen Lovold, Manager of Care Management 651-254-5107
Jennifer Kreitz, Supervisor of Care Management 651-254-9259

HOURS Monday through Friday: 8:00 am to 4:30pm
Weekends-Saturday/Sunday: 8:00 am to 4:00 pm

NOTE: On weekends, Care Management coverage is limited to four staff, both case managers (CM) and social workers (SW). If you are trying to reach the assigned CM/SW please see AMION for contact information.

DESCRIPTION OF DEPARTMENT

The Care Management's licensed social workers and registered nurse case managers are assigned to all inpatient medical and surgical units. Most units have a dyad/triad team of a social worker(s) and case manager(s) who collaborate to facilitate the progression of care, to coordinate discharge-planning needs, and to address psychosocial needs or barriers patient may have. Patients, families, health care providers and/or other concerned persons may request Care Management services. Hospital staff may make a referral via telephone, physician/nursing orders, or call the social worker and/or case manager directly.

CONTINUING CARE PLANNING

Contact the assigned social worker or case manager when it is determined that a patient may need supportive services in the community. The Care Management staff is knowledgeable about both local and out-of-area resources to best meet the needs of the patients/families.

In many cases, either the case manager or the social worker can handle discharge needs of a patient. However, the team discusses the cases and determines whether social work or case management intervention is more appropriate. In some cases, the team works together to best meet the needs of the patient/family.

PSYCHOSOCIAL ASSESSMENT

Following referral, the social worker will meet with the patient and family to assess psychosocial needs and develop a plan and/or recommendations to address the needs. The social worker will also consult with the referring person and will participate in the interdisciplinary patient care planning process. The social worker will work with the interdisciplinary team and the patient/family to accomplish agreed upon goals for discharge.

PROGRESSION OF CARE

The case manager is the main contact and facilitator of patient care, including progression of care and discharge planning. Case managers use the Milliman guidelines to assist them in determining best-care practices and appropriate care for patients. The case manager will work with the interdisciplinary team and the patient/family to accomplish agreed upon goals for discharge.

CARE MANAGEMENT INDICATORS

- Adjustment reaction to illness, injury or disabling condition.
- Chemical dependence or substance abuse.
- Child welfare concerns such as suspected neglect, abuse, fetal exposure to controlled substances, or parental difficulty in following the treatment plan.
- Complex Medical needs (i.e. Wound care, IV antibiotics, Wound VAC's).
- Concerns about advance directives, living wills, conservatorship or guardianship.
- Discharges to nursing home for long term care, transitional care, acute rehab.
- Equipment or home care needs upon discharge.
- Experience of sexual or physical violence.
- Financial concerns such as loss of income or lack of medical insurance.
- Homelessness or lack of adequate, accessible or affordable housing.
- Inability to return to previous living situation or need for extended care.
- Issues related to progression of care.
- Lack of clothing, food, transportation to medical appointments or other essentials.
- Personal and family problems causing distress.
- Referrals to Clinics/ follow- up clinic appointments.
- Suspected or known domestic conflict or violence.

CHAPLAINCY SERVICES

LOCATION Regions Hospital
2ND Floor, Central Section

DEPT PHONE 651-254-2072

CONTACT PERSON Rob A. Ruff, Director

PHONE 651-254-1431

HOURS There is a chaplain on-call at all times, 24 hours a day, 7 days a week. Chaplains are in-house Monday through Friday, 8:00 am to 10:00 pm. There is also a Catholic priest available at all times. The chaplain and priest on-call can be paged via the hospital operator (651-254-3456). The on-line Amion schedule also has a listing for which chaplain and priest are on-call.

STAFF

Rob Ruff, Director of Chaplaincy Services
Helen O'Brien, Staff Chaplain
Robert Osterlund, Staff Chaplain
Fr. Ron Harrar & Fr. Antony Skaria, Catholic priests
Donald Patterson, Senior Chaplain
Beth Stassen, Staff Chaplain
Lisa Watson, Staff Chaplain

DESCRIPTION OF DEPARTMENT/SERVICE

Chaplains at Regions Hospital are available to provide spiritual and emotional support to patients, families, and staff. Chaplains work with patients and families to help them find meaning in the midst of illness, hospitalization, and treatment. The purpose of the Chaplaincy Department is to support the hospital's commitment to holistic care by:

- Providing spiritual care with compassion and respect;
- Honoring the importance of spirituality and religious beliefs in health and healing;
- Promoting the integration of spiritual care into the total patient care program;
- Contributing to a healing environment within the hospital.

Hospital staff are encouraged to contact a chaplain whenever support for patients and family members might be helpful, especially in response to changes in medical condition, life-limiting diagnosis, death of a patient, Code 2, significant personal loss, or other crises which can raise spiritual and emotional concerns.

Chaplains serve as members of the interdisciplinary health care team. Each nursing station has a staff member assigned as the primary chaplain. As their schedules permit, chaplains attend team rounds and care conferences. They provide another perspective on the care of the patient and family. As non-medical personnel chaplains can serve as a bridge between staff, patients, and families. Chaplains are available as consultants and educators in the areas of spirituality, religious customs, and belief systems. Chaplains are among those staff members who serve as consultants for the Regions Ethics Consult team. A number of our chaplains are trained, experienced Critical Incident Stress Debriefing facilitators and are available to lead debriefing sessions for hospital staff after particularly difficult, stressful cases.

Ongoing ministry provided includes: supportive visits through request, referral, and daily rounds; consultation with staff; worship opportunities and provision of sacraments; referrals as needed to community religious and spiritual resources. Worship is conducted in the Chapel of the Divine Healer located near the west entrance of the hospital. Services include daily Roman Catholic Mass, Friday Muslim prayer, Wednesday afternoon prayer service, Memorial Services, and special services.

Staff chaplains are Board Certified through the Association of Professional Chaplains. Requirements for certification include: endorsement by a denominational body, graduate theological education, ministry experience and clinical training. Chaplains have completed at least one year of full time residency through the Association for Clinical Pastoral Education (ACPE).

HealthPartners Research Foundation

Location	8170 33rd Ave. S., MS 21111R Minneapolis, MN 55440	
Contacts	Kate Rardin-Leahy, Senior Manager, Development and Planning	952-967-5035
	Bobette Godding, Manager, Office of Research Subjects (IRB/ACUC)	651-254-3391
	Betty Jo Haggerty, Manager, Research Operations	952-967-5078

HealthPartners Research Foundation (HPRF) supports research activities that discover new knowledge and accelerate the use of knowledge to improve the health and health care of our members, patients and community. In particular, research efforts focus on projects that enhance health care outcomes and/or the cost effectiveness of health care delivery. HealthPartners medical, dental, and other health professionals conduct research in their areas of interest and through collaboration with organizations across the country and around the world. Research activities conducted through HPRF are intended to result in public-domain and/or in peer-reviewed publications.

Research Oversight
Three subcommittees, Clinical Research, Health Services Research, and Basic Science Research, review all research applications using established criteria related to the science of the proposal, the fit of the proposal in the HealthPartners organization, and the potential to improve the health or health care of patients, members and the community.

Institutional Review Board/Animal Care and Use Committee
All research using human or animal subjects must also be reviewed by the Institutional Review Board (IRB) or the Animal Care and Use Committee (ACUC) to ensure compliance with federal guidelines.

Research Training
All researchers and study staff must complete training on the responsible conduct of research before beginning research (using human or animal subjects). The training pertains to both internally and externally funded research. For training requirements, contact the IRB office at 651-254-2928.

Research Opportunities
All residents who wish to conduct research must have a HealthPartners employee as an advisor on the project and complete the required research training.

Grant Programs
Each year, the HPRF Board of Directors allocates funds to support internal Discovery and Partnership grants. Projects with scientific merit and the potential to produce meaningful results are considered for funding on a competitive basis. Pilot projects that may evolve into a more developed investigation funded by an external source are encouraged. All employees of HealthPartners are eligible. The Research Committee makes funding decisions for the HPRF Board of Directors. To find out more, contact the IRB office at 651-254-2928.

Grant Cycles and Receipt Dates
The HPRF internal research grant program has quarterly grant cycles (January, April, July, and October) on the third Friday of the month.

Application Forms and Guidelines
Applying to conduct research at HealthPartners is through an electronic submission process. Please contact the IRB office for assistance in accessing the electronic forms (651-254-2928).

Application Assistance
All research applicants for internal or external funding should contact Kate Rardin-Leahy at 952-967-5035. She as well as the other staff listed above can help with questions about policies and procedures or for referral to experienced investigators and statisticians. Contact them as early as possible to ensure ample time for assistance.

Institute for Medical education/Graduate Medical Education Resident Research Support
Residents in HealthPartners IME/GME programs may receive up to $2,000 to support a research project. This funding will be awarded through the HPRF review process (including IRB review). For more information, contact Jen Augustson at 952-883-7285 or Jeanette.L.Augustson@healthpartners.com.

LINEN SERVICES

LOCATION Dock Area, 1st Floor, Regions Hospital **DEPT BEEPER** 651-629-GOWN (4696)

CONTACTS Steve Meland, Dock & Linen Services Supervisor **PHONE** 651-254-9587
Tom Collins Housekeeping Supervisor **PHONE** 651-254-9974
Spectra Link – Linen Employee **PHONE** 651-254-4696

HOURS "GOWN" pager is available 3:30 am-6:00 pm Monday – Friday, and 3:30 am-noon weekends. Off hours and holidays call the Materials Storeroom at x49589

DESCRIPTION OF DEPARTMENT/SERVICE

(Updates may occur after print date of this manual, please refer to most current information updates provided by Linen Services).

The Materials Management department of Regions Hospital is responsible for a variety of services, which will accommodate your experience as a resident here. A full-time Housekeeper is assigned to cleaning resident call rooms and keeping them supplied with clean linen.

Scrubs are provided in the Residents Call Room locker room area located on 2nd Floor of the south building. Please take only one set of scrubs and **return them daily** to one of the soiled linen hampers located outside the call rooms. Scrubs are the property of Regions Hospital and must not leave the hospital.

PROVISION AND DISTRIBUTION OF SCRUB ATTIRE

Policy: In order for the hospital to maintain control of the environmental conditions and certain surrounding areas of patient care, the hospital will provide scrub attire and scrub attire laundering services only to those areas of the hospital where scrub attire is approved by this policy. Materials Management Linen Department will be responsible for the supply of scrub attire in OR and Labor & Delivery. Residents may wear scrubs to other departments, but should not wear scrubs unless necessary to help reduce linen laundering costs. Personnel in the following areas must wear hospital-issued scrub attire:

APPROVED DEPARTMENTS FOR WEARING HOSPITAL SCRUBS

Operating Room	HP Same Day Surgery
Post Anesthesia	Cardiac Cath Lab
Burn Center (select staff)	Labor and Delivery - C-Section Suite only
Pathology	Reprocessing
Ambulatory Surgery Center	GYN Specialties
Bio-Med	Research

Scrub attire is NOT considered personal protective equipment (PPE). Personnel performing duties requiring PPE will need to obtain barrier quality attire before performing these duties.

REQUIREMENTS FOR SCRUB USAGE

1. Staff working in the above departments must wear hospital provided scrubs, no other scrub attire will be allowed in these departments.

2. Entry into designated scrub locker rooms will require the display of a hospital ID photo card or department staff must accompany the individual.

3. Staff wearing hospital provided scrubs are expected to come to work in street clothes, and change back to street clothes when leaving the hospital. ***The hospital reserves the right to stop and question any individual leaving the building wearing or carrying hospital issued scrubs***.

4. Staff leaving the hospital building (smoking, breaks) is expected to have a cover garment (isolation gown) on and not sit on the ground with their scrubs.

5. Staff assigned to perform duties in designated hospital scrub departments will use scrubs from that department, changing into their own uniform when leaving the designated scrub department to do other work in the hospital. (Examples: A housekeeper cleaning the O.R. and then moves to other area in the hospital where hospital scrubs are not required.)

SCRUB POLICY # RH-SP-RM 01:11

Surgical attire is worn to promote high level cleanliness and hygiene within the surgical environment and to provide a barrier to contamination that may pass from personnel to patients, patients to personnel, as well as from personnel to sterile instruments. Additional protective barriers are worn in order to prevent exposure to blood or body fluid contamination during the reprocessing of instruments and equipment. Scrub suits are appropriate for designated areas (e.g. OR and L&D). In all other areas, a long white coat must be worn over the scrub suit.

- *Hospital provided scrubs are to be worn* ***inside*** *the hospital only.*
- *Scrubs are not to be worn outside for breaks or smoking*
- *Scrubs are not to be worn while traveling between hospitals*
- *Scrubs are not to be worn home; or to and from work*
- *Before leaving the hospital, staff should change into street clothes and deposit used scrubs in the laundry hamper*

PROVISION AND DISTRIBUTION OF LAB COATS

Policy: In order for the Hospital to maintain control of the environmental conditions surrounding specified patient care areas and ancillary services, the Hospital will provide lab coats and lab coat laundering services only to those areas where scrub attire is required such as staff physicians, residents and the Pathology Department.

Procedure:

1. All resident and staff physician lab coats are purchased by the Clinics and they will make original and replenishment purchases of lab coats. Pathology is on a rental program.

2. Only hospitalists will be issued lab coats with embroidered names on them. Soiled lab coats should be returned to room C-3195 located on third floor in the south section for processing. Clean coats will be returned in one to two weeks.

3. Resident physicians can pick up one lab coat from room C-3195 on third floor across from the Pathology Lab. A soiled lab coat must be exchanged for a clean one. These are currently located in room C-3195 in a variety of sizes.

4. Lab coat provisions can be made for professional guests to the Hospital. The hosting department will be held responsible for acquiring and prompt, accurate return of the lab coats to room C-3195 upon completion of the visit.

PARKING

LOCATION Parking Office, 2nd Floor, Main Building **DEPT PHONE** 651-254-3967

CONTACT Terry Gustafson, Office Manager

HOURS 7:00 am to 5:00 pm, Monday through Friday

DESCRIPTION OF DEPARTMENT/SERVICE

Resident Parking
All Residents must park in the East Ramp for all shifts. This ramp is accessed using your ID badge.

Bus Passes
We carry “Go To” cards and 31 Day cards. See the Parking Office for more information. We also carry bus schedules.

Lockers
The Parking Office distributes lockers. There is a $10.00 deposit for each locker assigned. Lockers come furnished with combination locks. There are a limited number of available lockers. See the Parking Office for more information.

Escorts
Safety escorts to and from your vehicle are available through the Security Department 24 hours a day, 7 days a week. Please call 651-254-3979 for assistance.

VERY IMPORTANT MISCELLANEOUS INFORMATION

The control card you are issued is valid ONLY in the East Ramp. It will NOT be accepted in any other lot or ramp at any time.

If you have trouble with your parking card at any time, please drive into the West Ramp, pull a ticket and bring your ticket to the Parking Office with your ID badge. We do not want you to receive a warning or violation from Security nor do we want you to pay the full daily rate for parking. If you forget your parking card, you must come to the Parking Office for assistance.

The Security Department issues warnings to vehicles improperly parked. There is no fee charged for a warning. They also have the authority to issue a City of St. Paul Parking Violation. The fees charged on these violations range from $25 and up. If you receive a City of St. Paul Parking Violation and would like to dispute it, please contact the Security Office within 5 business days. Disputes after 5 days must be made with the Violations Bureau and are far more unlikely to be dismissed. Their address and phone number is on the ticket. If you have questions about a warning or a violation that you receive, you must discuss it with Security at 651-254-3979.

If you parked in the West Ramp, the booth attendants must have a validation from the Parking Office or you will be charged the regular published rate. Remember to stop by the Parking Office during office hours.

Any suggestions concerning parking should be sent in writing to the Manager of Parking. We welcome all comments.

REGIONS HOSPITAL MEDICAL LIBRARY

Location 2nd Floor, East Section, Room E2803
Regions Hospital

Dept Phone: 651-254-3607
Fax: 651-254-3427

Contacts Mary Wittenbreer, MLIS, MALS
Head Librarian
Phone: 651-254-3609

Jennifer Feeken, MLIS
Librarian
Phone 651-254-3608

Jennifer Neville, MLIS
Librarian
Phone: 651-254-9527

E-mail MedicalLibrary@HealthPartners.com

Hours 8:00 AM – 4:30 PM, Monday-Friday

DEPARTMENT DESCRIPTION/SERVICE

Medical Library Intranet site (On myPartner)

The Intranet site is your access to subscribed databases, online journals, a book catalog and library services. It is available on all Regions Hospital, HealthPartners Clinic office computers. It is also available remotely with a key fob.

- Go to myPartner (HealthPartners' intranet site)
- Click on Departments
- Click on M-O
- Click on Medical Library (Regions)
- Or you can book mark the site at http://regionsmedicallibrary.healthpartners.com

Library Collection Description

- We currently subscribe to over 375 journal titles. Most are available electronically.
- Most journal titles have been collected for 15 years while select titles have been collected over 50 years.
- Journals do not circulate
- The book collection consists of current reference books plus a core book collection covering most disciplines.
- Non-reference books can be checked out for two weeks. Please enter your name, date and a contact number or email on the checkout card found in the back of the book.

Library Services

- An interlibrary loan service is available for items not found in the library collection. The medical library is part of an arranged network of local, regional, and national libraries that allows access to other collections for document delivery.
- Journal articles and books can be requested either in person, by phone, fax, through our Intranet site or e-mail at MedicalLibrary@HealthPartners.com. Please allow 2-5 business days for delivery. Articles are sent electronically to your email address.
- The librarians provide a literature search service.
- Journal and literature search forms are found on the library's intranet site.

Resources – Databases

- **Access Medicine**
- **Cochrane Library**
- **DynaMed**
- **MDConsult**
- **MEDLINE** – Available through PubMed and OVID. Online journal access through PubMed is through the PubMed with LinkOut specific URL found on our Intranet site.
- **Micromedex**
- **Natural Medicines**
- **PsycINFO**
- **Psychiatry Online**
- **STAT!Ref**
- **UpToDate**
- Questions on searching? Ask a librarian or use the database search aids available in the Medical Library

Other Resources

- **Online Journals Access and List** – Most of our journals are also available online. No user names or passwords are required. Look for this black and green icon to access full-text articles when searching our databases.

- **Book Catalog** – Use this to search both the print and electronic book collections..
- **eBook List** – Use this to search our ebook titles by subject.
- **Small Group Meeting/Work Areas** – Several areas can accommodate groups of 2-5
- **Classes** – The librarians are available to teach small groups or instruct on an as needed basis.
- **Refworks: Personal Citation Manager** – Import citations from various databases and create bibliographies

Internet Access and E-mail Access

- Twelve public end-user workstations are available for Internet access
- Access to your Microsoft Outlook accounts
- Microsoft Office, including Microsoft Word, Excel, Access and Power Point are also available

Photocopying

The Library has one copy machine that is department code accessible. The Library limits photocopying to items from the Library collection only. Photocopying is self-serve; all patrons are expected to copy their own materials. The Library posts and enforces the United States Copyright Law (Title 17, United States Code).

After Hours Access

Swipe card after-hours access is limited to medical students, residents and physicians and other staff who are attending school.

Comments and Suggestions

Please do not hesitate to ask for further information, orientation to different databases or questions about electronic journal access. We welcome your suggestions!

SECURITY

LOCATION Regions Hospital
1st Floor, Central Building
Suite C 1381

DEPT PHONE 651-254-3979 Security Routine
651-254-3969 Security Emergency

CONTACT PERSON Rick Huston **PHONE** 651-254-3629

HOURS 24 hours a day, 7days a week

DESCRIPTION OF DEPARTMENT/SERVICE

The hospital's facility is patrolled on a 24-hour basis by the campus security department. Campus security officers are uniformed for high visibility to the public and to staff. All campus security officers are equipped with a two way radio to provide timely and efficient response to incidents or problems in and on the hospital's campus. The campus security department utilizes patrol vehicles for the purpose of maintaining routine patrols of and timely response to parking lots and other areas around the campus. To augment the patrol function, the campus security department utilizes closed circuit television and alarm systems to monitor areas both inside and outside the facility. The security control center serves as the control dispatch center for all calls received. The security control center is located on the first floor of the Main Building.

Security Incident Reporting

Security incidents include any crime, or unusual activity which could result in a crime, or which may result in harm or loss to individuals, or which may result in damage to the facility. The hospital's policy requires all employees to report security incidents upon discovery. This ensures a timely response and helps in the reporting of details which can aid in the prevention of further activity, identification of perpetrators and accurate reporting of facts surrounding the incident. Reporting security incidents immediately also ensures you that there will be a formal record of the event or activities to support your claim in the future. To report an incident, notify the campus security department by using the numbers at the top of the page.

Safety Escorts

The campus security department will offer a safety escort to anyone at any time of the day from any building, which the hospital leases and/or owns to the person's vehicle as long as it is parked in a lot which is leased and/or owned by the hospital. To acquire an escort to your vehicle, simply call the campus security department at 651-254-3979 and let the dispatcher know where you would like to be met and what your destination will be. An officer will be sent to your location to meet you, escort you to your vehicle and wait until you are safely in your vehicle and departing before clearing the area.

Workplace Violence

Regions Hospital will not tolerate violence in the workplace. Regions Hospital may take disciplinary action, up to and including termination, and may also support criminal prosecution of those who threaten or commit work-related violence against its employees, customers and other visitors.

Who to call

If you encounter/witness any act of violence, contact the Safety and Security Department at extension 43969 immediately. If you work off campus, you should call the police (911), and Security, if the situation is or potentially violent.

Personal Safety Tips

- When walking, be alert to your surroundings.
- When you feel afraid, your mind may be sending you a warning that something is not right or that you are in danger.
- Never walk alone at night.
- Park and travel in well-lit areas.

Switchboard Operators – Guest Experience

LOCATION 640 Jackson, Room 1271
Regions Hospital

DEPT PHONE 0 **or** 651-254-3456

CONTACTS Karen Peterson, Telecommunications
Krista Kretman, Switchboard Supervisor

HOURS 24 Hours per Day, 7 Days per Week

DESCRIPTION OF DEPARTMENT/SERVICE

Monday through Friday 7am-3pm there are three operators; evenings there are two operators 3pm-11pm and nights there is one operator (11pm-7am). *Their responsibilities include:*

1. Answer and expedite outside calls.
2. Patient Information
3. Page doctors and other key personnel, and make announcements.
4. Alert security of a disturbance.
5. Answer ALL hospital STAT calls/Page all Codes/Track all Hospital Codes
6. Send test pages to all code pagers daily
7. Answering Service for Geriatrics/Integrated Home Care
8. Pager Support Services for Hospital
9. After Hours AMION (On Call Schedule) Support

Important ways in which house staff should function to gain maximum use of the switchboard system are:

1. Dial '0' for hospital operator.
2. Dial '9' for an outside line.
3. Dial the desired 5 digit number for inter-hospital calls (Last 5 digits of telephone number, 4-XXXX)
4. Dial '11111' for STAT pages.
5. Answer all pages promptly or arrange for someone to take a message.
6. *The* hospital *has a* direct dial long *distance system, which may* be *accessed from some phones. To* place a long distance call, dial 9-1-area code and number followed by your department's account code. International calls can be made by using a credit card only.

Pager System:
All pagers *have* long-range capability. *Any touch-tone phone can* be *used to* place *a page. There is no* need to sign in or out of the system. On-call personnel are responsible for finding coverage when their pager *is off. Most of the* Pagers *are* equipped *with a* digital read *out of the* number to *be* called; *these* have no voice-message capability. If you feel your pager is defective take it to the switchboard and they will give you a replacement.

To initiate a page to a digital beeper:

1. Dial '9' (if in the hospital).
2. Dial the 7 or 10 digit beeper number.
3. Listen for one ring and four quick beeps.
4. Dial the number to be called. (Due to many different 3 digit prefixes, it is always best to dial 10 digits when paging from within a medical center.)
5. If you wish to indicate the degree of urgency of your page, hit the asterisk sign (*); this creates a dash on the beeper. Then dial 1, 2, 3 or 4. Press # to send the page.

VOLUNTEER SERVICES

LOCATION: Room C2400, 2nd Floor, North Bldg. **DEPT. PHONE:** 651-254-5709

CONTACT PERSON:		**PHONE:**
	Amy Greening, Volunteer Services Supervisor	651-254-2717
	Ali Hourigan, Volunteer Coordinator	651-254-4770
	Bonnie Watson, HealthPartners Volunteer Coordinator	651-254-9249

DESCRIPTION OF DEPARTMENT/SERVICE

Since 1965, Regions Hospital and HealthPartners volunteers have helped health care professionals and staff provide a positive experience for the patients, families and guests of Regions Hospital and the HealthPartners Clinics. Volunteer Services places over 700 volunteers annually for Regions Hospital, the Specialty Centers at 401 and 435 Phalen Avenue, and the HealthPartners Clinics. Since 2009, Volunteer Services has been a part of the overarching Guest Experience department at Regions and is continually striving to provide quality volunteer service to our departments, patients and guests. Volunteers can be easily recognized by their uniform of red polo shirts and black pants.

SERVICES

In 2011, volunteers offered over 53,000 service hours to Regions Hospital and the HealthPartners Clinics. We welcome your referrals for potential volunteers. Please call our department at 651-254-5709 or email volunteerservices@HealthPartners.com, if we can be of assistance to you.

IME/GME POLICIES

HealthPartners
Institute for Medical Education

Subject ACCESS TO ELIGIBILITY TO BOARD CERTIFICATION		**Attachments** ☐ Yes ☒ No
Key words:	Board, Certification, Compliance, Requirement	**Number** IME-32
Category	Human Resources (HR)	**Effective Date** July 21, 2009
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 21, 2009
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose

To establish a policy for all post-graduate training programs sponsored by, the HealthPartners Institute for Medical Education (HP/IME) to ensure compliance with the Accreditation Council for Graduate Medical Education (ACGME) Institution, Common Program and/or Specialty Requirements.

Scope

This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HP/IME.

Definition

Department – refers to the home department of any given Residency Program.

Residency Program (RP) – refers to a residency or fellowship educational program, accredited by the ACGME or CPME, for purposes of clinical education.

Resident physicians – refers to all interns, residents and fellows enrolled in a HealthPartners IME post-graduate training program.

Designated Institutional Official (DIO) – refers to the Executive Director of the Institute for Medical Education.

Policy

The Graduate Medical Education Committee (GMEC) approved leave policies are in compliance with, and governed by, the regulations of the various specialty boards and accrediting organizations.

It is the responsibility of the department, residency program, and resident physicians to be in compliance with the ACGME Program Requirements concerning the effect of leaves of absence on satisfying the criteria for completion of the training program, and guaranteeing eligibility for certification by the relevant certifying Board prior to granting leave.

American Board requirements should be reviewed by the residency program director and resident physician to ensure that the trainee is familiar with the responsibility of having to make up time away from training. If extended leave results in the requirement for additional training in order to satisfy American Board requirements, financial support for the additional training must be determined when arrangements are made for the leave and the makeup activity.

References

See also the relevant Residency Program Manual for specific departmental policies and procedures.

###

HealthPartners

Institute for Medical Education

Subject	APPROPRIATE DRESS/ATTIRE	**Attachments** ☐ **Yes** ☒ **No**
Key words	Appropriate, Areas, Attire, Code, Designated, Dress, Scrubs	**Number** IME-21
Category	Human Resources (HR)	**Effective Date** November 20, 2001
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** November 20, 2001
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Scope

Resident physicians are expected to present a clean and neat appearance. Jewelry, make-up, and fragrances must be in good taste, not extreme, and should not interfere with patient care.

Policy

Professional attire is appropriate for all physicians while involved in patient care. For males, this preferably means dress shirt and tie. For females, this preferably means dresses, blouses, skirts, sweaters, or dress slacks. Footwear must be clean, in good repair, and provide for adequate safety.

For males and females, a long white coat over professional attire is appropriate.

Scrub suits are appropriate for designated areas, e.g. OR and L&D. In all other areas, a long white coat must be worn over the scrub suit. Scrub suits are never appropriate outside the hospital.

###

HealthPartners
Institute for Medical Education

Subject	DIO DESIGNEE	Attachments ☐ Yes ☒ No
Key words	Designee, Designated, DIO, Official	**Number** IME-30
Category	Business Practices (BP)	**Effective Date** July 21, 2009
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 21, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose

To establish a policy for all post-graduate training programs sponsored by, or affiliated with, the HealthPartners Institute for Medical Education (HP/IME) for business continuity and to ensure compliance with the Accreditation Council for Graduate Medical Education (ACGME) Institution Requirements.

Scope

This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by, or affiliated with, the HP/IME.

Definition

Residencies – refers to a residency or fellowship educational program, accredited by the ACGME or CPME, for the purpose of clinical education.

Designated Institutional Official (DIO) – refers to the Executive Director of the HP/IME.

Policy

All residencies are accountable to the Designated Institutional Official (DIO). In the absence of the DIO, the Director of Graduate Medical Education shall serve as the DIO designee.

###

HealthPartners
Institute for Medical Education

Subject	DISASTER RESPONSE	**Attachments** ☐ Yes ☒ No
Key words	Disaster, Response, Safety, Sponsoring, Transfer	**Number** IME-28
Category	Business Practice (BP)	**Effective Date** July 1, 2007
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 2007 **Retired Date** Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose

- To comply with the ACGME Institutional Requirement I.B.8. which reads as follows:

  I.B. Commitment to Graduate Medical Education (GME)
  8. The Sponsoring Institution must have a policy that addresses administrative support for GME programs and residents in the event of a disaster or interruption in patient care. This policy should include assistance for continuation of resident assignments.

- To provide guidelines for communication with and assignment/relocation of housestaff (resident/fellow) manpower in the event of a disaster impacting the graduate medical education programs sponsored by HealthPartners Institute for Medical Education (IME).

- To protect the well being, safety and educational experience of residents enrolled in our training programs.

Scope

This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education.

Definition

A disaster is defined herein as an event or set of events causing significant alteration to the residency experience at one or more residency programs.

Responsibilities/Requirements

Following declaration of a disaster, the GMEC working with the IME DIO and other sponsoring institution leadership will strive to restructure or reconstitute the educational experience as quickly as possible following the disaster. In order to maximize the likelihood that residents will be able to complete program requirements within the standard time required for certification in that specialty, the IME DIO and GMEC will make the determination that transfer to another program is necessary. Once the IME DIO and GMEC determine that the sponsoring institution can no longer provide an adequate educational experience for its residents, the sponsoring institution will, to the best of its ability, arrange for the **temporary transfer** of the residents to programs at other sponsoring institutions until such time as the Institute for Medical Education is able to resume providing the experience.

The IME DIO will communicate with the offices of GME and Medical Staff Services at Regions Hospital to coordinate any issues regarding the temporary transfer, credentialing, relocation and housing of our residents.

Residents who transfer to other programs as a result of a disaster will be provided by their Program Director(s) with an estimated time that relocation to another program will be necessary. Should that initial time estimate need to be extended, the resident will be notified by their Program Director(s) using written or electronic means identifying the estimated time of the extension.

If the disaster prevents the sponsoring institution from re-establishing an adequate educational experience within a reasonable amount of time following the disaster, then **permanent transfers** will be arranged.

The IME DIO will be the primary institutional contact with the ACGME and the Institutional Review Committee Executive Director regarding disaster plan implementation and needs within the sponsoring institution.

In the event of a disaster affecting other sponsoring institutions of graduate medical education programs, the IME DIO will work collaboratively with the DIO of the affected sponsoring institution to accept transfer residents from other institutions. This will include the process to request complement increases from the ACGME as may be required for accepting additional residents for training. Programs currently under a proposed or actual adverse accreditation decision by the ACGME will not be eligible to participate in accepting transfer residents.

Programs will be responsible for establishing procedures to protect the academic and personnel files of all residents from loss or destruction by disaster. This should include at least a plan for storage of data in a separate geographic location away from the sponsoring institution.

###

HealthPartners
Institute for Medical Education

Subject	DUPLICATION AND ATTESTATION OF CERTIFICATES	Attachments ☐ Yes ☒ No
Key words	Attestation, Completion, Certificate, Duplication	**Number** IME-24
Category	Business Practices (BP)	**Effective Date** April 15, 2003
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** April 15, 2003
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose

To establish a policy for all post-graduate training programs sponsored by HealthPartners Institute for Medical Education for transfer students regarding completion or attestation of post graduate year one and completion of residency training certificates.

Scope

This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. All information contained in this policy shall be used as minimum criteria.

Policy

The post-graduate year one and completion of residency training certificates are confidential and secured documents signed by appropriate institutional officials and sealed with the institutional seal. One original is presented to the resident upon successful completion of post-graduate year one and residency training. Requests for duplicate "original" certificates will not be honored to preserve authenticity.

The resident may copy certificates at any copy or photo-imaging center.

In the event a certificate is lost, an attestation certificate may be requested by contacting the Graduate Medical Education Office at 651-254-1504. The cost for an attestation certificate is $25.00, payable to Regions Hospital Graduate Medical Education.

###

HealthPartners
Institute for Medical Education

Subject DUTY HOURS		Attachments ☐ Yes ☒ No
Key words	Duty, Hours, Program, Residency	**Number** IME-6
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** **July 1, 1999**
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To establish a policy for all post-graduate training programs within HealthPartners Institute for Medical Education to monitor and schedule appropriate work/duty hours of the Residents.

Scope
This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. All information contained in this policy shall be the maximum limit for Resident duty hours. More detailed duty hour information shall be delineated by each clinical department in its respective Departmental Policy for Resident Duty Hours. The Graduate Medical Education Committee must approve all policies.

Definition
Resident/House Staff- Refers to all Residents and fellows enrolled in a post-graduate training program sponsored by HealthPartners IME.

Post-Graduate Training Program - Refers to a residency or fellowship educational program, accredited by the ACGME or CPME, for purposes of clinical education.

Responsibilities/Requirements

A. The Program Director is responsible for the duty schedules in his/her respective department. The Program Director is responsible for making the ultimate decisions regarding scheduling of all duty hours for all Residents within their scope of supervision.

B. Duty hours including on-call duty hours must be in accordance with ACGME requirements.

- Residents are limited to a maximum of 80 duty hours per week, including in-house call, averaged over four weeks. In certain cases, starting in July 2004, residency programs will be allowed to increase duty hours by 10 percent if doing so is necessary for optimal resident education and the program receives approval from the appropriate RRC.
- Residents must be given one day out of seven free from all clinical and educational responsibilities, averaged over four weeks.
- Residents cannot be scheduled for in-house call more than once every three nights, averaged over four weeks.
- Duty periods cannot last for more than 24 hours, although residents may remain on duty for six additional hours to transfer patients, maintain continuity of care or participate in educational activities.
- Residents should be given at least 10 hours for rest and personal activities between daily duty periods and after in-house call.
- In-house moonlighting[1] counts toward the weekly limit. In addition, program directors must ensure that external and internal moonlighting does not interfere with the resident's achievement of the program's educational goals and objectives.
- Residents must report all external moonlighting hours to their Program Director on a monthly basis.

C. On a periodic basis, but no less than quarterly, Program Directors must review their duty hour schedules and processes. They must be reported to the Graduate Medical Education Committee at least once a year to ensure compliance with applicable ACGME/CPME requirements.

The Central GME Office will conduct an audit of the duty hour processes and schedules on a periodic basis, but no less than once per year, to ensure compliance with applicable ACGME/CPME requirements.

D. Any Resident working in excess of the hours specified in Section B above should report the excess hours to the Executive Director of HealthPartners IME.

E. On-call rooms are provided for Residents with nighttime duty hours.

###

[1] See also Moonlighting Policy #IME-8 in the current GME Resident Handbook

HealthPartners
Institute for Medical Education

Subject	END OF TRAINING PROCEDURE	Attachments ☐ Yes ☒ No
Key words	Summary, Improvement, GMEC, Report, Training	Number IME-19
Category	Business Practices (BP)	Effective Date July 1, 1999
Manual	Graduate Medical Education	Last Review Date May 17, 2011
Issued By	Graduate Medical Education	Next Review Date May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	Origination Date July 1, 1999 Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	Contact: Graduate Medical Education

Purpose
To establish a policy within the HealthPartners IME system to monitor continued quality improvement of Residency experience at Regions Hospital. The End of Training Evaluation is utilized to enhance and improve the educational experience.

Scope
This policy will apply to all training programs with residents rotating at Regions Hospital.

Responsibilities/Requirements
As a continued quality improvement mechanism, the process for results of "End of Training" evaluation follows:

1. The Manager of GME will run a "program specific" report with an anonymous summary of comments for all training programs.

2. The summary and comments by residents will remain anonymous.

3. A copy of the summary report will be given to Program Directors for review.

4. Within 30 days, the Program Director will develop a plan for improvements.

5. The Program Director will report on the findings and the plan for improvement as appropriate, to the GMEC Committee.

6. The GMEC will make recommendations on the improvement plan and provide support as appropriate.

7. The GMEC will periodically review the progress of programs in resolution of outstanding issues.

###

HealthPartners
Institute for Medical Education

Subject	EVALUATION OF RESIDENTS	Attachments ☐ Yes ☒ No
Key words:	Academic, Educational, Evaluation, Hearing, Performance	**Number** IME-3
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To establish a policy for all post-graduate training programs within the HealthPartners IME System to use in the formal evaluation of Residents' performance and for the Residents' evaluation of the hospital and the program. Evaluation is utilized to enhance the educational process.

Scope
This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. All information contained in this policy shall be used as minimum criteria for evaluation. More detailed evaluation criteria shall be delineated by each clinical department in their respective Departmental Evaluation Policy. The Graduate Medical Education Committee must approve all policies.

Definition
Resident/House Staff- refers to all Residents and fellows enrolled in a HealthPartners IME post-graduate training program.

Remediation - the act or process of remedying or correcting; see Policy for Fair Hearing

Probation - A formal level of academic or professional discipline; see Policy for Fair Hearing

Responsibilities/Requirements

A. Evaluation of Residents

1. To enhance the educational process and keep all Residents apprised of their educational progress/advancement, all Program Directors (or designees) must formally evaluate the

performance of each Resident at six (6) month intervals. Because the position of Resident involves a combination of supervised, progressively more complex and independent patient evaluation and management functions and formal educational activities, the competence and academic performance of the Resident will be evaluated by a careful and deliberate review, including documentation of the Residents' performance with respect to skills, abilities, progress, clinical judgment, medical knowledge, and/or professional growth. The Program shall maintain a confidential record of the evaluations. These evaluations shall be in writing, dated, and signed by both the Program Director and the Resident.

2. A confidential record of all formal evaluations must be kept as part of the Residents' personnel file and be available upon request of the Resident at all times.

3. At the conclusion or termination of each Resident's training, a formal summation of performance during the duration of training will be completed by the Program Director and maintained as permanent documentation of the program. A copy of this final evaluation will be forwarded to the Office of Graduate Medical Education for permanent archiving.

4. All documentation of Residents' performance by the faculty, formal or informal, must be maintained as permanent documentation by the department,

5. The Program Director shall be responsible for communicating the Departmental Policy for Evaluation to all Resident/House Staff and faculty.

6. Evaluations will be one of the tools utilized in determining promotion, as specified in the Policy for the Promotion of Residents.

B. Evaluation by Residents

1. Each Program Director shall assure that at least annually, each Resident formally evaluates the teaching faculty and the program in writing.

2. These evaluations should be anonymous and confidential. Program Directors must assure Residents are free to comment frankly and openly without fear of intimidation or retaliation.

3. In addition to the Departmental evaluation process, the Office of Graduate Medical Education will conduct an annual end-of-the-year summary evaluation of the program, the institution and the overall educational experience. All Residents are required to complete the institutional evaluation. Reports of the evaluation will be communicated to the Program Directors and the Graduate Medical Education Committee.

C. Disciplinary Action

1. Residents are expected to meet and adhere to academic, clinical and professional standards set forth by the Institutional and Program Requirements, as well as the Institution and the Department. If at any time a Resident exhibits unsatisfactory performance, remediation is necessary. In most circumstances, the Resident will continue to perform his/her daily duties during the remediation process.

2. Inadequate performance should be clearly communicated, in writing, to the Resident as early as possible, and at minimum, at the six-month formal evaluation.

3. If the Program Director deems it necessary, the Resident may be placed on one of two levels of discipline:

   a) **DEPARMENTAL REMEDIATION:** Any Resident whose performance is assessed to be unsatisfactory by the Program Director may be placed on Departmental Remediation.

      (i) The Program Director shall inform the Resident in writing of the deficiencies noted in academic, clinical, or professional performance.

      (ii) A specific program for Departmental Remediation should clearly be identified, in writing, as well as criteria for successful completion of the remediation.

      (iii) Departmental Remediation must be assigned for a specific period of time, not to exceed six (6) months in duration.

      (iv) Upon successful completion of Departmental Remediation, the Resident will be removed from this disciplinary status. Documentation will remain part of the Residents' permanent file, but will only be disclosed upon written authorization of the Resident or through legal process.

      (v) If the Departmental Remediation is not successfully completed, the remediation may be repeated for up to another six (6) month period, or the Program Director may increase the level of discipline to Institutional Probation (see below).

      (vi) Departmental Remediation is not considered to be a reportable disciplinary action.

      (vii) Assignment of Departmental Remediation is not grounds for a Resident to request a Fair Hearing.

   b) **INSTITUTIONAL PROBATION:** If a Resident fails to meet the requirements set forth in the Departmental Remediation, the next level of discipline, Institutional Probation, may be assigned.

      (i) The Program Director shall inform the Resident in writing of the decision to place him/her on Institutional Probation status. This letter must be copied to the Executive Director, IME.
      (ii) This letter should contain a very specific program for remediation, as well as criteria (goals and objectives) for successful completion of the probation.
      (iii) Institutional Probation must be assigned for a specific period of time, not to exceed six (6) months in duration.
      (iv) Upon successful completion of Institutional Probation, the Resident will be removed from this disciplinary status. Documentation will remain part of the Residents' permanent file, but will only be disclosed upon written authorization of the Resident or through legal process.
      (v) If the Institutional Probation is not successfully completed, the Probation may be repeated for another six (6) month period, or the Resident may be recommended for termination (Refer to the Policy for Termination and the Policy for non-Renewal of Contracts).
      (vi) Assignment of Institutional Probation is considered to be grounds for a Resident to request a Fair Hearing.

c) In most circumstances, Residents should be placed on Departmental Remediation prior to being assigned to Institutional Probation.

d) The Executive Director of IME, pursuant to Minnesota Statutes Section 147.111, will report institutional Probation to the Minnesota Board of Medical Practice.

###

HealthPartners
Institute for Medical Education

Subject	EXPERIMENTATION AND INNOVATION	Attachments ☐ Yes ☒ No
Key words	Education, Experimentation, GMEC, Innovation Program, Projects,	Number IME-31
Category	Provision of Care (PC)	Effective Date July 21, 2009
Manual	Graduate Medical Education	Last Review Date May 17, 2011
Issued By	Graduate Medical Education	Next Review Date May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	Origination Date July 21, 1999 Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	Contact: Graduate Medical Education

Purpose

To establish a policy for all post-graduate training programs sponsored by the HealthPartners Institute for Medical Education (HP/IME) to ensure compliance with the Accreditation Council for Graduate Medical Education (ACGME) Institution, Common Program and/or Specialty Requirements.

Scope

This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education.

Definition

Resident physicians - refers to all interns, residents and fellows enrolled in a HP/IME post-graduate training program.

Residency Program (RP) – refers to a residency or fellowship educational program, accredited by the ACGME or CPME, for the purpose of clinical education.

Designated Institutional Official (DIO) – refers to the Executive Director of the Institute for Medical Education.

Policy

The Graduate Medical Education Committee (GMEC) supports well planned projects that promote high-quality education and patient care in the settings where resident physicians learn and practice. However, projects that deviate from the ACGME Institution, Common Program and/or Specialty Requirements may be considered experimental or innovative and, as such, require prior authorization from the GMEC and the DIO before submission for approval to the related Residency Review Committee (RRC).

Procedures

A. A RP must complete the "Program Experimentation and Innovation Project Proposal Form" (attached and available on the ACGME website[1]).
B. The completed form is submitted to the GMEC for approval. If approved, the DIO signs the form.
C. The RP submits the approved form to their RRC for review.
D. The RRC notifies the RP of the outcome of the review and if the proposal is approved.
E. If approved, the duration of the approval shall not exceed the next scheduled site visit.
F. Monitoring is determined by the RRC and may include progress reports.

###

[1] Please refer to the following ACGME websites to access the form and for further information on the process:
1) Process for submitting a proposal:
http://www.acgme.org/acWebsite/navpages/nav_program_experimentation.asp
2) Program Experimentation and Innovation Project Proposal Form:
http://www.acgme.org/acWebsite/navpages/ProgramExperimentationInnovativeProjectsProposalform.doc
3) ACGME Policy and Procedure manual for information on entire process:
http://www.acgme.org/acWebsite/about/ab_ACGMEPoliciesProcedures.pdf (page 112 on menu bar)

HealthPartners
Institute for Medical Education

Subject	FAIR HEARING PROCESS	Attachments ☐ Yes ☒ No
Key words	Adjudication, Board, Executive, Fair, Hearing	**Number** IME-13
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To establish a policy for all post-graduate training programs within HealthPartners Institute for Medical Education (IME) System to use in the adjudication of all actions to Residents resulting in dismissal or otherwise threatening the career of the Resident.

Scope
This policy will apply to all training programs accredited by the Accreditation Council for Graduate medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education.

Definition
Resident/House Staff- refers to all Residents and fellows enrolled in a HealthPartners IME post-graduate training program.

Remediation - the act or process of remedying or correcting; see Policy for Evaluation of Residents (IME-3)

Probation - A formal level of academic or professional discipline; see Policy for Evaluation of Residents (IME-3)

Termination - The act of severing employment prior to the expiration date of the Resident's contract.

Dispute Resolution

First, the resident and Program Director will attempt to resolve all disputes through an informal, in-person, confidential meeting. **If the dispute is with the Program Director, the resident may go directly to the Executive Director, HealthPartners Institute for Medical**

Education. The Program Director will afford the resident full opportunity to respond to any of the concerns raised.

Formal Hearing

A. A Resident may request a Fair Hearing at any time which an action has been taken by the Program that may threaten the Residents' career or terminate the Resident's residency contract. Examples of these actions include Institutional Probation, Non-Renewal of Contract, and Termination.

B. A Fair Hearing must be requested within ten (10) working days of the written notification of the action. All requests for Fair Hearing shall be made in writing, and addressed to the Executive Director of IME and copied to the Program Director. If the Resident fails to request a hearing within the foregoing ten-day period, his/her rights pursuant to this policy shall be deemed to be waived.

C. Once the request for hearing has been received by the Executive Director of IME, the Program Director will be notified and the Grievance Policy/Process will be commenced.

D. A designee of the Executive Director of IME will appoint a Fair Hearing Board and the Chair as identified below. The first meeting of the Fair Hearing Board will be within fifteen (15) working days of the written request.

E. The Fair Hearing Board will consist of the following five voting members:

   1. CHAIRMAN: A physician representing the medical staff leadership of HealthPartners or Regions Hospital (e.g. Medical Director of HPMG, Regions Chief of Staff, Chair of the Patient Care Committee etc…)
   2. Two (2) faculty members of other programs not directly associated with the Resident.
   3. Two (2) Residents from programs other than that of the Resident in question, and at similar levels of training.

F. In addition to the five voting members listed above, the following members of administration will staff and serve as advisors to all Fair Hearing Committees:

   1. Regions Hospital Vice President for Human Resources
   2. Regions Hospital Vice President for Medical Affairs

G. Neither the Resident nor the Hospital shall be represented by legal counsel at the proceeding. However, each may produce witnesses and documentation on their behalf. In addition, at the hearing the Resident shall have the following rights:

   1. The right to hear all adverse evidence, present his/her defense, present written evidence, and call and cross-examine witnesses; and
   2. The right to examine his/her residency files prior to or at the hearing.

H. The proceedings of the hearing shall be recorded.

I. The Fair Hearing Board shall establish the appropriateness of the discipline by a preponderance of the evidence.

J. After the hearing, the Fair Hearing Board will reach a decision by majority vote based on the record at the hearing, either:

1. In favor of the Resident; or
2. Against the Resident; or
3. Develop a revised disciplinary action.

K. A written report of the Fair Hearing Board's decision (including a statement of the reasons for its decision) shall be produced and provided to the Resident within ten (10) working days of the conclusion of the Hearing process. The Chairman of the Fair Hearing Board shall meet with the Resident to review the decision of the Board, and to review all further action.

L. All proceedings and decisions of the Fair Hearing Board shall be reported to the Graduate Medical Education Committee (GMEC) in a confidential manner, for its information.

M. Although the discipline will be implemented on the Effective Date, the Residents' stipend shall be continued until (i) his or her ten (10) day period to appeal expires, (ii) the Fair Hearing Panel issues its written decision, or (iii) the termination date of this Agreement, whichever occurs first.

N. The decision of the Fair Hearing Board in these matters shall be final.

O. Notwithstanding any other Hospital, Department(s), and Program Policies and procedures to the contrary, the foregoing procedures shall constitute the sole and exclusive remedy by which the Resident may challenge the imposition of discipline.

P. The Hospital, the Department(s), and an affiliated hospital, each has a right to impose immediate summary suspension upon the Resident if the Resident's conduct is reasonably likely to be detrimental to patient safety or the delivery of quality patient care. In such cases, the Resident may avail him or herself of the hearing procedures described above.

###

HealthPartners
Institute for Medical Education

Subject	FREEDOM OF EXPRESSION	**Attachments** ☐ Yes ☒ No
Key words	Academic, Expression, Freedom, Public	**Number** IME-22
Category	Business Practices (BP)	**Effective Date** November 28, 2001
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** November 28, 2001 **Retired Date** Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To establish a policy for all post-graduate training programs sponsored by HealthPartners Institute for Medical Education for freedom of expression in training.

Scope
This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. All information contained in this policy shall be used as minimum criteria.

Policy
HealthPartners Institute for Medical Education believes in the principles of academic freedom and responsibility. These are rooted in the belief that the mind, ennobled by the pursuit of understanding and the search for truth, and the state are well served when instruction is available to individuals with adequate training regardless of sex, sexual orientation, race, age, religion, color, national origin, disability, or veteran status, at an institution dedicated to the advancement of learning.

Academic freedom is the freedom to discuss all relevant matters in the classroom, to explore all avenues of scholarship, research and creative expression and to speak or write as a public citizen without institutional discipline or restraint. Academic responsibility implies faithful performance of academic duties and obligations, the recognition of the demands of the scholarly enterprise and the candor to make it clear that the individual is not speaking for the institution in matters of public interest.

###

HealthPartners
Institute for Medical Education

Subject	GENERAL RESPONSIBILITIES OF THE RESIDENT	Attachments ☐ Yes ☒ No
Key words	Ethical, Program, Professional, Responsibilities	**Number** IME-2
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To provide guidelines to Resident/House Staff regarding their general responsibilities as a postgraduate trainee.

Scope
This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. More specific guidelines may be developed by each Program, and approved by the Graduate Medical Education Committee.

Definition
Resident/House Staff- refers to all Residents and fellows enrolled in a HealthPartners IME post-graduate training program.

Post-Graduate Training Program - refers to a residency or fellowship educational program, accredited by the ACGME or CPME for purposes of clinical education.

Responsibilities/Requirements

A. Each Resident is expected to avail himself/herself of the educational opportunities offered within the institution, provide medical treatment to the hospital's patients in a competent and caring manner, and conduct himself/herself in a moral, ethical and professional manner at all times.

B. To meet these responsibilities, the Resident is expected to:

1. Attend and actively participate in all conferences and teaching rounds within the assigned department.
2. Render appropriate medical care to our patients in a kind and caring manner under the supervision of the attending physician.
3. Attend assigned clinics.
4. Participate in the evaluation of the program, his/her peers and teaching faculty as requested by the Program Director.
5. Do independent study using the services and resources offered through the medical library.
6. Participate in research activities and quality improvement of the Hospital
7. Document care and complete/sign patient medical records in a timely manner
8. Volunteer to serve as a member of various staff and hospital committees
9. Be on time and present for all assignments
10. Respond to pages promptly
11. Conduct himself/herself in an ethical and moral manner
12. Maintain a professional appearance and comportment
13. Assume progressive responsibilities as he/she gains experience
14. Contribute to the successful operation of the Hospital
15. Provide supervision to less senior Residents and medical students
16. Document completion of procedures and submit information to Program Director's office
17. "Sign out" before leaving the hospital, as appropriate for the clinical service
18. Accept 'Sign out" from departing Residents
19. Cooperate with nursing and other staff
20. Report to the Program Director any event that may expose you and/or the Hospital to liability
21. Comply with all departmental policies

###

HealthPartners
Institute for Medical Education

Subject	GRIEVANCE RESOLUTION	Attachments ☐ Yes ☒ No
Key words	Grievance, IME, Problems, Report, Resolution	**Number** IME-12
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To establish a policy for all post-graduate training programs within the HealthPartners IME to use in the formal evaluation of Residents' complaints and grievances.

Scope
This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education.

Definition
Resident/House Staff- refers to all Residents and fellows enrolled in a HealthPartners IME post-graduate training program.

Grievance - a cause of distress (such as an unsatisfactory working condition) felt to afford reason for complaint or resistance.

Responsibilities/Requirements

A. Occasionally, problems may arise in the course of a training program that must be addressed. For incidents that occur during a specific shift on a patient unit, Residents/House Staff should report any problems directly to the Resident in charge at that time. If the Resident in charge is unable to rectify the situation, the attending on the team should be consulted. If the matter is still not resolved to the Residents' satisfaction, the following procedure should be observed:

    1. For any grievance that is not associated with a particular incident on a patient unit or for any grievance that is not resolved as stated above, Residents/fellows should report problems

directly to their Chief Resident. If the Resident does not feel as though the Chief Resident has effectively resolved the issue, or the service has no Chief Resident, he/she should take the problem to the Program Director for resolution.

2. If satisfactory resolution is still not apparent after the Program Director has become involved, then the Resident should provide a written grievance outlining the problem to the Executive Director, IME.

3. Upon receipt of the grievance report, the Executive Director, IME will first ensure the Program Director has been properly notified of the issue. A grievance committee will then be formed by the Executive Director, IME, consisting of the following individuals:

   a) The grievant's Program Director
   b) Executive Director, IME
   c) Vice President of Human Resources, Regions Hospital
   d) A Resident not involved with the situation

4. Upon hearing the grievance, the committee will investigate any and all issues associated with the complaint and will provide a final written decision to the Resident.

5. All grievance committee decisions will be brought to the Graduate Medical Education Committee for information purposes.

###

HealthPartners
Institute for Medical Education

Subject HEALTH INFORMATION MANAGEMENT (HIM)		Attachments ☐ Yes ☒ No
Key words	Compliance, HIM, Information, Management, Records	**Number** IME-9
Category	Medical Information (MI)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Residents must be in compliance with institutional policies related to medical records.

###

[1] See HIM departmental section description in current GME Resident Handbook

HealthPartners
Institute for Medical Education

Subject HOSPITAL CLOSURE/PROGRAM ELIMINATION/REDUCTION IN FORCE		**Attachments** ☐ Yes ☒ No
Key words	Closure, Elimination, Hospital, Residency, Reduction, Training	**Number** IME-16
Category	Business Practices (BP)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999 **Retired Date** Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To establish a policy for all post-graduate training programs within the HealthPartners IME to state the intentions of the System regarding the potential for reduction or elimination of the resident physician work force.

Scope
This policy applies to all residents/fellows in training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education.

Definition
Resident/House Staff- refers to all residents and fellows enrolled in a HealthPartners IME post-graduate training program.

Post-Graduate Training Program - refers to a residency or fellowship educational program, accredited by the ACGME or CPME, for purposes of clinical education.

Responsibilities/Requirements

1. The Sponsoring Institution will inform the GMEC, the DIO, and the residents as soon as possible, when it intends to reduce the size or close either a program or the Sponsoring Institution, and at least five months prior to elimination of a residency program.

2. All current contracts will be honored.

3. Every effort will be made to ensure residency programs will only be eliminated or downsized at the end of the academic year.

4. Every effort will be made to help each resident find alternative training in an ACGME or CPME accredited program.

5. Proper care, custody and disposition of residency education records, and appropriate notification to licensure and specialty Boards.

###

HealthPartners
Institute for Medical Education

Subject IMPAIRED RESIDENT/FELLOW POLICY		Attachments ☐ Yes ☒ No
Key words	Impairment, Investigation, Report	**Number** IME-10
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
Any employee, staff member, or medical staff who believes that a member of the Resident staff is functioning while impaired for any reason should report such concerns to the residency director.

Scope
This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education.

Definition
An impaired Resident/Fellow shall be defined as any Resident/Fellow who, by virtue of physical disability, mental illness, psychological impairment, chemical substance abuse or misconduct, is unable to safely care for patients, perform duties normally expected of a Resident physician or engage in peer interaction necessary for patient care.

Policy
The residency director will obtain as much detailed information as possible at this time and begin an investigation. The residency director is to determine whether such investigation should be carried out by himself, by a committee, or by an outside consultant or some other appropriate mechanism. If an investigation reveals possible impairment, the HealthPartners Institute for Medical Education Executive Director will be notified by the residency director.

If based on the initial report, the conclusion is that there is no substance to the report, such report will be discarded and will not appear in the file of the Resident. In any case, the results of the investigation shall be communicated to the Executive Director.

Impaired Resident/Fellow Procedure

1. There should be regular monitoring of Resident/Fellow performance by the Program Directors and the faculty. When a suspicion of impairment is detected, an in depth interview with the Resident/Fellow by the Program Director and one other faculty member shall be carried out. Mutually agreeable resources may be utilized to establish the fact and severity of the impairment.

2. As soon as the Program Director is aware of a problem with Resident/Fellow impairment, an immediate method of handling the problem should be determined.

3. The Program Director and the Resident/Fellow, after discussion, will formulate a plan for reduction, and/or elimination, of the impairment. The plan should stipulate specific goals and objectives. If agreement is reached, the Program Director and the Resident/Fellow both sign the plan. The original is kept in the Residents'/fellow's file, copies are sent to the Resident/Fellow, the Program Director, and the department head. There shall be a periodic review of the impairment by the Program Director.

4. If a leave of absence is involved in the plan, it must meet the criteria stated in the regulations of the appropriate specialty Board.

5. If the Program Director and the Resident/Fellow cannot agree on either the fact of the impairment or plan for remediation of the impairment, then the regular dismissal policies and procedures of the HealthPartners Institute for Medical Education may be utilized.

6. If required, reporting of the impaired physician to the Board of Medical Examiners shall be carried out under the provisions of State of Minnesota Statutes.

###

HealthPartners
Institute for Medical Education

Subject MEAL ALLOTMENT		**Attachments** ☐ Yes ☒ No
Key words	Allotment, In-House, Meal, On-Call	**Number** IME-26
Category	Human Resources (HR)	**Effective Date** May 1, 2003
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** May 1, 2003
		Retired Date Not Applicable
Review Responsibility Graduate Medical Education Committee		**Contact:** Graduate Medical Education

Purpose

To establish a policy for all post-graduate training programs sponsored by, or affiliated with, the HealthPartners Institute for Medical Education for consistent administration of meal allotment dollars between the programs.

Scope

This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by, or affiliated with, the HealthPartners Institute for Medical Education.

Definition

Resident physicians - refers to all interns, residents and fellows enrolled in, or affiliated with, a HealthPartners IME post-graduate training program.

Residencies – refers to a residency or fellowship educational program, accredited by the ACGME or CPME, for purposes of clinical education.

Policy

Residencies are provided budget allotments for meal swipe cards based on the number of in-house call days for residents per month. This is administered by the GME office. Any issues regarding implementation, or the need for additional call nights, please call the GME Manager at 651-254-1530.

Procedures

A. Food may be purchased by resident physicians at the hospital cafeteria or at the Overlook Café using meal swipe cards.

B. A discount may be available to resident physicians between the hours of 7PM and 9PM at the Overlook Café in recognition of the higher cost of food at this location.

C. After 9PM, resident physicians have food available using the vending machines outside the cafeteria. The vending machines have sandwiches, yogurt, cookies, cereal, milk, soup, fruit and other food.

###

HealthPartners
Institute for Medical Education

Subject MOONLIGHTING		Attachments ☒ Yes ☐ No
Key words	Activities, Moonlighting, Training	**Number** IME-8
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To establish guidelines for employment outside of HealthPartners Institute for Medical Education residency and fellowship training.

Scope
This policy will apply to all Residents participating in post-graduate training programs in the HealthPartners Institute for Medical Education.

Definition
Resident/House Staff- refers to all Residents and fellows enrolled in a HealthPartners IME post-graduate training program.

Post-Graduate Training Program - refers to a residency or fellowship educational program, accredited by the ACGME or CPME for purposes of clinical education.

Moonlighting - refers to any and all clinical activities outside of the scope of the defined post-graduate training program.

Responsibilities/Requirements

A. A Resident must not be required to engage in moonlighting activities.

B. Moonlighting is permissible so long as, in the judgment of the Program Director, such activity does not interfere with the Residents' ability to meet his/her

educational obligations in a satisfactory manner. The Program Director has the right to restrict a resident from moonlighting.

C. The Residents' performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission to moonlight.

D. A Resident who moonlights is not provided coverage of professional liability insurance by HealthPartners IME or its affiliates. The professional liability policy for residents/fellows does not cover any activities that are not part of the formal education program.

E. The Program Director determines moonlighting policy for all Residents within their scope of supervision. Program Directors will forward a copy of their policy to the Executive Director of HealthPartners Institute for Medical Education. Approval does not extend coverage for professional liability.

F. The Resident's moonlighting activities are governed by a separate written agreement between the Resident and the entity for which the Resident will provide the moonlighting services.

G. Residents on J-1 Visas are not permitted to be employed outside the training program. A resident on an H-1B Visa wishing to moonlight must obtain a separate H-1B Visa for each facility where the resident works outside the training program.

H. Residents desiring to moonlight must prospectively seek permission from the Program Director. If granted, the Program Director must provide a written statement of permission that is then made part of the Resident's file.

I. Residents are not allowed to moonlight on a service where they are simultaneously fulfilling a rotation.

J. Residents must report all external moonlighting hours to their Program Director on a monthly basis.

K. On a periodic basis, but no less than quarterly, Program Directors must review their duty hour schedules and processes. They must be reported to the Graduate Medical Education Committee at least once a year to ensure compliance with applicable ACGME/CPME requirements.

L. The Central GME Office will conduct an audit of the duty hour processes and schedules on a periodic basis, but no less than once per year, to ensure compliance with applicable ACGME/CPME requirements.

###

Attachments:

A. Moonlighting Privileges Process

B. HealthPartners Physician Services Department Process for Hiring Temporary or Moonlighting Physicians

IME – 8 Attachment A

Moonlighting Privileges Process

Use: Program Directors, Residents, Program Coordinators, and GME Office

Scope: As a document defining the process for a resident to obtain privileges to moonlight. Addressing requirements for moonlighting privileges the credentialing process, liability insurance, supervision, billing and restrictions.

I. Requirements for Moonlighting Privileges:

Moonlighter must be credentialed through HealthPartners
Moonlighter must have a permanent MN License
Moonlighter must have a DEA License
Moonlighter must have professional liability insurance

II. Credentialing Process:

Contacts: Physician New Hire Coordinator at 952-883-5793, HealthPartners Physician Services.

When contacted by the resident, Physician Recruitment Coordinator (952-883-5333) sends out a HealthPartners or Regions Hospital physician credentialing and privileging employment application packet for the resident to complete.

Upon completion of the application Physician Services initiates the hire, HealthPartners or Regions Hospital credentialing, and 3rd party enrollment of all moonlighters who will be working for HealthPartners or Regions Hospital.

The moonlighting resident will be credentialed as a fee-based practitioner.

The credentialing process takes an **average of 120 days to complete**. Moonlighting privileges will not be granted until the credentialing process is complete.

III. Liability Insurance:

Liability Insurance is paid by HealthPartners if the moonlighter is employed by and working in the HealthPartners system. Regions Hospital pays the Liability Insurance if the moonlighter is employed by and working at Regions Hospital.

IV. Billing:

Residents who are properly credentialed through HealthPartners can bill for their services independently, as long as they receive a UPIN or provider number.

V. Restrictions:

The Program Director has the right to restrict a resident from moonlighting activities. (See GME Moonlighting Policy IME-8)

###

IME-8 Attachment B.

HealthPartners Physician Services Department
Process for Hiring Temporary or Moonlighting Physicians

If you are interested in having a physician work within your department and have determined that HealthPartners will employ and pay them, please note the following necessary steps:

1. Please contact Physician Services Physician Recruitment Coordinator (952-883-5333) to send the candidate a Group Health, Inc. employment application and personnel paperwork. This notification should be a minimum of 120 days prior to the anticipated start date to allow for the processing of the employment application, personnel paperwork and credentialing processes to be completed.

   - Please e-mail physicianrecruitment@healthpartners.com or call 952-883-5333 with the physician's name, address, phone number and anticipated start date.
   - HealthPartners cannot pay a physician until the completed personnel forms are completed.

2. When the employment application is returned, previous/current malpractice and licensure are verified and reference letters are requested (by Physician Services). Per our legal department, we cannot hire any physician/moonlighter without documented verification of a current Minnesota License.

3. An offer letter is sent to the physician by Physician Services asking the physician to respond in writing within two weeks if they are accepting the offer.

4. Once an acceptance is received, an employment letter is sent to the physician (by Physician Services).

5. At the time of hire, the processes of HealthPartners credentialing, 3rd party payer enrollment, and hospital privileging, if appropriate, is initiated by Physician Services, Physician New Hire Coordinator. A credentialing packet will be put together and sent to the physician for completion.
   - HealthPartners credentialing must be approved prior to the physician's start of employment.
   - Hospital privileging must be approved if the physician will be doing any hospital work or providing services at any hospital.
   - 3rd party payer enrollment must be in process prior to the physician's start.

Physician Services will also request malpractice insurance to be issued and will forward payroll paperwork to the payroll department.

###

HealthPartners
Institute for Medical Education

Subject	NON-DISCRIMINATION	Attachments ☐ Yes ☒ No
Key words	Applications, Discrimination, Status	**Number** IME-25
Category	Human Resources (HR)	**Effective Date** March 15, 2005
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** March 15, 2005
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

:

Purpose

To establish a policy for all post-graduate training programs sponsored by the HealthPartners Institute for Medical Education to use in the recruitment of students into its residency programs.

Scope

This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education.

Policy

HealthPartners Institute for Medical Education residency programs shall consider residency applications on the basis of the applicant's preparedness, ability, aptitude, academic credentials, communication skills, personal qualities such as motivation and integrity, and such other factors as may be deemed appropriate for the specific program. HealthPartners Institute for Medical Education residency programs do not consider residency applications on the basis of race, color, creed, religion, sex, sexual orientation, disability, veteran status, marital status, status with regard to public assistance, familial status, or national origin.

###

HealthPartners
Institute for Medical Education

Subject NON-RENEWAL OF CONTRACT		Attachments ☐ Yes ☒ No
Key words	Contract, Hours, Probation, Renewal	**Number** IME-15
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To establish a policy for all post-graduate training programs within the HealthPartners IME to use in the termination of Residents' employment prior to the completion of the residency training program, but at the conclusion of a contract period.

Scope
This policy will apply to all training programs accredited by the Accreditation Council for Graduate medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education.

Definition
Resident/House Staff- refers to all Residents and fellows enrolled in a HealthPartners IME post-graduate training program.

Remediation - the act or process of remedying or correcting; see IME Policy # 13 re: Fair Hearing Process

Probation - A formal level of academic or professional disciplines; see IME Policy #13 re: Fair Hearing Process

Responsibilities/Requirements

A. Failure in performance to progress academically or professionally may be cause for a Program Director (or designated peer review group) to choose not to renew a Resident's contract.

B. Should a program director deem it necessary not to renew a resident's contract, the resident must be provided written notice of such intent not to renew no later than four months prior to the end of the resident's current contract.

C. Evaluations by the teaching faculty must be considered when the Program Director decides not to renew the contract for academic reasons.

D. The Resident should be placed on either Departmental Remediation or Institutional Probation prior to the decision not to renew his/her contract.

E. When the decision not to renew the contract is made, the Resident's status on either Departmental Remediation or Institutional Probation should be extended to cover the remainder of the employment period.

F. When a Resident is notified of the decision not to renew his/her contract, the Resident should also be formally apprised of their right to a Fair Hearing, as detailed in the IME Policy #13 re: Fair Hearing Process.

G. The Office of Graduate Medical Education should be notified immediately upon the Department's decision not to renew an employment contract. All written communication to the Resident regarding the decision not to renew the contract should be approved by the Office of Graduate Medical Education, in conjunction with Legal Affairs, prior to submission to the Resident.

###

HealthPartners
Institute for Medical Education

Subject	RESIDENT REAPPOINTMENT, PROMOTION AND PROGRAM COMPLETION	Attachments ☐ Yes ☒ No
Key words:	Completion, Evaluation, Hearing, Performance, Promotion, Training	Number IME-4
Category	Human Resources (HR)	Effective Date July 1, 1999
Manual	Graduate Medical Education	Last Review Date May 17, 2011
Issued By	Graduate Medical Education	Next Review Date May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	Origination Date July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	Contact: Graduate Medical Education

Purpose
To establish a policy for all post-graduate medical education training programs sponsored by HealthPartners Institute for Medical Education to use in the reappointment and promotion of Residents to the next level of post-graduate training.

Scope
This policy will apply to all training programs accredited by the Accreditation Council for Graduate medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. All information contained in this policy shall be used as minimum criteria for promotion. Each clinical department in its respective Departmental Promotion Policy shall delineate more detailed promotion criteria. The Graduate Medical Education committee must approve all policies.

Definition

Resident/House Staff - Refers to all Residents and fellows enrolled in a HealthPartners IME sponsored post-graduate training program.

Remediation - The act or process of remedying or correcting; see IME Policy #3 re: Evaluation of Residents.

Probation - A formal level of academic or professional discipline; see IME Policy #3 re: Evaluation of Residents.

Responsibilities/Requirements

I. Reappointment and Promotion

A. The decision to re-appoint and promote a Resident to the next level of postgraduate training shall be done annually by the Program Director upon review of the Resident's performance.

B. The Program Director shall consider all evaluations of the Resident's performance (refer to the IME Policy # 3 re: Evaluation of Residents) and any other criteria deemed appropriate by the Program Director.

C. Residents/Fellows will be promoted from each level of training after satisfying all requirements for that training level, and offered subsequent annual contracts through program completion unless:

1. They are dismissed, or their contracts are not renewed based on academic performance that is below satisfactory;
2. They are dismissed, or their contracts are not renewed based on non-academic behavioral violations;
3. They are ineligible for a continued appointment at the time renewal decisions are made based on failure to satisfy licensure, visa, immunization, registration or other eligibility requirements for training; or
4. Their residency/fellowship program is reduced in size or closed (see IME Policy #16 re: Hospital Closure, Program Elimination or Reduction in Force).

D. Any Resident whose promotion is pending due to academic performance should be placed on either Departmental Remediation or Institutional Probation (refer to the IME Policy #3 re: Evaluation of Residents and the IME Policy # 13 re: Fair Hearing Process).

E. If a Resident is on departmental Remediation or Institutional Probation at the time of contract renewal, the Program Director may choose to either extend the existing contract for the length of time necessary to complete the remediation process (not to exceed six months) or to promote the Resident to the next level. If the Resident's performance continues to be unsatisfactory, he/she may either be placed on the next level of discipline or terminated.

F. A Resident may request a Fair Hearing (refer to the IME Policy #13 re: Fair Hearing Process) in the case of contract extension pursuant to (E) above or non-renewal pursuant to IME Policy #15.

II. Completion of Program

A. HealthPartners IME follows the standards and guidelines established by the appropriate accrediting body (ACGME or CPME) for each residency training program. The length of the program is determined by the ACGME or CPME standards and each resident must complete the requirements for the program in which he/she is enrolled.

B. Program Directors must insure that residents, who have absences in excess of allowed vacation/sick time, complete all training requirements of their respective accreditation standards and specialty board requirements.

###

HealthPartners
Institute for Medical Education

Subject		Attachments
REGISTRATION FOR AFFILIATED RESIDENTS AND MEDICAL STUDENTS		☐ Yes ☒ No
Key words:	Affiliated, Experience, Registration, Residents, Students	**Number** IME-18
Category	Human Resources (HR)	**Effective Date** August 21, 2001
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999 **Retired Date** Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To establish a policy for all affiliated residents and medical students to register with the Graduate Medical Education Division of HealthPartners Institute of Medical Education on the first day of their clinical learning experience at Regions Hospital.

Scope
This policy will apply to all affiliated residents and medical students that are participating in clinical learning experiences through Regions Hospital.

Definition
Affiliated Resident- refers to a resident that is rotating through Regions Hospital and HealthPartners Institute for Medical Education.

Medical Student- refers to a student in medical school that will be participating in clinical learning experiences through Regions Hospital.

Responsibilities/Requirements

A. All affiliated resident and medical students must:

1. On the first day of their rotation at Regions Hospital register with the Graduate Medical Education Department at which time they will complete various forms relative to their past education, current training, and requests for Photo ID Badge, door access and parking,

2. Sign a professionalism statement agreeing to act in a professional manner and observe confidentiality,
3. Sign a GME orientation summary form regarding key code words, information and phone numbers used at Regions Hospital, and
4. Receive a copy of either the current GME Resident Handbook containing HealthPartners Institute for Medical Education policies.

B. Affiliated Residents must also sign a form indicating what dates they expect to be at Regions Hospital or HealthPartners facilities and supply a copy of an ECFMG certificate if applicable. The resident must inform the Graduate Medical Education Office of any changes in dates after the original form is signed.

C. Department Coordinators

1. Send the names of the affiliated residents and medical students to the graduate medical education coordinator as soon as the names are available, and
2. Send the affiliated residents and medical students to register in the Graduate Medical Education Department on the first day of their rotation.

Disciplinary Action

A. The Graduate Medical Education Department will alert each department when the affiliated residents and/or medical students have not complied with the policy to register with the department.

B. Residents and medical students must register to assure continued funding for medical education and compliance with hospital policies. Failure to register may result in withholding of resident benefits and loss of program funding. Learners who do not comply will not be granted access to confidential patient information and will report to the program director at their home institution for reassignment to another institution.

###

HealthPartners
Institute for Medical Education

Subject RESIDENT AWAY ROTATIONS		**Attachments** ☒ Yes ☐ No
Key words:	Agreement, Away, Educational, Off-Site, Rotations, Site	**Number** IME-20
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

This policy will apply to all rotations away from HealthPartners Clinics and Regions Hospital, including "month-out" experiences.

BACKGROUND

Historically some residents in HealthPartners Institute for Medical Education (IME) programs have taken an elective "month-out" rotation for an enriched educational experience. The benefits of such, national or international, elective rotations have been recognized as they afford the resident exposure to a particular patient population to which they would otherwise be unexposed. Examples of such rotations include a month long experience at a toxicology referral center for in-depth study of pesticide and organophosphate poisoning for a resident training in emergency medicine; or a month long experience at a tropical hospital for study of tropical diseases for a family practice resident interested in travel medicine.

Additionally, it is sometimes necessary to have IME residents participate in an "off-site" rotation at a local hospital, clinic or other facility for a special educational experience that meets specialty-specific educational criteria. Examples of such "off-site" rotations include a three-day rotation at an industrial manufacturing company for a resident training in occupational medicine, or a one-day-a-week psychiatry rotation at a specialized mental health treatment center, lasting three months.

Recognizing the need for the above-mentioned unique educational experiences, IME is desirous of maximizing opportunities for our resident physicians. However, because of the current financial climate of increased federal regulations and limited resources, it is necessary that residents on any "off-site" rotations (domestic or foreign) be eligible for federal funding, OR that they have an alternate source of funding for their salary and benefits.

PURPOSE

To maximize quality learning opportunities for our resident physicians while ensuring that all regulatory, curricular and institutional requirements for accreditation and for fiscal responsibility are met.

DEFINITIONS

1) Provider = hospital or hospital=based clinic (regardless of location, domestic or foreign, and regardless of whether or not the hospital accepts Medicare patients);

2) Non-provider = any facility other than a hospital [i.e. a clinic, an institution, a corporation (3M, General Mills etc.) that is NOT hospital-based].

3) Sponsoring Institution = Regions Hospital/HealthPartners IME.

4) Participating Institution = an entity other than Regions serving as a site for resident education.

5) Non-provider site resident training agreement = an agreement between Regions and a non-provider site. The non-provider site resident training agreement protects the resident from misunderstandings regarding malpractice, clinical responsibilities and educational performance. Such agreement may include any teaching cost required by the non-provider.

6) Provider site resident training agreement = a contract between Regions and a "provider" site whereby all details are covered PLUS, it involves an exchange of dollars by way of reimbursing the hospital (Regions) for the intern and/or resident salary and benefit costs.

POLICY[1]

Off-site rotations are to be held:

a) at a "non-provider" site (regardless if domestic or foreign), PROVIDED an appropriate non-provider site resident training agreement is in place covering all the five requisite ACGME points[2], OR

b) at a United States "provider" site PROVIDED an appropriate provider site resident training agreement is in place acknowledging that the provider site will claim the resident for Medicare reimbursement, and that the sponsoring institution (Regions) will be reimbursed for the resident's salary and benefits for that specific rotation.[3]

PROCEDURES

1) A resident interested in an "off-site" elective rotation must notify their program director no later than 120 days prior to the start date of the proposed rotation.

---

[1] This policy is applicable to resident physicians only. Faculty members interested in accompanying residents on a foreign "month-out" rotation need to negotiate those arrangements with their department chair and HealthPartners Medical Group (HPMG).

[2] See Appendix "A" excerpted from the ACGME Institutional Requirement Section I.C.1 through I.C.3, [Effective July 1, 2007]

[3] In the event that the "provider" site declines reimbursement of resident S&B, the resident may seek alternate funding to reimburse the hospital. Alternate funding might come from grants, donations or other departmental funding. Educational grants, for example from pharmaceutical or medical device manufacturers, must be handled through IME. Residents may not participate in rotations in an unsalaried status

2) If the program director approves of the proposed rotation, he/she shall forward the request on the designated template [provided by the IME GME Division], along with his/her approval, to the Director of Graduate Medical Education.

   The proposal shall include a summary of the proposed rotation, including:
   a. The proposed institution and location for the rotation including postal and email address
   b. Identification of officials responsible for resident education and supervision including detailed contact information
   c. An outline of the educational goals and objectives. The proposal should emphasize how the rotation fits in the educational plan of the resident, and how the experience will augment the resident's knowledge through experiences not available within this institution
   d. The period of assignment [proposed start and end dates]
   e. Financial support, including the source of funding for travel (if applicable)
   f. Provision of resident benefits, including malpractice insurance
   g. Institutional responsibility for teaching supervision and evaluation of the resident
   h. A designation of which institutional policies and procedures will govern the resident during the rotation
   i. A commitment from the resident to present a written and oral summary of the experience on return
   j. Signature of the Residency Program Director indicating support for the proposed rotation, and providing the following assurances:
      (1) that the resident's clinical performance and educational progress warrant rotations outside the direct supervision of the Residency Program Director,
      (2) that other rotations will be appropriately staffed during the resident's absence, and
      (3) that the rotation will not delay the resident's graduation from the program.

3) The GME Director will review the request along with the IME Executive Director. *NOTE: No proposal submitted to the GME Director later than 60 days prior to the onset of the rotation will be approved.*

4) If approved, the required signatures of all institutional officials will be requested. Once all the required signatures are obtained, copies of the signed/approved agreement will be returned to the resident, and to the residency program director.

5) The signed agreement must be in place <u>before the rotation begins</u>. Residents who leave without having an agreement in place may jeopardize their employment and risk not fulfilling requirements for graduation on time.

###

Attachment: Appendix A

IME-20

APPENDIX 'A'

Excerpt from 2007 ACGME Institutional Requirements, Section I.C.1 through I.C.3

I. Institutional Organization and Responsibilities
C. Institutional Agreements

I.C.1 The Sponsoring Institution retains responsibility for the quality of GME, including when resident education occurs in other sites.

I.C.2 Current affiliation agreements must be renewed every five years and must exist between the Sponsoring Institution and all of its major participating institutions. (See *ACGME Glossary* for definitions.)

I.C.3 The Sponsoring Institution must assure that each of its programs has established program letters of agreement with its participating sites in compliance with the Common Program Requirements.

###

HealthPartners
Institute for Medical Education

Subject RESIDENT/FELLOW DOCUMENTATION REQUIREMENTS		**Attachments** ☐ Yes ☒ No
Key words:	Documents, Documentation, Requirements	**Number** IME-29
Category	Human Resources (HR)	**Effective Date** February 20, 2008
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** February 20, 2008
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To outline the documents and routing required for appointing, continuing, graduating or terminating a HealthPartners IME resident/house staff (trainee). Documents must be received by the by HealthPartners IME post-graduate training program (program) before the trainee starts in their program.

Scope
This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. All information contained in this policy shall be used as minimum criteria. The policy outlines which documents the MMCGME Services unit of the Medical School requires. The policy also outlines documents that are required by HealthPartners IME post-graduate training program but may not need to be sent to MMCGME Services. Documents not required by MMCGME Services must be retained by the program and/or forwarded to the HealthPartners IME central GME office.

Definitions
Resident/House Staff- refers to all interns, Residents and fellows enrolled in a HealthPartners IME post-graduate training program.

Post-Graduate Training Program - refers to a residency or fellowship educational program, accredited by the ACGME or CPME for purposes of clinical education.

MMCGME Services unit – refers to the Metro Minnesota Council for Graduate Medical Education Services unit of the Medical School charged with administering the residency tracking system known as Residency Management System (RMS).

Responsibilities/Requirements

Incoming residents/fellows or transfers:

Upon receipt of an appointment letter from the HealthPartners IME post-graduate training program and prior to the start date noted on the residency/fellowship agreement the trainee must provide the program with the following required documentation.

1) A copy of the Human Resources Information Form (HRIF)
2) A copy of the medical school diploma
3) A copy of the certificate of completion for all prior GME training
4) A copy of the fully executed residency/fellowship agreement
5) Verification of immigration and VISA status as well as a copy of an ECFMG Certificate indicating the validation dates, if applicable

Copies of the documents outlined above **must be** forwarded to MMCGME Services within 30 days of the trainee start date.

The following documents are required by the HealthPartners IME post-graduate training program. **Do not forward** to MMCGME Services. Retain copies in program and distribute to the accordingly.

1) HIPAA confirmation
2) Transcripts
3) Residency Permit
4) W-4
5) Authorization of deduction
6) A copy of a current temporary or permanent license to practice medicine in the state of Minnesota
7) A copy of the letter of appointment (or email)
8) National Provider Identification (NPI)

Continuing residents/fellows or transfers:

Copies of the following documents **must be** forwarded to MMCGME Services (within 30 days of the trainee's continuation date or event):

1) A copy of the fully executed residency/fellowship agreement
2) Time away extends documentation (LOA form)
3) Name change documentation

Graduating or terminating residents/fellow:

Copies of the following documents **must be** forwarded to MMCGME Services (within 30 days of the trainee's graduation or termination date):

1) A copy of the certificate of completion for the program
2) Termination/resignation form
3) Time away extends documentation (LOA Form)

General Procedure

The HealthPartners IME post-graduate training program must provide MMCGME Services with copies of the required documentation (as identified above) **within 30 days** of the event (examples of events include start date, continuation date, graduation date or termination date). The program must retain copies of the documents, in perpetuity (as required by the Centers for Medicare and Medicaid Services, CMS) within their department in a secure location.

###

HealthPartners
Institute for Medical Education

Subject RESIDENT/FELLOW LEAVE POLICY		Attachments ☐ Yes ☒ No
Key words:	Absence, Family, Discretion, Fellow, Leave, Resident	**Number** IME-7
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Family Medical Leave Of Absence

This policy applies to Residents/Fellows who have been employed with Regions Hospital for a total of 12 months prior to the commencement date of the leave, and who have worked at least 1,040 hours for Regions Hospital in the 12-month period prior to the commencement of the leave. (Refer to Regions Hospital Policy 60:06:11) Eligible Residents/Fellows are entitled to a total of 12 work - weeks of combined paid and unpaid leave during a 12-month period, for one or more of the following reasons:

1. For the birth and care of a newborn child of the employee, or for the placement with the employee of a son or daughter for adoption or for foster care.
2. For the employee when unable to work because of a serious health condition
3. For the employee to care for an immediate family member who has a serious health condition

If Family Medical Leave is granted, pay for such leave shall be up to six weeks, which shall not count against Paid Time Off. Once paid time off is used up, any additional leave will be without pay.

Family Medical Leave shall be granted through formal request to the Program Director. The Resident/Fellow should exercise consideration in informing the Program Director as early as possible to allow scheduling of curriculum plans to accommodate the leave.

It is the responsibility of the Resident/Fellow and the Program Director to ensure that Board eligibility and RRC requirements are met within the original residency period or that alternative arrangements are made.

Academic Leave and Conferences
Time away from the hospital for academic leave and conferences may be granted in addition to the regular paid time off. This is under the jurisdiction of the residency program, which must ensure that the time away is well spent and fits within the curriculum and content of their residency. If the Resident/Fellow is assigned to an off-service rotation, the residency program needs to make mutually agreeable arrangements with any department that may be affected. If requested, the Resident/Fellow must provide for a replacement, either with another Resident/Fellow or a qualified substitute.

Personal Leave of Absence
Personal Leave of Absence applies to all Residents/Fellows of Regions Hospital who do not qualify for FMLA benefits because they do not meet the eligibility requirements (Refer to Regions Hospital Policy 60:06:11 and 60:06:08).

A personal leave of absence for education, personal time off, or for a serious health condition of the Resident/Fellow or immediate family member may be granted at the discretion of the Program Director. If a Personal Leave of Absence is granted, the length of time for this leave is at the discretion of the Program Director.

The Resident/Fellow can continue to be covered under the health and disability insurance benefits as provided by the hospital, but will be responsible for payment of the premiums. To request a Leave of Absence Process Guide and to arrange for payment of the premiums please contact the Human Resources Department at 651-254-0957.

If the Resident/Fellow is assigned to an off-service rotation, the residency program needs to make the appropriate arrangements with any department that may be affected.

Responsibility for meeting the certification requirements of the relevant American Board rests with the individual Resident/Fellow and Program Director.

Vacation/Continuing Medical Education (CME) Time
Vacation and CME time varies with the policies of each department. These policies are in compliance with and governed by the regulations of the various specialty Boards and accrediting organizations. For specific details, see the section on Resident/Fellow leave policies in the program policy manual.

Program Directors must approve requests for all leaves and PTO time. All Residents/Fellows are allowed three weeks of paid time off for each 12-month academic year. Additional time off is at the discretion of the Program Director.

Other Leaves (e.g. Bereavement/Funeral Leave)
Application for other kinds of leave not addressed by this policy may be submitted to the Program Director who will act in consultation with the appropriate parties (e.g., GME Administration, Human Resources, and Legal Department).

###

HealthPartners
Institute for Medical Education

Subject		Attachments
RESIDENT MEMBERSHIP ON THE GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)		☐ Yes ☒ No
Key words	GMEC, Membership, Residents, Sponsored	**Number** IME-17
Category	Business Practices (BP)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

1. The GMEC committee shall have Resident representation from each HealthPartners Institute for Medical Education sponsored program in addition to a Chief Resident from Internal Medicine.

2. Residents will be selected by their peers within their program and may elect to choose a proxy if unable to attend.

3. Programs will be responsible for notifying the GMEC which residents will represent their program. Resident members will be responsible to inform other residents of issues raised at the GMEC, and communicate to the GMEC issues relating to Residents.

4. Regular resident attendance is expected from each of the IME programs.

###

HealthPartners
Institute for Medical Education

Subject SELECTION AND CREDENTIALING OF RESIDENTS		Attachments ☐ Yes ☒ No
Key words:	Application, Credentialing, Graduation, Selection	**Number** IME-1
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999 **Retired Date** Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose

To establish a policy for all post-graduate training programs within the HealthPartners Institute for Medical Education to use in the selection of Residents and to further establish a procedure for the credentialing of Residents.

Scope

This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. All information contained in this policy shall be used as minimum criteria for selection. More detailed selection criteria shall be delineated by each clinical department in its respective Departmental Selection Policy. The Graduate Medical Education committee must approve all policies.

Definition

Resident/House Staff- refers to all Residents and fellows enrolled in a HealthPartners Institute for Medical Education post-graduate training program.

Match - refers to the formal process of matching Residents to hospitals, administered by the National Residency Matching Program (NRMP).

Responsibilities/Requirements

A. All applicants for a Resident/House Staff positions must be (pending) graduates of:

1. An LCME (Liaison Committee on Medical Education) accredited medical school; or

2. An AOA (American Osteopathic Association) accredited medical school; or

3. A medical school listed in the World Health Organization Directory of Medical Schools; or:

4. Completion of a Fifth Pathway program provided by an LCME-accredited medical school.

B. All applications for Resident/House Staff positions must be submitted by one of the following methods:

1. The Electronic Residency Application Service (ERAS); or

2. The Universal Application for Residency Training

C. The Program Director, or designee, will evaluate and select the candidates he/she believes to be the most qualified for the positions available within the training program.

D. PROCEDURE. Once an applicant is selected for an interview, the following procedure must be employed by all programs:

1. The following credentials must be collected for each candidate:

a) Application and Indemnity statement completed and signed.
b) Original Dean's letter.
c) Original (certified) Medical School Transcript.
d) Verification of graduation from the Medical School. (Appointments to PGY-1 positions may be made prior to graduation, however, it is the responsibility of each Program Director to verify graduation before the intern begins in the program and file documentation in the personnel file).
e) Two (2) letters of reference from attending physicians familiar with the individual's performance. If the candidate has previously been in a post-graduate training program, one letter must be from the candidate's former Program Director.

2. Candidates of medical schools that are not accredited by the LCME or the AOA must have the following additional documentation:

a) Official certified translations of all documents listed above in English; and

b) Certification by the Educational Commission of Foreign Medical Graduates (ECFMG).

3. All candidates should interview with the Program Director *(or designee)* and one or more members of the faculty. Telephone interviews will only be granted in lieu of a personal interview in the event of business necessity.

4. All eligible residency programs are expected to participate in the National Residency Matching Program (NRMP) and to follow all rules and requirements set forth by that organization.

5. All candidates should be evaluated based on the following minimum criteria:

    a) Preparedness
    b) Ability
    c) Aptitude for the specialty
    d) Academic credentials
    e) Communication skills
    f) Personal qualities, such as motivation and integrity

6. All candidates invited for interviews must be given the following information in written format:

    a) Salary and benefits information
    b) Explanation of Professional Liability coverage for Residents
    c) Any conditions of employment

7. Upon selection (or after the Match), contracts shall be prepared by each Program Director and forwarded to the Office of Graduate Medical Education for review and signature by Executive Director, IME.

8. If any of the required credentials documentation is missing, contracts cannot be issued.

9. HealthPartners Institute for Medical Education, Inc., and Regions Hospital are equal opportunity employers. Residency programs will not discriminate with regard to sex, sexual orientation, race, age, religion, color, national origin, disability, or veteran status.

###

HealthPartners
Institute for Medical Education

Subject	SEXUAL AND GENERAL HARASSMENT	Attachments ☒ Yes ☐ No
Key words	Conduct, General, Harassment, Report, Sexual	**Number** IME-11
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose

To provide a method to deal with complaints of sexual and general harassment promptly and effectively. To ensure that all employees, Residents, fellow, co-workers, managers and non-employees, including patients or visitors are respected and encouraged to communicate any behavior considered to be an act of harassment.

Scope

This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education.

Policy

The HealthPartners IME is committed to maintaining a working environment free from acts of sexual or general harassment. Any act of sexual or general harassment by Residents or fellow or non-employees will not be tolerated under any circumstances. Those found in violation of this policy will be subject to disciplinary action up to and including termination.

Definition

Sexual harassment is prohibited by Title VII of the federal Civil Rights Act of 1964, the Minnesota Human Rights Act and the City of Saint Paul Human Rights Ordinance. Sexual Harassment is defined for purposes of this policy as unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature (including gender-based conduct directed at an individual because of his or her gender) when:

Submission to conduct is made either explicitly or implicitly a term or condition of an individual's employment; or

Submission to or rejection of such conduct by an individual is used as a basis for employment decisions affecting such individual; or

Such conduct has a purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment.

Sexual harassment includes, but is not limited to, repeated offensive sexual flirtations, advances or propositions; continued or repeated commentaries about an individual's body; offensive sexual language; and the display in the work place of sexually suggestive pictures or objects.
General harassment is defined as disruptive or abusive behavior, either written or verbal, which has a purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment.

The following are some examples of the kinds of behavior which are prohibited (not all inclusive):

- Verbal and/or physically abusive behavior, which has the effect of interfering with a person's work performance.
- Derogatory statements and negative stereotyping.
- Threatening another person either verbally or physically.
- Impertinent and inappropriate comments written in medical records or other official documents.

###

Attachments:

A. Procedures: Internal
B. Procedures: External

IME-11 Attachment A.

Procedures: Internal

A. Filing a Sexual or General Harassment Complaint:

Any Resident or fellow who feels that he/she is being harassed, or any Resident or fellow who witnesses acts of harassment, must make the incident known through the following internal procedure.

The HealthPartners IME encourages any Resident or fellow who feels that he/she is being harassed or any Resident or fellow who witnesses acts of harassment to confront the person(s) engaged in harassment, informing them that such conduct or communication is offensive, will not be tolerated, and to stop such conduct or communication.

If the Resident or fellow does not wish to directly confront the person(s) alleged to be engaging in harassment or direct communication has been unsuccessful, he/she should contact his/her Program Director. If the Program Director is the subject of the complaint, the employee should contact the Executive Director of IME or the VP of Medical Affairs. Residents and fellows may also report an incident to the RAP program, who will report to the Executive Director of IME.

If the harassment does not stop after the following steps 1 and 2 above, a complaint may be filed with the Executive Director of IME or the VP of Medical Affairs.

B. Investigation of a Complaint:

Program Directors have the responsibility of maintaining a working environment free of harassment. A Program Director, upon hearing a complaint of harassment or witnessing any inappropriate behavior, must report it immediately to the Executive Director of IME. ###

The Executive Director of IME will coordinate the investigation.

The determination of harassment will be made on a case-by-case basis. The investigation may include interviews with the employee making the allegations, the employee who is the subject of the complaint and appropriate witnesses. All complaints will be investigated promptly and be kept confidential within the bounds of the investigation and the law.

The employee making the complaint and the subject of the investigation will be advised of the final disposition of the complaint by the Executive Director of IME.

C. Penalties for Harassment:

If an alleged case of harassment is determined to be in violation of this policy, disciplinary action up to and including termination will be determined by the results of the investigation. Due to the sensitive nature of this type of discrimination, any Resident or fellow who is found to have made false claims is subject to disciplinary action, up to and including termination. Retaliatory action against complaining Resident or fellow or witness will not be tolerated. If a violation is found to exist, appropriate disciplinary action will be taken, up to and including termination.

###

Attachment B.

Procedures: External

All employees are encouraged to use the internal procedures to resolve a complaint, however, this procedure does not replace your right to file a formal charge with one of the following external agencies:

a) Minnesota Department of Human Rights
b) Equal Employment Opportunity Commission
c) Saint Paul Department of Human Rights
d) File a private civil suit in State court

A complaint of harassment, which is filed through an external procedure, cannot subsequently be filed with the IME. Similarly, the IME will cease its handling of a complaint of harassment upon receiving notice that the complainant has subsequently pursued relief through an external procedure.

When a complaint of harassment is made by a Resident or fellow against an individual employed by another organization, he/she should report his to his/her Residency Program Director.

###

HealthPartners
Institute for Medical Education

Subject SUPERVISION OF RESIDENTS		**Attachments** ☐ Yes ☒ No
Key words:	Attending, Supervisory, Training,	**Number** IME-5
Category	Human Resources (HR)	**Effective Date** July 1, 1999
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 1999
		Retired Date Not Applicable
Review Responsibility Graduate Medical Education Committee		**Contact:** Graduate Medical Education

Purpose

To establish a policy for all post-graduate training programs within the HealthPartners IME to ensure all post-graduate programs provide increasing amounts of responsibility with appropriate supervision of Residents and other educational trainees.

Scope

This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. All information contained in this policy shall be used as minimum criteria for supervision. More detailed supervision criteria shall be delineated by each clinical department in its respective Departmental Supervision Policy. The Graduate Medical Education Committee must approve all policies.

Definition

Resident/House Staff- refers to all Residents and fellows enrolled in a HealthPartners IME post-graduate training program.

PGY refers to 'Post Graduate Year' or the year of training the Resident is currently enrolled in past completion of medical school.

Responsibilities/Requirements

A. Every resident is assigned to a designated clinical service. On call schedules and rotation schedules are developed on a monthly basis to provide Residents with a variety of service and patient mix. Residents may see patients initially but (supervisory) back up is available at all times.

B. In all Resident care cases, the ultimate responsibility rests with the attending physician, who supervises all Resident activities.

C. The requirements for on-site supervision are established for and by each department in accordance with sub-specialty residency requirements.

D. It is the responsibility of each Program Director to establish detailed written policies for supervision in their respective program. All departmental policies are reviewed and approved by the Graduate Medical Education Committee.

###

HealthPartners
Institute for Medical Education

Subject	TERMINATION/DISMISSAL OF RESIDENT	Attachments ☐ Yes ☒ No
Key words	Conduct, Dismissal, Hearing, Termination	Number IME-14
Category	Human Resources (HR)	Effective Date July 1, 1999
Manual	Graduate Medical Education	Last Review Date May 17, 2011
Issued By	Graduate Medical Education	Next Review Date May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	Origination Date July 1, 1999 Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	Contact: Graduate Medical Education

Purpose
To establish a policy for all post-graduate training programs within the HealthPartners IME to use in the termination of Residents' employment prior to the date of expiration of the Residents' contract.

Scope
This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. All information contained in this policy shall be used as minimum criteria for dismissal. More detailed termination/dismissal criteria shall be delineated by each clinical department in its respective Departmental Termination/Dismissal Policy. The Graduate Medical Education committee must approve all policies.

Definition
Resident/House Staff- refers to all Residents and fellows enrolled in a HealthPartners IME post-graduate training program.

Remediation - the act or process of remedying or correcting; see Policy for Fair Hearing

Probation - A formal level of academic or professional discipline; see Policy for Fair Hearing

Termination - the act of severing employment prior to the date of expiration of the Residents' contract

Responsibilities/Requirements

1. Termination of a Residents' employment prior to the established expiration date of the contract may be accomplished only for good reason.

Voluntary Termination/Resignation

1. If the Resident desires a termination of employment, a letter of resignation should be submitted to the Program Director stating the reason for the action.

2. An interview may be requested by the Program Director and/or the Executive Director, IME or the Vice President of Medical Affairs (or designee).

3. Termination may be granted with the concurrence of the Program Director, and the IME Executive Director, or in the Executive Director's absence, the Vice President of Medical Affairs of the Hospital.

4. Voluntary terminations will be reported by the Executive Director, IME (or designee, i.e., the Program Director) to the Minnesota Board of Physician Quality Assurance in accordance with relevant regulations. Such report will be made within ten (10) days of any action.

Grounds for Discipline or Involuntary Termination

1. The Hospital may elect to terminate a Residents' employment prior to the established contract expiration date due to:

   a) Academic or Professional (Gross) Misconduct

   b) (i) Engaging in conduct that is detrimental to the safety of patients, employees, or others,
   (ii) engaging in conduct that is detrimental to the delivery of quality patient care,
   (iii) disruption of the operations of the Hospital, departments, or any affiliated hospitals, or
   (iv) violation of the standards of professional conduct and ethics.

   c) Unsatisfactory performance

   d) Abandonment of position/employment

   e) Any disciplinary action as detailed in the Annotated Code of the state of Minnesota

   f) Failure to comply with (i) the policies of the Hospital, departments(s), medical staff, (ii) the policies of the facilities and other sites to which the Resident has been assigned and rotates, and (iii) the terms and conditions of this Agreement;

   g) Commission of an offense under federal, state or local laws or ordinances, which impacts upon the Residents' abilities to appropriately perform his/her normal duties in the Program.

   h) Failure to meet the expectations established by the Program Director as set forth in the Departmental Resident Policy and Procedure Manual, a copy of which shall be provided to the Resident at the start of the Program.

2. The Program Director, with approval of the Executive Director, IME, shall notify the Resident in writing of the decision to terminate employment.

3. Upon notice of termination, the Resident has the right to request a Fair Hearing, as described in the Policy for Fair Hearing.

4. All involuntary terminations will be reported to the Minnesota Board of Medical Practice by the Executive Director of IME, pursuant to Minnesota Statutes Section 147.111. Such reporting will be made within ten (10) day of any action. Such action is reportable when the change takes place with the individual's privileges, not after the Fair Hearing Process.

###

HealthPartners
Institute for Medical Education

Subject TRANSFER RESIDENTS	**Attachments** ☐ Yes ☒ No
Key words: Accepted, Formal, Transfer	**Number** IME-23
Category Human Resources (HR)	**Effective Date** November 28, 2001
Manual Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By Graduate Medical Education	**Next Review Date** May 2013
Applicable This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** November 28, 2001
	Retired Date Not Applicable
Review Responsibility Graduate Medical Education Committee	**Contact:** Graduate Medical Education

Purpose
To establish a policy for all post-graduate training programs sponsored by HealthPartners Institute for Medical Education for transfer students.

Scope
This policy applies to all training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), and the Council on Podiatric Medical Education (CPME) sponsored by the HealthPartners Institute for Medical Education. All information contained in this policy shall be used as minimum criteria.

Policy
HealthPartners Institute for Medical Education has no formal transfer program. Transfers are accepted on a space available basis.

Residents must complete a formal application process and be accepted by the receiving program to qualify for transfer.

###

HealthPartners
Institute for Medical Education

Subject		Attachments
	VENDOR RELATIONS	☒ Yes ☐ No
Key words:	Consulting, Donations, Entertainment, Ethical, Fees, Grants, Honorarium, Promotional, Relations, Rules, Sponsorship, Vendors	**Number** IME-27
Category	Business Practices (BP)	**Effective Date** July 1, 2007
Manual	Graduate Medical Education	**Last Review Date** May 17, 2011
Issued By	Graduate Medical Education	**Next Review Date** May 2013
Applicable	This policy will apply to all training programs with residents rotating at Regions Hospital.	**Origination Date** July 1, 2007
		Retired Date Not Applicable
Review Responsibility	Graduate Medical Education Committee	**Contact:** Graduate Medical Education

:

All residency programs shall comply with the Regions and HealthPartners' Vendor Relations Standards contained in the Code of Conduct [copy attached].

###

Attachment:

A. Guide to Vendor Relationships for HealthPartners and Its Related Organizations

GUIDE TO VENDOR RELATIONSHIPS FOR HEALTHPARTNERS AND ITS RELATED ORGANIZATIONS

HealthPartners and its related organizations work with a wide variety of vendors and potential vendors – such as suppliers, drug companies, staffing agencies, consultants, law firms and many more. These relationships are necessary and important to the work we do. However, sometimes these relationships also bring with them a personal or informal component. For example, have you ever eaten some pizza brought in by a sales rep? Have you gone to a sporting or entertainment event courtesy of someone you do business with? Received a holiday gift basket from a consultant? Won a raffle for a mountain bike at a conference?

Although they may seem innocuous, these types of arrangements have the potential to create conflicts of interest, or the appearance that individuals in our organization may have a personal stake in their relationships with our vendors. Studies have shown that inappropriate relationships between the staff of health care organizations and their vendors can undermine patient and member trust, interfere with professional decision-making and result in the waste of health care resources.

While your Code of Conduct addresses conflicts of interest, entertainment, gifts and favors in general, it is not intended to resolve all possible vendor arrangements and interactions. For that reason, we have created this guide to supplement the Code of Conduct, and to help all staff[1] make sound decisions when working with vendors[2].

This guide has three components that together describe the process you must follow whenever you are thinking about entering into (or renewing) a relationship with a vendor – whether that relationship is formal or informal.

1. Ethical Considerations. These are fundamental questions to ask yourself each time you are considering a vendor arrangement. Your answers to these questions will help you decide whether an arrangement passes your personal standards of integrity.

2. Basic Rules and Examples. These are basic, practical rules that you must follow in every vendor relationship. The examples given describe some common types of arrangements in health care, and identify which ones are considered acceptable and which are not.

3. Beyond the Basics – Getting Help. If the arrangement you are considering appears to meet the Ethical Considerations but is not addressed in the Basic Rules, then you are asked to consult with the Corporate Integrity Department. They will help you make a decision that reflects not only the organization's values and responsibilities, but also your own.

---

[1] "Staff" includes employees, employed providers, privileged providers, residents, interns, students, volunteers and Board members of HealthPartners and its related organizations.
[2] "Vendors" include current and prospective suppliers and their representatives, including staffing services, consultants, pharmaceutical and medical device companies, and service providers such as law firms and auditors.

1. <u>Ethical Considerations</u>

The following questions were designed to help you conduct your own "gut check" when considering any interaction with a vendor. If the interaction does not pass your own "gut check," then you should not agree to it. (You may notice that most of these questions reflect the organization's Values of Teamwork, Respect, Passion and Integrity.)

- ❑ **Will the interaction enhance (as opposed to erode) the *trust* of others?** Consider the trust of patients, members, coworkers and others.
- ❑ **Does the interaction *respect* the interests of those affected by it?** Some of the people who may be directly or indirectly affected by our relationships with vendors are patients, members, research participants, customers, regulators and the community as a whole.
- ❑ **Would I be able to *face myself and my colleagues* if this interaction were to come to light?**
- ❑ **Would I be *proud* of this interaction if it were disclosed to those affected by it** (for example, my patients and colleagues) **or to the larger community** (for example, in the media)?
- ❑ **Is this interaction consistent with the *values of the organization*?**

If you did not answer "yes" to all of these questions, then you should not proceed with the interaction.

2. <u>Basic Rules and Examples</u>

These are basic, practical rules that you must follow in every vendor relationship. Gifts, donations, grants, sponsorships, entertainment activities, promotional items, consulting fees and honoraria may only be accepted or solicited from vendors if the interaction meets *all* of the following Basic Rules.

HealthPartners and its related organizations encourage appropriate interactions between staff and vendors as long as those interactions

- ❑ Are designed to benefit patients or members, or to educate HealthPartners staff;
- ❑ Will not lead to overutilization, underutilization or inappropriate utilization of health care services;
- ❑ Will not raise patient safety or quality of care concerns;
- ❑ Would comply with federal and state laws including those relating to referrals (Anti-Kickback and Stark), tax-exemption and public programs;
- ❑ Do not present a conflict of interest;
- ❑ Will not compromise staff's independent judgment or interfere with professional duties;
- ❑ Will not embarrass or damage the reputation of the organization; and
- ❑ Comply in all other ways with the organization's Code of Conduct.

On the next page are examples of interactions that you may face when working with vendors. The organization has identified which ones staff may engage in, and which ones they may not.

<u>Examples</u>. This list is not exhaustive, but it does identify several of the more common types of arrangements and interactions with vendors.

<u>Permitted Interactions</u>

Staff are permitted to interact with vendors in the following situations, so long as the Basic Rules on the previous page are also followed:

- Clinical and non-clinical department heads/chiefs may invite vendor representatives to present product information to staff for the purpose of staff education and product assessment; in such cases, vendors will not be permitted to provide meals, snacks, trinkets or other non-educational items. Sales representatives of vendors will not be permitted to canvas or "drop in" at clinical or administrative sites without such an invitation, although they may mail product literature to staff.
- Staff may attend modest meals and receptions sponsored by vendors at conferences if such events are incidental to an educational program that has been approved for continuing education credit.
- Staff may attend modest and occasional business courtesy meals (worth no more than $75) at the invitation of a vendor.
- Staff may attend occasional legitimate charitable events at the invitation of a vendor.
- Staff may solicit vendor support for patient care, research, education or fundraising purposes in accordance with organizational standards for those activities.

<u>Non-Permitted Interactions</u>

The following vendor interactions are not permitted:

- Staff may not accept cash or cash-equivalents (such as gift certificates) from vendors.
- Staff may not accept any item or service worth more than $75 that is primarily intended for personal use.
- Staff may not participate in leisure activities sponsored by a vendor, such as golf, sporting events, theater, "spa days", etc., unless it is a legitimate charitable event, or unless staff pay their own way and participation would not compromise independent judgment, interfere with professional duties, or embarrass or damage the organization's reputation.
- Staff may not provide consulting or other services for which they are compensated by a vendor without full and continuing disclosure to the organization and prior written approval of the Vice President, Associate Medical Director or equivalent to whom his or her department or division reports.
- Anything that is not permissible for an employee to accept is also not permissible for the employee's immediate family (spouse, partner, parent, child) to accept from a vendor.

3. Beyond the Basics – Getting Help

Most of the arrangements and interactions with vendors that HealthPartners staff will face are covered by the Ethical Considerations, Basic Rules and Examples. This guide was designed to help you work through those common situations. However, we know it is not possible to construct a set of rules – or even to anticipate – all possible scenarios.

If the interaction you are considering appears to meet the Ethical Considerations but is not covered by the Basic Rules, then you should consult with the Corporate Integrity Department. Corporate Integrity staff has worked with a broad spectrum of clinical and business leaders in the organization to develop a detailed set of "Vendor Relations Standards" for the purpose of addressing uncommon or unanticipated vendor interactions. When you contact Corporate Integrity, they will work through the Vendor Relations Standards to help you make a decision that reflects not only the organization's values and responsibilities, but also your own. Corporate Integrity may also consult with the leadership steering group, listed below, to provide guidance on particular issues or types of issues.

For more information about vendor relations in general, or for help in working through a particular decision, contact the Corporate Integrity Department. If you wish, you may consult the Vendor Relations Standards directly – they are posted on ERIC. However, because this is such a complex and ever-changing area, we believe you will find the expertise of those who are most familiar with the details of the Vendor Relations Standards to be an important resource.

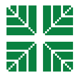
Vendor Relations Leadership Steering Group

Tobi Tanzer, Vice President of Corporate Integrity and Corporate Compliance Officer
Eric Anderson, Director, Corporate Integrity
Rick Bruzek, Vice President, Pharmacy Services, HealthPartners
Patti Dalen, Vice President, Regions Hospital Foundation
Cheryl Magnuson-Giese, Sr. Director, Physician Services
Nancy McClure, Sr. Vice President, HPMG & Clinics
J. Daniel Nelson, MD, Associate Medical Director
Carl Patow, MD, Vice President and Executive Director
Don Postema, Ethicist, Medical Ethics Committee
Rob Sauer, Associate Counsel
Andrea Walsh, Exec. Vice President and Chief Marketing Officer

Corporate Integrity Contact Information

Email: CorporateIntegrity@healthpartners.com
Web: http://intranet.healthpartners.com/Intranet/Menu/0,1646,7643,00.html
General Number – 952-883-5124
Corporate Integrity Hotline 1-866-444-3493
Tobi Tanzer, Corporate Compliance Officer – 952-883-5195
Eric Anderson, Director of Corporate Integrity – 952-883-6241

IME/SELECTED REGIONS HOSPITAL POLICIES



Regions Hospital

Subject ALCOHOL AND DRUG TESTING FOR EMPLOYEES (REASONABLE SUSPICION)	Attachments ☐ Yes ☒ No
Key words Alcohol, drugs, confirmatory testing, impairment, reasonable suspicion, intoxication, under the influence	**Number** **RH-HR-HR-60-10-24**
Category Human Resources (HR)	**Effective Date** **March 15, 2010**
Manual Human Resources	**Last Review Date** **February 2010**
Issued By Human Resources	**Next Review Date** **2013**
Applicable This policy is applicable to all employees of Regions Hospital, except those employees subject to mandatory drug testing by federal law or regulation. Except as to the sale and transfer of alcohol and/or illegal drugs, this policy does not apply to an employee while on Hospital premises solely for the purpose of receiving medical treatment or visiting a person who is receiving medical treatment.	**Origination Date** **04/01/99** **Retired Date** **NA**
Review Responsibility Regions Human Resources and Employee Health Services	**Contact** HR or EHS

I. PURPOSE

Regions Hospital is committed to maintaining a work environment which is free from the influence of alcohol and/or illegal drugs to protect the health, safety, and well being of our patients, employees, and visitors. Regions Hospital has therefore adopted this Alcohol and Drug Testing Policy for employees. This policy is not intended as and should not be construed as a contract between the Hospital and any employee, except as required by applicable labor contracts.

II. POLICY

Regions Hospital prohibits the use, possession, transfer and sale of alcohol and/or illegal drugs while working, while on all premises owned or operated by the Hospital, and while operating any Hospital vehicle, machinery or equipment. It also prohibits reporting for work, and working anywhere on behalf of Regions Hospital under the influence of alcohol and/or illegal drugs.

The use and possession of properly administered prescription drugs or medication is permitted, provided that the effects of these drugs do not interfere with the employee's job performance or pose a direct threat to the health or safety of the employee, co-workers or patients. The use of prescription medications which contain a controlled substance but are used for a purpose or by a person for which they were not prescribed or intended, is prohibited.

VOLUNTARY DISCLOSURE:

Employees are encouraged to voluntarily disclose the excessive use of alcohol and/or illegal drugs before being confronted, tested, or otherwise involved in drug and/or alcohol-related discipline or proceedings. An individual who does so will be granted time off for treatment, rehabilitation, and counseling in accordance with applicable labor contracts and/or non-contract Hospital policies. Employees who voluntarily disclose the excessive use of alcohol and/or illegal drugs before being confronted, tested, or otherwise involved in drug and/or alcohol-related discipline or proceedings will not be discriminated against because of this disclosure, nor will the information which is disclosed about use be used as the sole basis for discipline. Resources are available to employees through the Employee Assistance Program (EAP).

GROUNDS FOR TESTING:

Testing will be requested or required only under the circumstances described below. No test will be sought for the purpose of harassing an employee. All tests are conducted by a laboratory licensed by the State of Minnesota and certified by the National Institute on Drug Abuse. No test will be conducted by a testing laboratory owned or operated by Regions Hospital. Test results will be reported to Employee Health Service after review by a licensed Medical Review Officer (MRO).

A. Reasonable Suspicion

An employee may be requested or required to undergo an alcohol test and/or drug test if there is a reasonable suspicion that the employee:

(a) is under the influence of alcohol and/or illegal drugs;
(b) has violated the policy statement above;
(c) has caused himself/herself or another employee to sustain a personal injury on any Regions premisis;
(d) has caused a work-related accident, or
(e) has operated or helped operate machinery, equipment, or vehicles involved in a work-related accident.

B. Treatment Program

An employee may be requested or required to undergo alcohol and/or drug testing if the employee has been referred by Regions Hospital for chemical dependency treatment. The employee may be requested or required to undergo alcohol and/or drug testing without prior notice during the evaluation or treatment period and for a period of up to two years following the referral for prescribed chemical dependency treatment.

NOTIFICATION:

When requesting or requiring an employee to undergo alcohol and/or drug testing, Regions Hospital will provide the employee with a copy of the Alcohol and Drug Testing Policy and provide the employee with an opportunity to read the policy.

An employee should not drive home if they are suspected of being under the influence. Other transportation options should be arranged.

RIGHT TO REFUSE TO UNDERGO ALCOHOL AND DRUG TESTING AND THE EFFECT THEREOF:

Any employee has the right to refuse to undergo alcohol and/or drug testing. An employee who refuses to be tested and/or whose behavior prevents meaningful completion of alcohol and/or drug testing will be subject to discharge or other disciplinary action in conformity with applicable labor contracts and/or non-contract Hospital policies. If an employee refuses to undergo alcohol and/or drug testing, no test will be administered.

RIGHTS IN CASE OF A POSITIVE TEST:

A. After Initial Positive Result and First Time Positive Result on Confirmatory Test

If the initial result on the alcohol and/or drug test is positive, the sample, which was tested, will be subject to a second, confirmatory test. No employee will be discharged, disciplined, discriminated against, or requested or required to undergo rehabilitation solely on the basis of an initial test result which is positive.

An employee will not be discharged (per Minnesota Statute 181.953 subsection 10 B) based on a first time positive result on a confirmatory test for alcohol and/or illegal drugs requested or required by the Hospital unless he or she has been given the opportunity to participate in a drug or alcohol counseling or rehabilitation program and has refused to participate or has failed to successfully complete the counseling program. Additionally, an employee must go to the Employee Assistance Program and comply with their recommendations. Failure to do so will lead to discharge. For employees with required licensure or registration for their position the appropriate licensing or certification boards will be notified of the positive test as appropriate.

B. Subsequent Positive Result on Later Confirmatory Test

An employee who receives a positive result on a confirmatory test for alcohol and/or illegal drugs requested or required by the Hospital and who has previously received a positive result on a confirmatory test for alcohol and/or illegal drugs requested or required by the Hospital may be subject to disciplinary action, up to and including discharge, in accordance with applicable labor contracts and/or non-contract Hospital policies, so long as the previous positive result occurred within the three preceding years.

If the result of the confirmatory test is positive, an employee has the right to explain the reasons for the positive test and to request a confirmatory retest of the sample, to be conducted at the employee's expense. Any employee wishing to exercise these rights must do so within five (5) working days of receiving the positive confirmatory test. In the case of employees covered by labor contract, additional internal appeal mechanisms may be available.

NEGATIVE RESULTS:

If the initial result of the alcohol and/or drug test is negative or the confirmatory test result is negative, the employee is considered to have satisfactorily completed the alcohol and/or drug test.

ADDITIONAL RIGHTS OF EMPLOYEES:

An employee who is requested or required to undergo alcohol and/or drug testing will be provided with a copy of the test results upon request.

CONFIDENTIALITY:

The fact that an employee has been requested or required to take an alcohol and/or drug test, the result of the test, and information acquired in the alcohol and/or illegal drug testing process shall be treated in a manner consistent with the Hospital's treatment of other private and confidential information concerning employees. Voluntary disclosure by an employee of the excessive use of alcohol, prescribed medication that contain controlled substances and/or illegal drugs before being confronted, tested, or otherwise involved in drug and/or alcohol-related discipline or proceedings will also be treated in a manner consistent with the Hospital's treatment of other private and confidential information concerning employees. This information will not be communicated by the Hospital to individuals inside or outside of the Hospital without the employee's consent except to those who need to know this information to perform their job functions, and as permitted or required by law or regulation.

NON-REGIONS EMPLOYEES:

For Non-Regions employees where there is reasonable suspicion of unauthorized drug or alcohol use their employer will be notified and the employee will be removed from the worksite.

III. PROCEDURE(S)

1) If there is reasonable suspicion that an employee is under the influence of alcohol or drugs, Security should be notified at 651-254-3979.
2) Security will notify trained resource personnel to assess the situation.

IV. DEFINITIONS

Illegal Drugs – Means controlled and uncontrolled (i.e. pot, meth, cocaine) substances, and includes prescription medication which contain a controlled substance and which are used for a purpose or by a person for which they were not prescribed or intended.

Medical Review Officer (MRO) – Physician licensed by the State of Minnesota to review drug testing results.

V. COMPLIANCE

Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

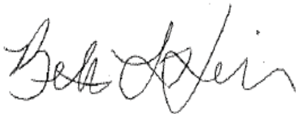
VI. ATTACHMENTS

None

VII. OTHER RESOURCES

Alcohol Use #RH-HR-HR 60:10:29
Drug Free Workplace Policy #RH-HR-HR 60:10:10
Employee Assistance Program #RH-HR-HR 60:10:19

VIII. APPROVAL(S)



Beth L. Heinz
Vice President

IX. ENDORSEMENT

Employee Health Service
Human Resources Leadership Team

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

+++

REGIONS HOSPITAL

POLICY/PROCEDURE	Page 1 of 2
Subject Regions Hospital Code of Ethics	No. 50:01:28 Effective Date July 1, 1996 Supersedes: No.
ISSUED BY: Administration Date: July 1, 2002	Dated: July 1, 1999

Regions Hospital has established this code of ethics in recognition of the institution's responsibility to our patients, staff, physicians and the community we serve. It is the responsibility of every member of the staff and physicians to act in a manner consistent with this organizational statement and its supporting policies. Our performance is guided by the institution's values. They are:

- A commitment to integrity
- A commitment to merits
- A commitment to openness
- A commitment to equal opportunity
- A commitment to using resources responsibly
- A commitment to learning

The Hospital will constantly strive to adhere to these values in all aspects of service we offer. Our values relate specifically to ethics in Patient Care, Billing Practices, Confidentiality and External Relations and our interactions with each other.

Patient Care

We recognize the dignity and worth of everyone with whom we interact, especially our patients and their families. Patients will be admitted, treated, discharged and transferred based on their clinical needs and without regard to age, ancestry, color, disability, national origin, race, religious creed, sex, sexual orientation, veteran status, or ability to pay for the services rendered.

It is accepted that the patient should be the primary decision maker in their own health. We will involve patients and family members in decisions regarding the care that we deliver to the extent that such is practical and possible. We will also seek to inform all patients about the therapeutic alternatives and the risks associated with the care they are receiving. Regions Hospital endorses the AHA Patient Bill of Rights and the Patient Self-Determination Act. The patient or appropriate representative has the right to share in and approve decisions related to his or her care including the use of life sustaining treatment. The patient has the right to accept, forgo or withdraw from treatment offered.

The need for information regarding diagnosis, treatment and/or research options and prognosis, delivered in common language, is seen as fundamental for informed choice. The organization will provide for the protection of those unable to be their own advocate as a result of incompetence or incapacity.

Billing Practices
We shall distribute accurate, comprehensible and timely bills to patients and payers for those services provided by the Hospital. We shall be responsive and courteous to all inquiries and requests for assistance concerning this issue. We will attempt to resolve questions and conflicts associated with patient billing to the mutual satisfaction of the patient and the Hospital.

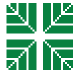
Confidentiality
The Hospital recognizes its obligation to promote confidentiality. Patient information will not be shared in an unauthorized manner and sensitive information concerning patient, personnel and management issues will be maintained in the strictest of confidences. This information will be shared only with those individuals authorized to review and act on such information.

This information includes the medical record, computerized information, personnel records and management records. Information will be safeguarded and released only in a strictly controlled manner or as required by law. Employees, physicians, students are expected to control the informal transmission of confidential information of any kind. It is also acknowledged that personnel and management issues will be maintained in confidence, and used only by those authorized to view and act on such information.

External Relations
We will fairly and accurately represent ourselves and our capabilities to the public. We will create vehicles of communication that are responsive and sensitive to our community. All business practices will support the mission of the Hospital. Fair business practices will be observed in marketing services. Suppliers will be selected on the basis of quality, effectiveness and appropriateness and be designed to meet identified needs while seeking to avoid unnecessary expense. Institutional representatives will practice honesty, market with objective and fair representations, avoid conflict of interest, maintain confidentiality of information, make contracting decisions based on established standards and seek to maintain quality care in a cost effective manner. The Hospital will strive to maintain an open and honest relationship with other providers and other institutions.

Each of these principles support the organization's overall commitment to carry out the values in all activities with employees, patients, physicians and all other recipients of Hospital services. All activities will be conducted with integrity, compassion and an overriding concern for human welfare and dignity. Those individuals who are a part of this organization are expected to make a good faith effort to constantly meet or exceed a standard of exceptional service in a consistently courteous manner. It is the organization's goal that every person in contact with Regions Hospital be able to enjoy an atmosphere which fosters individual respect, personal safety and privacy.

+++



Regions Hospital

Subject	Attachments
CONFIDENTIALITY OF PATIENT/MEMBER INFORMATION - EMPLOYEE ACCESS AND USE	☐ Yes ☒ No
Key words Discipline, Acknowledgement, Privacy, Medical Records, Protected Information, Computers, Security, Data, Monitoring	**Number** RH-HR-HR-60-10-32
Category Human Resources (HR)	**Effective Date** August 1, 2005
Manual Human Resources	**Last Review Date** July 2011
Issued By Human Resources	**Next Review Date** July 2012
Applicable All Regions Hospital Employees, Vendors, Contractors, Interns, Trainees, Volunteers, Other members of the workforce for purposes of this Policy, these individuals shall be referred to as "employees"	**Origination Date** August 1, 2005 **Retired Date** Not Applicable
Review Responsibility Human Resources, Corporate Integrity	**Contact** Human Resources

I. PURPOSE

The purpose of this Policy is to provide employees with specific guidance and expectations regarding the appropriate access to and use of "Protected Information" in order to perform their work. This guidance and expectations are pursuant to the Privacy Policy, which sets forth Regions Hospital's overall policies regarding the protection of Protected Information.

II. POLICY

Employees shall access Protected Information only to the extent necessary to perform their assigned duties. Employees must not use Protected Information for their individual or personal use except as specifically provided in this Policy.

All employees must exercise every reasonable precaution in safeguarding Protected Information in their possession or control. This includes, but is not limited to:

A. Keeping confidential patient/member charts and other confidential documents and information where they will not be readily visible or accessible by unauthorized persons
B. Not conducting conversations involving Protected Information where other employees or patients/members can overhear them (e.g., elevators, hallways, common areas, break rooms etc.)
C. Disposing of documents that contain Protected Information in an appropriate manner designed to preserve confidentiality, (e.g., confidential document destruction containers, shredding)

COMMUNICATING PROTECTED INFORMATION

Employees must not discuss or communicate Protected Information with any other person, including a co-worker, or organization unless it is necessary in the performance of assigned duties. Protected Information must not be disclosed to parties outside the organization without appropriate written patient or member consent or authorization or as otherwise permitted in accordance with the Privacy Guidelines established pursuant to the Privacy Policy or other written privacy procedures established by the employee's Department.

MONITORING OF PROTECTED INFORMATION

Employees' access to Regions Hospital's information systems, databases and files may be monitored on a regular or occasional basis.

EMPLOYEE ACCESS TO HIS/HER PROTECTED INFORMATION

Employees may, ***on a limited basis***, access their own Protected Information (e.g., own medical or dental record, appointment schedule information, pharmacy information, claims information, etc.) through Regions Hospital's systems or files. However, such personal access shall only be on an incidental and occasional basis and shall not interfere with normal business activities or adversely impact the employee's or a co-worker's job performance. In addition, employees may not modify, print, copy, or forward their Protected Information or in any way perform transactions involving their own Protected Information. Thus, employees' access to their own Protected Information via Regions Hospital's systems is permitted on a ***view only*** basis.

An employee may not use employment at Regions Hospital to access his/her Protected Information either directly or indirectly by asking another employee to access this Protected Information. An employee's ability or permission to access any Employer system containing Protected Information is dependent upon whether that person's job responsibilities require such system access. Accordingly, employees may not request or receive access rights to systems that contain his/her Protected Information for the purpose of viewing his/her information.

EMPLOYEE ACCESS TO PROCTECTED INFORMATION OF FAMILY MEMBERS

Protected Information about employees' family members, including minor children, must be treated in the same manner as that of other patients/members. The employee may not gain access to a family member's Protected Information as a result of his/her employment with Regions Hospital.

If an employee wishes to access the medical record, any medical information, laboratory results, appointment schedule information, pharmacy information, claims information, or any Protected Information of which his/her family member (including a minor child) is the subject, the employee may only access this information as would a non-employee patient/member – for example, with required written authorization from the family member through Member Services or the clinic, or, in the case of information available on-line, through member or patient portals.

An employee may not use employment at Regions Hospital to access the Protected Information of his/her family members either directly or indirectly by asking another employee to access this Protected Information.

EMPLOYEE ACCESS TO PROCTECTED INFORMATION OF CO-WORKERS

Protected Information about employees of Regions Hospital must be treated in the same manner as that of other patients/members. The employee may not gain access to another employee of Regions Hospital confidential patient/member information as a result of his/her employment with Regions Hospital. Employees may only access such Protected Information if it is necessary in the performance of the employee's assigned duties.

EMPLOYEE ACCESS TO PROTECTED INFORMATION FOR TRAINING

Employees may not access or use Protected Information of family members or co-workers for training purposes, except with the written authorization of the family member/co-worker and with the express approval of the employee's supervisor.

III. PROCEDURE(S)

Several of Regions Hospital's information systems and databases contain built-in security functions to automatically monitor inappropriate access to Protected Information and supervisors/managers receive reports on such access. Systems without automatic security functions may be monitored manually.

Departments may institute special operating procedures for managing Protected Information of co-workers.

DISTRIBUTION

All new employees are informed about confidentiality and this Policy during New Employee Orientation and shown where to access this Policy in Compliance 360. Employees must sign the Orientation Outline indicating that the employee has received information on confidentiality.

If a new employee does not attend New Employee Orientation, this will be covered during a 1:1 session with Human Resources. The Employee must sign the Orientation Outline as stated above. The Orientation Outline will be retained in the employee's personnel file in Human Resources.

SUPERVISOR/MANAGER RESPONSIBILITY

Supervisors/managers are responsible for ensuring that all employees are aware of this Policy and for periodically reviewing this Policy with employees under their supervision.

It is recommended that for employees whose job requires regular access to Protected Information this Policy be reviewed at least on a yearly basis and that the supervisor/manager have the employee sign the Standards of Conduct Form on a yearly basis.

Supervisors/managers are responsible for reviewing and monitoring reports regarding employees' access to Protected Information.

Supervisors/managers are responsible for the daily administration of this Policy.

IV. DEFINITIONS

"Protected Information" means information, including demographic, health or financial information that:

A. Identifies (or could reasonably be used to identify) a patient or member; and
B. Is not generally known by or made available to the public;
   and

C. Is collected or received by or on behalf of Regions Hospital (or any related organization) from
   1. a member (or his/her authorized representative);
   2. a patient (or his/her authorized representative);
   3. a member's or patient's health care provider or his/her agents; or
   4. a member's or patient's third party payer or health plan sponsor or his/her agents; and
D. Relates to or facilitates the past, present or future physical or mental health condition of the member or patient, or the past, present or future provision of health care to the member or patient.

"Protected Information" includes, but is not limited to:

A. Information contained in medical, dental, eye, mental health, or other patient charts
B. Information contained in Health Plan files, e.g., Claims, Membership Accounting, Member Services, etc.
C. Information contained in electronic systems and databases, e.g., electronic medical or dental records, Claims databases, Patient Accounting databases, Membership Accounting databases, Member Services databases, etc.
D. Appointment schedules
E. Other Protected Information maintained by Regions Hospital in conducting it business

Protected Information may be recorded or unrecorded, oral, written, or electronically stored.

V. COMPLIANCE
Failure to comply with this Policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS
NOT APPLICABLE

VII. OTHER RESOURCES

In addition to compliance with this Policy, an employee must also comply with any additional policies, procedures, or protocols that are established for the employee's specific job and/or area.

Policy on Privacy and Protection of Patient and Member Information (“Privacy Policy) – CI002

Code of Conduct

Discipline for Breaches of Privacy and Privacy Policies – RH-HR-HR 60-10-31

Privacy Guidelines for Care Delivery, Health Plan and Health Research

VIII. APPROVAL

Beth Heinz, Vice President of Operations

IX. ENDORSEMENTS

Human Resources Leadership Team,
Corporate Integrity

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

+++

Regions Hospital

Subject Death of a Patient	Attachments ☐ Yes ☒ No
Key words	**Number** **RH-PC-PC-02-01**
Category Provision of Care (PC)	**Effective Date** **July 1971**
Manual Patient Care Manual	**Last Review Date** **August 2010**
Issued By Nursing, Trauma, Pathology, Infection Control, Patient Care Committee	**Next Review Date** **March 2013**
Applicable All Regions Hospital Employees	**Origination Date** **July 1971** **Retired Date**
Review Responsibility Nursing, Infection Control, Patient Care Committee	**Contact** Nursing Administration

OUTLINE **See Page**

I. Purpose 2
II. Policy 2
III. Procedure(s) 3
  A. Death of a Patient Flow Chart 3
  B. Determination of Death 5
  C. Pronouncement of Death 5
  D. Nursing Responsibilities 6
    1. Notifications 6
    2. Reportable Cases to the Medical Examiner (ME) 7
    3. Family Decisions 9
    4. Organ, Tissue and Eye Donation 10
    5. Care of Body/Property/Viewing by Family 13
  E. Attending Physician Responsibilities 14
    1. Notifications 14
    2. Response to ME 14
    3. Post Mortem Consultation Form Completion 15
    4. Chart Completion 15
    5. Death Certificate Completion- Non Emergency Department 15
    6. Death Certificate Completion – Emergency Department 15
    7. Consultation with Family on Cause of Death 15
  F. Release of the Body 15
  G. Official Record of Deaths on Regions Hospital campus 16
  H. Summary of Forms and Documentation 16
IV. Definitions 17
V. Compliance ..... Not Applicable
VI. Attachment(s) ..... Not Applicable
VII. Other Resources 17
VIII. Approval(s) 17
IX. Endorsement 17

I. **PURPOSE**

To ensure the coordination of respectful care of a body following the pronouncement of death in all care units at Regions Hospital and HealthPartners Same Day Surgery Center (HPSC). In addition, this policy is designed to meet state and federal regulations as well as Joint Commission standards in regards to the communication, referral, consent, management, and procurement of organ, tissue, and eye donations.

II. **POLICY**

A. When a death occurs on the Regions Hospital campus or HPSC, the body is cared for with dignity and respect. The family or significant others are notified as quickly as possible and assisted to cope with this situation of loss.

B. As necessary, the appropriate legal authorities will be notified. The Patient Flow Coordinator (PFC) will assist in the coordination of after care for the body. The attending physician or designee will complete the patient's medical record and death certificate within a timely fashion. The official record of deaths for Regions Hospital will be based on the PFC's death log, supported by EPIC documentation.

C. All patient deaths, 20 weeks gestation and older will be referred for organ, tissue, and eye donation assessment. As per guidelines the LifeSource Coordinator (LC) will evaluate and recommend suitability for donation.

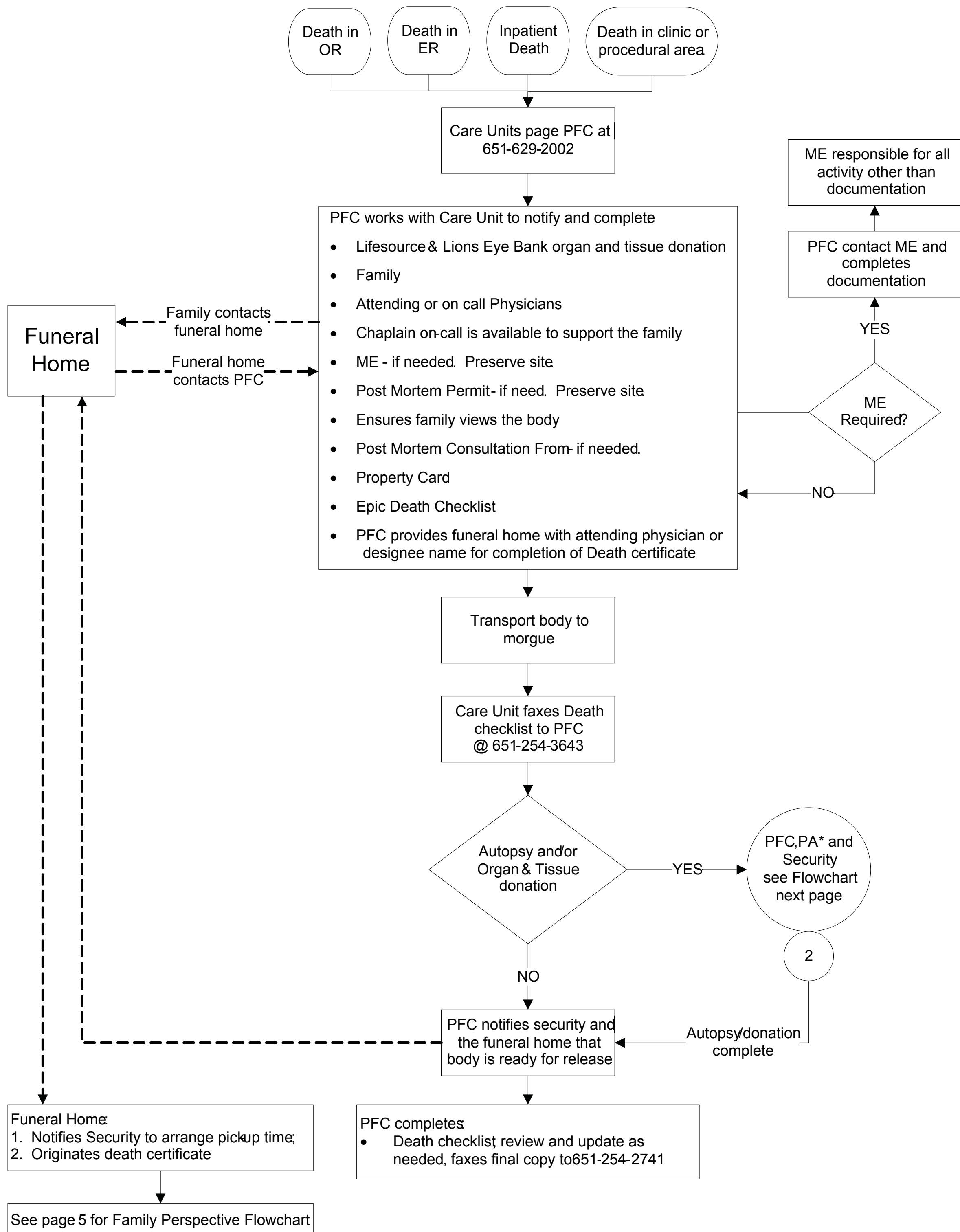
D. When the patient is a potential organ donor and the legal next of kin authorizes the donation or written donor designation exists, the LC will complete the written informed authorization.

E. A fatally ill patient who has total irreversible loss of brain function resulting in the diagnosis of brain death is potentially a suitable candidate for solid organ donation (e.g. kidney, heart, lung, liver, small bowel, pancreas) and the donation of tissues (e.g. eyes, bone, skin, connective tissue, heart for valves, arteries/veins).

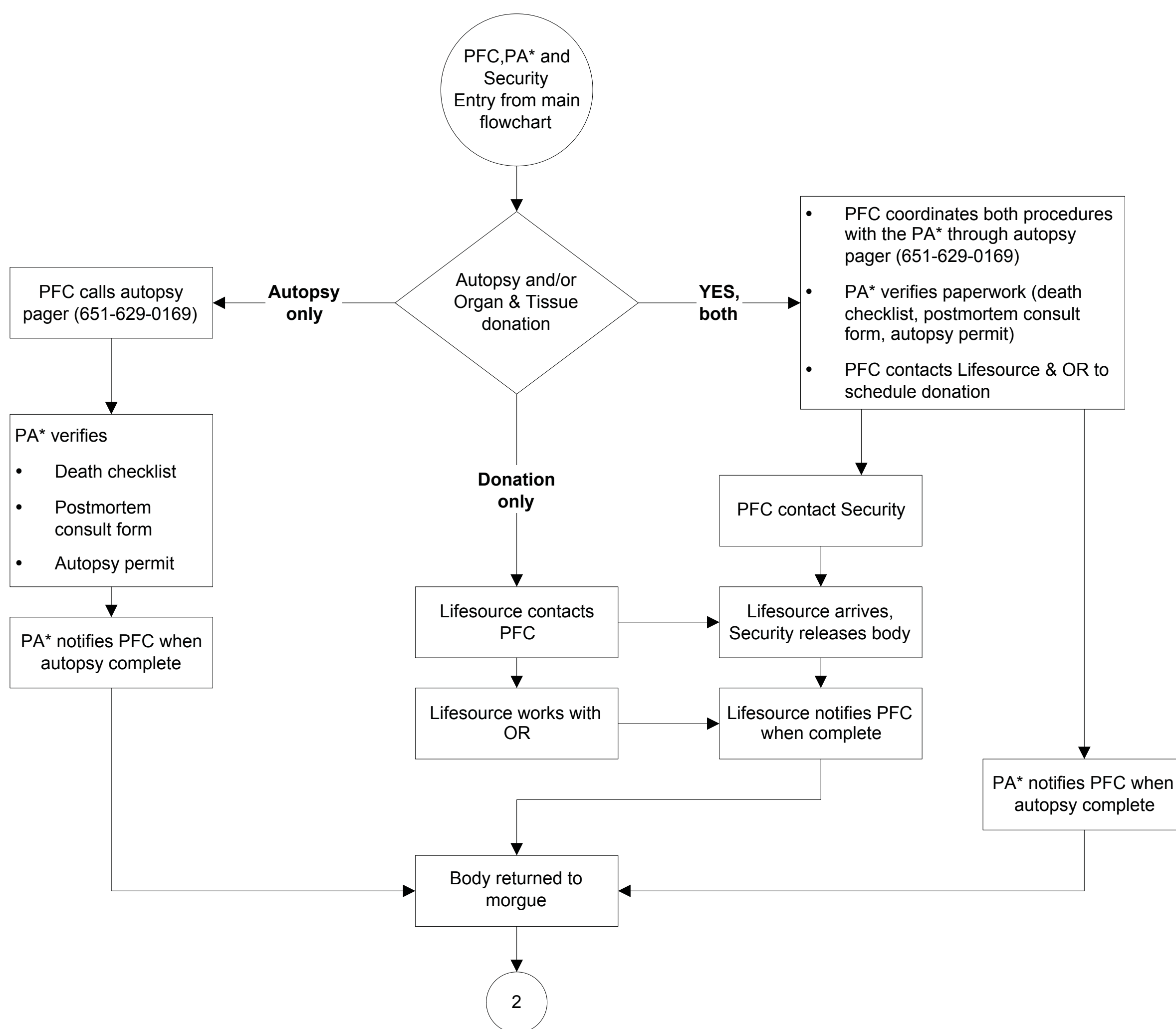
F. Individuals with complete and permanent cardiac and respiratory cessation may be potential suitable candidates for tissue donations, (e.g. eyes, bone, skin, connective tissue, heart for valves, arteries/veins).

III. **PROCEDURE(S)**

A. Death of a Patient Flow Chart

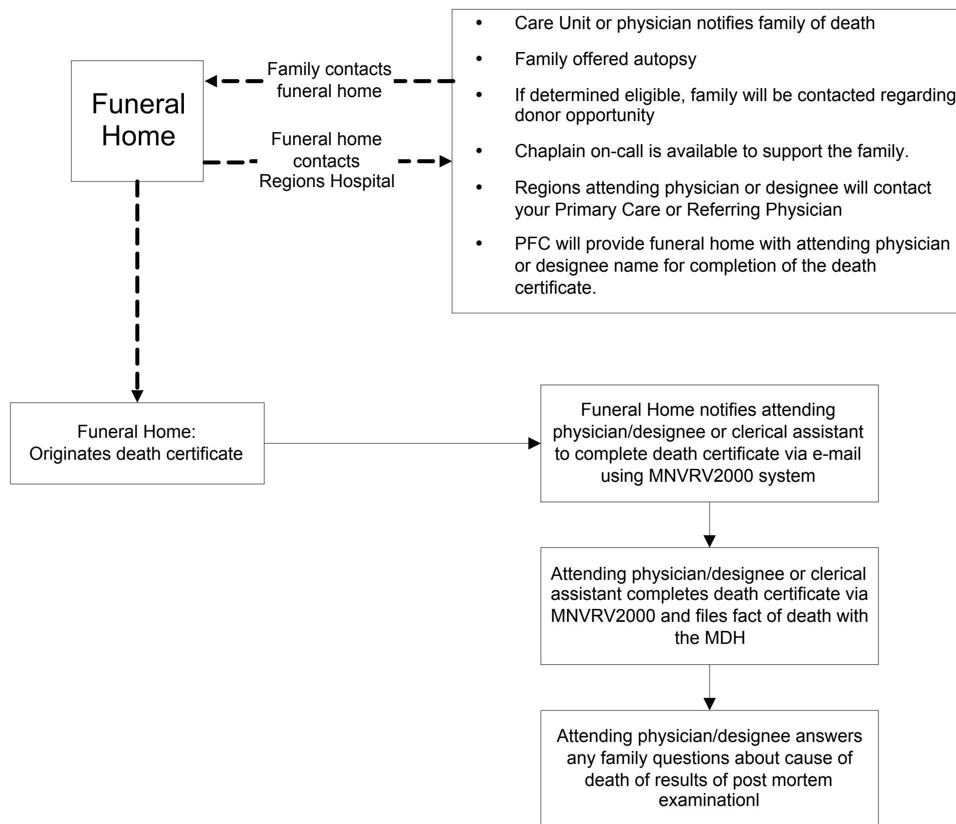


Patient Death Flowchart (page 2)



*PA - Pathology Assistant

Patient Death: Family Perspective



B. Determination of Death
   1. Brain Death
      a. See PC-02-15 Criteria for the Determination of Brain Death by Physicians
      b. Patients diagnosed with “Brain Death with intact cardiovascular system” are suitable candidates for organ, tissue, and eye donation.
      c. Physicians/Nurses responsible for the patient's care, or designee, will refer all patient deaths (patients with imminent brain death or cardiac and respiratory cessation) within one hour of meeting clinical triggers (the loss of two (2) or more brain stem reflexes or a Glasgow Coma Scale (GCS) of less than or equal to 5 in the emergency department) for donation evaluation by calling the donor referral number at 1-800-247-4273. Imminent brain death is defined as the loss of 2 or more brain stem reflexes. Do not discuss donation with the family prior to making the referral.

   2. Cardiac Death
      a. Individuals with complete cardiac and respiratory cessation are not suitable for organ donation but may be suitable for tissue donation (e.g. eyes, bone, skin, connective tissue, heart for valves, arteries/veins).
      b. Physicians and/or nurses responsible for the patient's care, or designee, will refer all patient deaths (cardiac and respiratory cessation) for donation evaluation as soon as possible after asystole by calling the donor referral number at 1-800-247-4273. Do not discuss donation with the family prior to making the referral.

C. Pronouncement of Death
   1. For all deaths, the death of a patient policy and procedure should be followed in all areas of the Regions Hospital regardless of the location in which the patient died (e.g. ED, Surgical Services, and clinics)

2. The Resident or nurse in the case of a Do Not Resuscitate / Do Not Intubate (DNR/DNI) patient may pronounce the death of a patient. The attending physician on the primary service responsible for the patient must be notified if the resident or nurse makes the pronouncement of death. Documentation is the same for all deaths.
   a. Nursing documentation regarding the death must include:
      i. Attending (on call) MD notification and time of MD notification.
      ii. Document patient's condition prior to death and emergency measures attempted.
      iii. Evaluation statement- "Emergency measures unsuccessful and patient expired at (include date and time of death)."
   b. See Section D regarding additional nursing responsibilities

3. Deaths occurring in Special Care Areas (e.g. Cath Lab, Dialysis, Imaging, HPSC)
   a. Page Patient Flow Coordinator (PFC) immediately at 651-629-2002 for direction.
   b. Secure patient belongings
      i. Return belongings to the family or
      ii. Place in safe located in the Business Office
   c. Complete property card and keep with body
   d. PFC will direct body viewing, transport, family and physician notification, and documentation

4. Fetal/Neonatal Deaths
   a. For Fetal Death (see definition of Fetal Death in Section D)
      i. Call Labor and Delivery for assistance.
      ii. Generate OB Consult with in-house OB service as well as RN from Birth Center Bereavement committee.
      iii. Refer to Fetal/Neonatal Loss Policy (L&D-C-185) and Procedure as outlined in the Labor and Delivery Manual.
      iv. Disposition of remains shall be determined by guidelines set by Anatomic Pathology, see chart in policy (L&D-C-185). Problems/questions related to this issue should be referred to the PFC at pager 651-629-2002.
   b. For Neonatal Death:
      i. Call Neonatal Services for assistance.
      ii. Generate Neonatal Consult with in-house NNP, Neonatology and RN from Birth Center Bereavement committee.
      iii. Refer to Fetal/Neonatal Loss Policy (L&D-C-185)
      iv. Disposition of remains shall be determined by guidelines set by Anatomic Pathology, see chart in policy (L&D-C-185). Problems/questions related to this issue should be referred to the PFC at pager 651-629-2002.

5. Dead on Arrival: See Emergency Medicine Administrative policies, A-N, Death and DOA section, page 7.

D. Nursing Responsibilities
   1. Notifications
      a. The attending (on call) MD must be notified. Note: This can be a joint responsibility with the resident.
      b. The Medical Examiner is notified, if applicable. For further instruction see Section D
      c. The physician or nurse notifies the family regarding the patient's death.
         i. If the family is present, the physician will talk with the family in private. Nursing is encouraged to be present during this discussion to reinforce what has been said and answer questions.
         ii. If the family is not present, the physician/nurse is to call and ask them to come

to the hospital.

iii. If the physician is unable to contact the family, he/she will notify the nursing staff. If necessary, the Director of Nursing/Patient Flow Coordinator (PFC) can be used as a resource in contacting the family.

iv. If the decedent is a resident of a nursing home or other care facility, nursing or family will contact the facility. If no family is present, this notification will be done by the responsible nurse.

v. If the patient is incarcerated, the responsible nurse will notify the Watch Supervisor. The Watch Supervisor will notify the Warden or Superintendent of the home institution. The home institution will provide direction on family notification.

vi. Provide family with any bereavement materials as applicable

vii. The physician or responsible nurse discusses the needed decisions of postmortem, ME possibilities, Selection of Mortuary, and Donations.

d. The PFC is notified of all deaths (651-629-2002) and a hold is placed on the body until the EHR death checklist is completed.

e. Chaplain-Chaplaincy services are available as needed or requested. Contact the on-call chaplain through Amion or the hospital operator.

f. EPIC/TeleTracking® notification.

i. Complete and print an EHR Death Checklist. The care unit faxes the completed EHR Death Checklist" to PFC at 651-254-3643, the original is placed in the patient's chart.

ii. Place a Discharge Actual Order into EHR.

iii. Enter "expired" status in Medipac to update patient status.

g. Completion of Property Card (See Section D).

2. Reportable Cases and the Medical Examiner (ME): Deaths which occur at Regions Hospital and meet the criteria below are reportable regardless of where the injury occurred.

a. Criteria for Reporting Death(s) to the Medical Examiner (ME)-(Reportable Deaths)

i. Death within first 24 hours of hospital admission

ii. Any death in which there is doubt as to whether it constitutes a medical examiner's case

iii. Deaths due to violent homicide, suicide or accident (e.g. all trauma)

iv. Deaths associated with burns, chemicals, electrical, thermal or radiation injury

v. All maternal deaths due to criminal abortion or miscarriage

vi. Deaths under unusual or mysterious circumstances

vii. Deaths that occur during, in association with, or as the result of a diagnostic, therapeutic or anesthetic procedure

viii. Deaths of inmates of public institutions, not hospitalized primarily for organic disease

ix. Deaths of persons in custody of law enforcement officers

x. Any death due to suspected neglect or abuse

xi. Any stillbirth of 20 weeks or more gestation, unattended by a physician

xii. All sudden deaths of persons not disabled by recognizable disease

xiii. All deaths in which a fracture of a major bone (femur, humerus, tibia etc.) has occurred within the past six months

xiv. Deaths of person whose body is to be cremated, dissected, buried at sea, or otherwise disposed of so that bodies will later be unavailable for examination.

b. Reporting and Documenting Cases to the ME

i. Report the case promptly to the office of the ME (651-266-1700)

ii. The office is open 24 hours daily. The physician/responsible nurse/procurement agency RN may make this call. The charge nurse will ensure that this reporting has been done.

iii. Information requested by the ME will include patient name, address, sex, race, marital status, next of kin, summary of history, physical findings, name of attending physician and other pertinent data.

iv. Documentation of this notification will be done on the EHR Death Checklist.

v. When notifying the ME office, the wishes of the family regarding postmortem exam should be conveyed. If the ME does the postmortem examination, a signed postmortem permit is not needed. A ME has jurisdiction to perform the postmortem exam regardless of family permission. In the case of the ME declining the need for their office to perform postmortem exam, a postmortem examination can be done by the hospital if permission has been obtained from the ME and family (See Section D, to obtain the family's permission).

vi. The ME will make a judgment as to whether they accept or decline jurisdiction. This decision will be done immediately at the time of the original contact with the ME's investigator <u>or</u> will be conveyed to the Regions PFC by the next working day. Until jurisdiction is decided the decedent's body is on hold and is to not be altered.

c. Medical Examiner Accepts Jurisdiction

i. The Medical Examiner will state that the case is under the jurisdiction of the Office of the Medical Examiner.

ii. The death certificate is signed only by the Medical Examiner in cases where the ME has accepted jurisdiction.

iii. The removal of clothing or effects, handling of the body, altering the scene, or the completion of a postmortem examination (except by specific authorization of the medical examiner, his deputies or investigators) should not occur. All clothing and belongings should be sent with the body to the medical examiner. Clothing and other personal belongings may assist the ME in their investigation of the death. If the relevancy of belongings for the investigation is questioned, verify with the ME their need for these articles. Do not send valuables already locked in the business office.

iv. Next of kin should be directed to contact the Office of the Medical Examiner (651-266-1700) for concerns regarding circumstances of death, cause of death, and concerns about personal effects. In many instances the ME personnel will be contacting the family for information, which may be helpful in the case.

v. The family should be informed to contact their Funeral Home/Mortuary.

vi. The body may not be removed from the nursing unit by mortuary personnel if the ME office is involved. In those circumstances where a request is made the charge nurse should notify the PFC for approval. If approved by the ME and PFC:

- Take the patient's chart to the morgue.
- Instruct the staff to record the death in the morgue logbook.
- Instruct the mortician to notify the PFC to access the morgue. The mortician will then remove the body from the nursing station via the morgue. The mortician will sign the logbook in the morgue.
- If the patient's name has not been entered into the morgue log by the time the funeral director arrives, nursing staff will accompany the funeral director back to the morgue to enter the name and drop off the chart (If the chart has not already been sent to the morgue.)
- Page the PFC when the body is taken from the care unit by the Funeral Home/Mortuary.

d. Medical Examiner Declines Jurisdiction

i. The Medical Examiner will authorize release of the body to the Funeral Home/Mortuary.

ii. The procedures for autopsy/postmortem care of the body/property should be

followed as if the case was a non-reportable death.

iii. The family/next of kin should be contacted about considering a Regions Hospital postmortem exam.

iv. The family should be informed to contact their Funeral Home/Mortuary

3. Family Decisions

a. Postmortem Examinations:

i. Postmortem examinations are performed at no cost to the family provided the death occurs at Regions Hospital.

ii. Permission should be sought from the family/next of kin for a postmortem examination for all patients. Responsibility for obtaining this permission belongs to the physician and/or responsible nurse who conveys the announcement of death to the family. If the family consents to a postmortem, the permit form (See Section H) should be completed (even prior to contact with the ME).

iii. Reinforce with the family that if the ME requires the postmortem, it will be done regardless of the family giving permission.

iv. The next of kin who has the legal authority, via MN state law 149A.80, to give permission for the postmortem examination are identified below in the accepted legal order. Legal order must be followed in obtaining consent for a postmortem examination.

- The person appointed in a dated written instrument signed by the decedent (does not include durable and nondurable power of attorney)
- The surviving, legally recognized spouse
- The surviving biological or adopted child or children of the decedent over the age of majority, see note below.
- The surviving parent or parents of the decedent
- The surviving biological or adopted siblings of the decedent over the age of majority, see note below.
- The person or persons respectively in the next degree of kinship in the order named bylaw to inherit the estate of the decedent
- The appropriate public or court authority

Note: You can rely on instructions given by the surviving child that they are the sole surviving child, or if there are multiple children, that they constitute a majority of the surviving children. You can rely on instructions given by the surviving sibling that they are the sole surviving sibling or if there are multiple siblings that they constitute a majority of the surviving siblings.

v. Physician/responsible nurse completes Section I of the Postmortem Permit and signs as a witness, if needed.

vi. Next of kin giving permission for the postmortem exam completes Section II of Postmortem Permit.

- As many signatures as can be easily obtained are recommended.
- When the next of kin resides a substantial distance from the hospital or the next of kin is not able to sign the postmortem permit in person telephone permission for the postmortem exam is acceptable with one (1) witness i.e., three way phone call. If permission is obtained via the telephone this must be documented on Section II of the post mortem permit by the witness.

vii. The PFC pages the Pathologist Assistant at (651-629-0169) to notify the need for a postmortem exam.

viii. The Physician must then complete the Postmortem Consultation Form (See Section H). The completed form should go with the body and chart to the morgue.

ix. Pathology Department Pathologists complete the postmortem examination.

x. Preliminary postmortem results are available 72 hours from autopsy.

xi. Final postmortem results are available no later than 90 days from autopsy.
xii. The postmortem report is given only to the person(s) who signed the postmortem permit.
xiii. Physician who completes the death certificate answers questions from family on postmortem results.

b. Selection of a Funeral Home/Mortuary
   i. Request the family select a Funeral Home/Mortuary
   ii. Inform the family they are responsible for notifying the Funeral Home/Mortuary themselves

4. Organ, Tissue & Eye Donation – *Note: LifeSource, The Upper Midwest Organ Procurement Organization, Inc. is the official procurement agency for Regions Hospital for organs and effective December 29, 2004 for tissues. The Minnesota Lions Eye Bank (MLEB) is used for eye donations.*
   a. The nurse calls Donor Referral #1-800-247-4273 if the patient is over 20 weeks gestation. Verify if patient meets criteria for organ/tissue/eye donation. Do not discuss donation with the family prior to making the referral.
   b. Brain Death –Organs, tissues and eyes. *Note: Refer all patient deaths (patients with imminent brain death or cardiac and respiratory cessation) within one hour of meeting clinical triggers (the loss of two [2] or more brain stem reflexes or have a Glasgow Coma Scale (GCS) of less than or equal to 5 in the emergency department).*
      i. Suitability for Donation
         - The contracted LifeSource Coordinator (LC) will determine if the patient meets criteria for organ, tissue, and/or eye donation after discussion with the physician/nurse, and/or evaluation of the medical record.
         - After brain death declaration, if suitable for organ donation, a LifeSource Coordinator (LC) will be on-site to offer the next of kin the option of donation or discuss the patient's donor designation in collaboration with the patient's physician, nurse, and other members of the healthcare team as appropriate.
         - If suitable for tissue/eye donation but not organ donation, the tissue/eye coordinator will discuss either the option of donation or donor designation with the family via the telephone using the assisted approach (family connection) after the patient's death.
         - Families of patients who do not meet donation criteria, per the LifeSource Coordinator, will be told by the physician/nurse responsible for the patient's care, or designee, that normally donation is discussed at this time, however, because of a contraindication defined by LifeSource Coordinator donation is not an option.
   c. Cardiac Death –Tissue and Eye Donation Only. *Note: Individuals with complete cardiac and respiratory cessation may be suitable candidates for tissue or eye donation (e.g. eye, bones, skin, connective tissue, heart for valves, arteries/veins). Referrals should be done as soon as possible after asystole.*
      i. Suitability for Donation
         - The LC will determine if the patient meets criteria for tissue and/or eye donation after discussion with the physician/nurse, and/or evaluation of the medical record
         - If suitable for tissue/eye donation, the LC will discuss either the option of donation or donor designation with the family via the telephone using the family connection.
         - Once the determination of suitability is made, the nurse will be asked to offer the family the brochure, Tissue & Eye Donation. At this point, tell the family that it has been determined that their loved one could be a donor

(the LC will be able to tell you whether or not your patient is a documented donor and how to relay this information to the family). Inform the family that a LC will speak with them now or will contact them later. If the family chooses to leave the hospital prior to speaking with a LC, obtain a telephone number where they can be reached.

- The LC will talk with the family via the telephone (at the hospital or at their home) and complete all necessary documentation.
- The LC will inform the PFC of the family's decision, and a copy of the authorization/disclosure form will be provided to medical records.
- Families of decedents who do not meet donation criteria, per the LC, should not be approached for donation. The nurse responsible for the patient's care, or designee, will tell families of these patients, that normally donation is discussed at this time; however, because of a contraindication defined by the LC donation is not an option. The medical contraindication given by the LC should be recorded on the Record of Death; Screening for Organs, Tissues & Eyes form. This form is provided by the LC.
- If suitable for eye donation only, the Minnesota Lions Eye Bank (MLEB) LifeSource Coordinator will offer the family the option of donation via the telephone using the family connection.

d. Use of Interpreters - When appropriate, due to cultural diversity, the International Clinic/Services should be contacted to be involved with the discussion. The person reviewing this issue will document the discussion on the patient's record. Such contact shall occur with due discretion and sensitivity regarding the circumstances, views and beliefs of the family.

e. Donor coordinators will make the final determination of a donor's suitability for which organs and tissues may be donated and will coordinate the organ, tissue, and eye retrieval with Regions Hospital and local/national transplant centers. If suitable for eye donation only, the MLEB Donation Coordinator will offer the family the option of donation via the telephone using assisted approach (family connection).

f. Determination of Donor Designation

   i. If donation is an option, the LifeSource Coordinator will lead the donor designation assessment for patients documented intent or refusal to donate. If Advanced Directives are noted on the chart, inform the Donation Coordinator of any patient's decision about donation. Do not ask the family for the information. Regardless of designation or not, discuss method of approach with Donation Coordinator

   ii. Medical Examiner: If the donor is subject to the medical examiner's jurisdiction and is a possible organ/tissue/eye donor, the medical examiner is called at the time of the first brain death determination. The medical examiner, or his designee, may then decide to externally examine the patient to obtain necessary medical/legal evidence or to decide to release the body for organ/tissue/eye donation. The external examination may include taking pictures. After the exam, the medical examiner will document on the medical record the decision as to the release of the body for organ donation. If the medical examiner is releasing the body for organ/tissue/eye donation, they will grant a telephone authorization for this procedure. The medical examiner's name, date and time of this telephone authorization to release the body, and if they will want to do an external examination, needs to be documented in the medical record.

g. Organ Procurement Procedure:

   i. After brain death and family authorization or disclosure, LifeSource Coordinator will remain on-site to clinically manage the patient, allocate the organs, and coordinate the organ recovery. Organ procurement is performed in the Regions Hospital operating room. The following forms will be sent with the body:

- EHR Death Checklist.
- Authorization or Disclosure for Organ, Tissue and Eye Donation. No other surgical consent form is necessary.
- Completed postmortem examination permit, if a postmortem or equivalent examination is requested. A permit is not necessary if the Medical Examiner assumes jurisdiction for the case.
- Patient records. - A copy of the patient's current medical record, including flow sheets and laboratory results. The Donation Coordinator will identify the specific portions of the chart to be copied. This data is given to the team(s) who will procure the organs.
- The patient's previous medical record.

ii. The body is transferred and signed into the morgue per the Regions Hospital Death of a Patient procedure when the organ donation procedure is completed.

iii. An operative report will be provided by the donation team.

h. Tissue Procurement Procedure:

i. After brain or cardiac death and family authorization/disclosure, LifeSource Coordinator will coordinate tissue recovery with the Patient Flow Coordinator. The body is transferred and signed into the morgue. The following forms will be sent with the body:

- EHR Death Checklist
- Authorization or Disclosure for Organ, Tissue and Eye Donation. No other surgical consent form is necessary.
- Completed postmortem examination permit, if a postmortem or equivalent examination is requested. A permit is not necessary if the Medical Examiner assumes jurisdiction for the case.
- Patient records. - A copy of the patient's current medical record, including flow sheets and laboratory results. The LifeSource Coordinator will identify the specific portions of the chart to be copied. This data is given to the team(s) who will procure the organs.
- The patient's previous medical record.

ii. Tissue procurement is performed in the Regions Hospital operating room. Room availability will be coordinated between the PFC and Operating Room Charge Nurse.

iii. The Tissue Coordinator will provide a copy of the authorization/disclosure for donation form along with documentation of which tissues were recovered for the patient chart.

iv. The body is transferred and signed into the morgue per the Regions Hospital Death of a Patient procedure when the tissue procurement procedure is completed.

v. Procured tissue will be packaged and held in the Regions Hospital Pathology Laboratory for courier retrieval.

i. Eye Procurement Procedure:

i. The Minnesota Lions Eye Bank (MLEB) coordinates eye donation and transplantation. The MLEB Certified Procurement Technicians remove the whole eyes or corneas only, determined by the LifeSource Coordinator, for corneal donation. Eye enucleation/insitu recovery can be performed in the OR, on the patient care unit, in the morgue, at the Funeral Home/Mortuary, or at the Medical Examiner's office.

ii. All potential eye donors should be treated using the following post-mortem care:

- Elevate head 10-20 degrees.
- Vertically paper tape eyes closed, when possible. Closing eyes as soon as possible is also important.

- Place light ice bags gently over taped, closed eyes before body is sent to the morgue.

iii. Notify the PFC when procurement procedures are completed

iv. The patient's chart is sent with the body.

v. All nursing documentation in the progress notes follows the same procedure as any other death.

5. Care of the Body/Property and Viewing by Family:

a. Care after Death/Viewing by Family - The purpose of caring for the body is to ensure cleanliness before taking it to the morgue and to ensure proper disposition of belongings.

i. Obtain the morgue cart by calling Materials Management x49588 or ordering it via EHR.

ii. Obtain a Morgue Pack from Materials Management or via EHR.

iii. Proceed with postmortem care after the patient has been pronounced dead and the relatives have left the room.

iv. Do not remove tubes, clamps, splints, casts, etc., if there is to be a possibility of a postmortem or if it is a ME reportable case. Do not wash the body.

v. Close eyes. If the eyes do not remain closed, paper tape may be used. If eyes are to be donated, vertically tape eyes shut and place small ice packs on eyes. Elevate the head of the bed 20°.

vi. In deaths due to violence, suspected homicide or suicide or if pending ME jurisdiction do not bathe the body. If chain of evidence is needed on ME or Pending ME case do the following:

- Never leave evidence unattended.
- Obtain a chain of Evidence Form (See Section H).
- Complete Chain of Evidence Form following the instructions on the form.
- Use paper bags (not plastic) for personal items such as; clothing, personal belongings, place jewelry inside a blue specimen cup and seal prior to placing in paper bag.
- Secure all packages with evidence tape available from Security
- Label the outside of the paper bag with the patient's name, "A" number, and the contents placed inside the bag. The contents in the bag should also be recorded on the Chain of Evidence Form.
- Make copies as designated.
- Evidence can only be released to the proper authorities and must be recorded on the Chain of Evidence Form.
- Call Security 651-254-3979 to secure evidence.

vii. If the patient was in isolation at the time of death, maintain the isolation procedure while preparing the body for the morgue.

viii. Complete death tags (2 for body, 1 for the morgue identification card plus the number needed for labeling belongings).

ix. Leave identiband on patient.

x. Replace dressings with fresh ones.

xi. If the false teeth are in the mouth, leave them there. If false teeth are not in the mouth, place them into a denture cup and place in shroud with body.

xii. If hair has been cut, contain and place in shroud with body.

xiii. Remove any narcotic patches from the deceased before transporting the body to the morgue. Discard according to policy for wasting narcotic patches.

xiv. Place one death tag around the ankle.

xv. Place body face up. Adjust defecation pad under buttocks and wrap the body diagonally in a morgue sheet, leaving arms loose at sides.
Note: If family is yet to view the body, place one arm outside of sheet. Once family has left:

xvi. Tape the morgue sheet securely, particularly around the sides of the head and neck.
xvii. Tape one death tag on the morgue sheet at the chest.
xviii. The Universal Precautions Tag will be placed on the ankle tag.

b. Care of Property/Body
   i. Disposition of all items should be identified and documented on the Property Card (See Section H).
   ii. All belongings including valuables should be given to relatives. If relatives are not present:
      - Rings, necklaces and other valuables are to be sent to the Business Office.
      - Glasses, dentures, prosthesis, clothing and any other items, which cannot be removed are sent to the morgue with the body.
   iii. Personal items/valuables may have been removed prior to death and submitted to police using chain of evidence procedure. Documentation of these items can be found on the Chain of Evidence Form need form# (See Section H). Check on the Property Card that a chain of evidence form was used.

c. Transfer of the Body/Property
   Note: If the body requires special needs (e.g. Bariatric patients) contact PFC for direction prior to transport.
   i. Transfer of the body to the morgue will take place as soon as possible after the death. The PFC should be notified if the transfer is not possible within a timely fashion. One reason for this exception may be family wishes to view the body on the unit. See Exception listed in Section F.
   ii. Remove the top of morgue cart, adjust cart to level of bed with crank.
   iii. Place the body face up on the tray of the morgue cart.
   iv. Replace cart top and cover cart with contoured cover.
   v. Call Patient Transport to assist with moving the body to the morgue.
   vi. Transport will call Security to open the morgue.
   vii. Transfer body to the morgue.
   viii. Patient transport will take the body to the morgue, the body is placed in an empty morgue crypt feet first. A lift is available in the morgue to assist with movement of the body.
   ix. In addition to the body, personal belongings (if there are any) should be placed in the crypt with the body.
   x. The medical record, the EHR Death Checklist, postmortem permit, postmortem consultation (if postmortem has been signed for) should be placed in the basket inside the anteroom to the morgue.
   xi. The identification card for morgue drawer should be placed in slot on door of crypt.
   xii. The required information is entered into the morgue logbook.

E. Attending Physician Responsibilities
   1. Notifications
      a. Family – See joint Nursing Responsibilities Section D.
      b. PFC (if applicable) – If you are unable (i.e. off service) to complete the patient's death certificate immediately inform the PFC of your designee at pager 651-629-2002.
      c. The primary physician and/or referring physician, if applicable.

   2. If applicable, the last attending physician may be contacted by the Medical Examiner (on all reportable deaths) inquiring information about past medical history of the decedent, the most likely cause of death, and the relationship of any physical or chemical injury.

3. If applicable, complete the post mortem consultation form for all autopsy requests performed at Regions Hospital.

4. Chart completion - Although most charting is done in Epic, the remaining paper documents will be made available to the Health Information Management (HIM) department 24 hours after the patient's death.

5. Death Certificate Completion – Non-Emergency Department (Death Certificates should be completed within 48 hours of receipt of request if at all possible.)
   a. The PFC will provide the family's designated Funeral Home/Mortuary with the name of the attending physician or their designee
   b. The designated Funeral Home/Mortuary will originate all death certificates by contacting the designated physician or clerical assistant through email.
   c. Complete death certificate using the State of Minnesota online reporting system MN VRV2000. Note: a user id is required.

6. Death Certificate Completion – Emergency Department (ED) (Note: All cases are reported to the Medical Examiner)
   a. If the Medical Examiner (ME) accepts jurisdiction the ME will complete the Death Certificate.
   b. If the ME denies jurisdiction the Primary Medical Physician will complete the Death Certificate.
   c. If the Primary Medical Physician refuses to complete the Death Certificate, the ME will assume the responsibility of Death Certificate completion.
   d. If there is no Primary Medical Physician available, the ME will complete the Death Certificate.
   e. Consultation and/or answering questions for the family about the circumstances leading to the death will be done by the ED physician.
   f. Funeral homes will be instructed by the PFC's to seek the Primary Medical Physician, or to contact the ME.

7. Consultation and/or answering questions for the family about the cause of death or postmortem results will be done by the physician who signs the death certificate.

F. Release of the Body
   1. PFC Responsibilities
      a. Verify the completeness of the EHR Death Checklist.
      b. The PFC will page the pathologist assistant at 651-629-0169 and leave a voicemail message.
      c. Communicate the authorized release of the body to inquiring Funeral Home/Mortuary personnel.
      d. Authorize security to release the body.
         i. It is unlawful for the family to transport a body out of the hospital; this must be done by a licensed Funeral Home/Mortuary.

   2. Exceptions: Removal of Body from Care Unit
      Occasionally, the family may request to have the funeral director remove the body from the care unit rather than having the staff take the body to the morgue. Removing the body from the care unit by the mortuary personnel <u>should be an exception</u> and only upon request of the family with approval by the PFC. If approved by the PFC the charge nurse should:
      a. Take the patient's medical record to the morgue.
      b. Record the death in the morgue logbook.
      c. Instruct the mortician to notify the PFC to access the morgue. The mortician will

then remove the body from the care unit via the morgue. The mortician will sign the logbook in the morgue.

d. If the patient's name has not been entered into the morgue log by the time the Funeral Home/Mortuary personnel arrives, nursing staff will accompany them to the morgue to enter the name and drop off the chart.

e. Page the PFC at 651-629-2002 when the body is taken from the care unit by the Funeral Home/Mortuary.

G. Record of Deaths on Regions Hospital campus

1. Patient Placement Office will compile a death record from the completed PFC Death checklist log. Patient name, birthdate, medical record/identification number, unit of death, date of death, time of death will be recorded.

2. Regularly the report summaries will be emailed to Pathology Administration and Quality Management for statistical and clerical reporting requirements.

H. Summary of Forms and Documentation

The following is a summary of the forms required for documentation, the purpose, use, and person responsible and routing of the form.

1. EPIC Death Checklist. All information must be entered into-EHR. Completed EHR Checklist is sent with chart.
   a. *Purpose:* To communicate both internally and externally information regarding the death, notifications, arrangements and disposition of body and belongings.
   b. *Use:* Contains all information related to death pronouncement, notifications, reporting, postmortem, property and form distribution. Used as both an information sheet and a checklist. Compete prior to taking the body to the morgue.
   c. *Person Responsible:* Charge Nurse/Nurse.
   d. *Routing:* EHR completed. 1 copy with the body (place on top of the chart) and fax 1 copy to the PFC at 651-254-3643.

2. Postmortem Permit Form in EHR Notes.
   a. *Purpose:* To provide documentation for the authorization of a postmortem exam.
   b. *Use:* All cases in which a postmortem exam will be done.
   c. *Person Responsible:* Physician or nurse.
   d. *Routing:* 1 copy with the body (place on top of chart).

3. Postmortem Consultation Form in EHR Notes.
   a. *Purpose:* To provide the pathologist and attending MD a method to communicate clinical information and desired information from the postmortem exam.
   b. *Use:* All cases in which a postmortem exam will be done.
   c. *Person Responsible:* Physician.
   d. *Routing:* 1 copy with the body (place on top of chart).

4. Property Card (Form #100-284-030). Located in Morgue Pack
   a. *Purpose: To communicate patient information and disposition of belongings.*
   b. *Use: Contains all information related to belongings and valuables disposition*
   c. *Person Responsible: Nurse.*
   d. *Routing:* Original copy in the chart, second copy with body.

5. Discharge Order Entered into EHR. If outpatient or death in special care area, the PFC will be a resource to assist with completion of documentation and appropriate system notification.
   a. *Purpose:* To provide a completed system process for a patient death.
   b. *Use* Patient status is updated in Medipac. Medipac is the final death record

repository for Regions Hospital

6. Chain of Evidence Form (Form #) Located in Care Unit

IV. DEFINITIONS

A. *Fetal Death* – death before the complete expulsion or extraction from the mother of a product of human conception, fetus and placenta, irrespective of the duration of pregnancy: the death is indicated by the fact that, after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as a beating heart, pulsation of the umbilical cord, or the definite movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps. This definition excludes induced termination of pregnancy.

B. *Neonatal Death* – death of a live-born neonate before the neonate becomes age 28 days (up to and including 27 days, 23 hours, and 59 minutes from the moment of birth).

C. *Family* – defined as family, significant other, or close personal friend/Responsible Parties

V. COMPLIANCE NOT APPLICABLE

VI. ATTACHMENTS NOT APPLICABLE

VII. OTHER RESOURCES

Internal
PC-02-15 Criteria for Determination of Brain Death by Physicians
PC-02-20 Donation After Cardiac Death
PC-10-27 Principles and Guidelines for Limiting Treatments
BC-02-10 Infant Loss – Nursing Interventions (Birth Center Manual)
Emergency Medicine Administrative policies, A-N, Death and DOA section, page 7

VIII. APPROVAL(S)

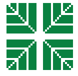
Chris Boese RN, MS, NE-BC

Chris Boese, RN, MS, NE-BC
Vice President Patient Care Services

IX. ENDORSEMENT

Patient Care Committee: September 2010

+++

 **Regions Hospital**

Subject EMPLOYMENT REQUIREMENTS FOR NEW EMPLOYEES	Attachments ☐ Yes ☒ No
Key words Employment, Hiring	**Number** **RH-HR-HR-60-05-05**
Category Human Resources (HR)	**Effective Date** **November 2010**
Manual Human Resources	**Last Review Date** **November 2010**
Issued By Human Resources	**Next Review Date** **November 2011**
Applicable	**Origination Date** **April 1989**
	Retired Date **Not Applicable**
Review Responsibility Human Resources	**Contact** Human Resources

I. **PURPOSE**
This policy was established in order to ensure:

A. That personnel and payroll information on all new employees is complete and correct to comply with established regulations and to ensure proper payment.

B. To ensure all employees are cleared medically to perform the functions for which they were hired prior to the day they begin work.

C. To ensure all employees have cleared the background study process prior to the day they begin work.

II. **POLICY**
Official job offers will not be made to applicants who are excluded from participation in any federal health care program.

All official offers of employment to applicants are made by the Human Resources Department and are contingent upon the following:

Health clearance and/or the ability to make a reasonable accommodation

A. Personnel/Payroll Forms - All new employees must complete all necessary personnel and payroll forms.

B. Employee Health Questionnaire and other necessary forms. All Prospective employees must be cleared for employment by the Employee Health Service prior to the first day of work.

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

Providing necessary Employment Eligibility Verification documentation (Form I-9) as established by law which must be submitted prior to first day of work.

Completing and successfully passing the Department of Human Services criminal background study as required by state law for employees who have direct patient contact as defined by state law.

Completing and successfully passing the hospitals background study requirements for verification of education, employment, criminal background, social security trace and FACIS as defined by the position of hire.

III. PROCEDURE(S)

Prior to making a final offer of employment to an applicant, the Human Resources Department will search the on-line database of excluded providers maintained by the Department of Health and Human Services – Office of Inspector General to ensure the applicant is not included on that database. If the Human Resources Department is not able to verify that an applicant is not currently excluded from Federal health care program participation, a written inquiry may be sent to the Department of Health and Human Services – Office of Inspector General for confirmation of the applicant's eligibility. If an applicant is currently excluded, a job offer will not be made. If an applicant represents that his/her exclusion has expired and the Office of Inspector General has reinstated him/her, the applicant must provide proof of reinstatement before and a final offer of employment is made.

A. At the time a hiring commitment is made to a prospective employee each prospective employee is scheduled for an EHS appointment, a Department of Human Services criminal background check is submitted (if required by the position), a background study is initiated through Verifications Inc., and the prospective employee is scheduled to attend new employee orientation, during which the new employee is required to complete necessary employment documentation.

If the Employee Health Service determines that the prospective employee is unable to perform the essential job functions, the Health Service will so notify both the Human Resources Department, and the prospective employee. The Human Resources Department will determine if a reasonable accommodation, in conjunction with EHS and the hiring department, can be made. If a reasonable accommodation cannot be made, then the offer of employment will be withdrawn.

If the DHS background study determines that the prospective employee is not cleared to work in a position requiring patient contact, the offer of employment may be withdrawn, unless otherwise directed by the Department of Human Services.

If the Verifications Inc, background study determines that the prospective employee should not be cleared to work, the Human Resources Department will review the findings and determine if the offer of employment will be withdrawn.

B. The prospective employee can only begin work at the Hospital when all required personnel/payroll forms have been completed and he/she has been cleared by the Employee Health Service prior to beginning work.

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

IV. DEFINITIONS
NOT APPLICABLE

V. COMPLIANCE
NOT APPLICABLE

VI. ATTACHMENTS
NOT APPLICABLE

VII. OTHER RESOURCES
NOT APPLICABLE

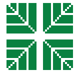
VIII. APPROVAL(S)

Beth Heinz, Vice President

IX. ENDORSEMENT
Human Resources Leadership Team

+++

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.



Regions Hospital

Subject FAMILY MEDICAL LEAVE OF ABSENCE (FMLA)	Attachments ☐ Yes ☒ No
Key words Family LOA, LOA, Family, Sick Leave, Leave of Absence, FMLA	**Number** **RH-HR-HR-60-06-11**
Category Human Resources (HR)	**Effective Date** **December 2007**
Manual Human Resources	**Last Review Date** **November 2010**
Issued By Human Resources	**Next Review Date** **December 2011**
Applicable Applies to all probationary and regular employees of Regions Hospital who meet the following eligibility criteria: 1) Employees must have been employed with Regions Hospital for a total of 12 months prior to the commencement date of the leave, and 2) Employees must have worked at least 1250 hours for Regions Hospital in the 12 month period prior to the commencement of the leave	**Origination Date** **April 1995** **Retired Date** Not Applicable
Review Responsibility Human Resources	**Contact** Human Resources

I. PURPOSE

To comply with the provisions of the Family Medical Leave Act of 1993, providing time off for certain family and medical reasons.

II. POLICY

Employees are eligible to a total of 12 work- weeks (prorated for part time employees) of leave during a 12- month period, for one or more of the following reasons:

1) For the birth and care of a newborn child of the employee, or for the placement with the employee of a son or daughter for adoption or for foster care

2) For the employee when unable to work because of his/her serious health condition

3) For the employee to care for an immediate family member who has a serious health condition.

Employees are required to use all available accrued benefit hours during leave (see policy # 60:02:09) including PTO, holiday, old vacation/holiday. Employees with extended sick leave hours should reference policy # 60:02:07.

Under certain circumstances employees may take FMLA leave intermittently; taking leave in blocks of time, or by reducing their normal weekly or daily work schedule. Intermittent leave is pro-rated according to the employee's FTE and shall not exceed a total of 480 hours for a 1.0 FTE.

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

Maintenance of Benefits

During the entire period of the 12 weeks of leave, the employer will maintain and contribute to the employee's coverage, under the medical, dental and life insurance plans, in the same manner as when the leave began. The employee remains responsible for his/her portion of the insurance premiums during this period.

Job Restoration

Upon return from the leave, the employee will be restored to his/her position in his/her department. (See Definition).

III. PROCEDURE(S)

- Employee requests leave within 30 days advance notice (unless it is an emergency).
- Employee obtains leave request form from the HR Service Center and has Benefits Administrator complete the HR section. A Process Guide is also available to assist the employee.
- Employee obtains manager's signature on form.
- Employee has physician complete the Certification of Healthcare Provider Form
- Employee returns signed request form and Physician Certification of Healthcare Provider Form to the HR Benefits Administrator in the HR Service Center.

- Employee should maintain contact with their manager during the leave of absence.

- Employee should contact manager two weeks prior to expected return to work.
- If leave is for employee, employee should have physician complete the Return to Work Form.
- If leave is for employee, employee must bring the completed Return to Work Form to the HR Benefits Administrator prior to or on first day of return to work. Employee must have this form in order to return to work.

IV. DEFINITIONS

Work-week: Seven (7) consecutive days, beginning with Sunday and ending on Saturday.

12- month period: Commences on the effective date of the requested leave. The previous 12-month period determines eligibility.

Position: Employees on FMLA have the right back to their same position including job title, department, FTE, shift, and schedule unless business policy or practices have changed regardless of the employee's presence or absence from the workplace.

Intermittent Leave: When an employee needs time away from work periodically due to medical condition as stipulated in Certification of Health Care Provider Form.

Immediate Family Member: Parent, spouse, child, domestic partner.

- Domestic Partner: An individual who is not married and sole partner to an unmarried employee, at least 18 years of age or older and lives in the same residence with an employee with the intent to reside together permanently. A domestic partner may be of the same or opposite sex.
- Parent: A biological parent or an individual who acted in the place of a parent ("in loco parentis") when the employee was a child. This term does not include parents-in-law.

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

- Spouse: A husband or wife as defined or recognized by state law.
- Son or Daughter (Child): A biological, adopted, foster child, stepchild, legal ward, or child of a person who acted in the place of a parent (“in loco parentis”) who is under 18, or if the child is over age 18 the child must be incapable of self-care or the child must have a mental or physical disability as defined by the Americans with Disabilities Act.

Serious Health Condition: an illness, injury, impairment or mental or physical condition that involves the following:

- Inpatient care in a medical care facility, including any period of inability to work or perform other regular daily activities due to the serious health condition, or any subsequent treatment in connection with such inpatient care.
- Continuing treatment by a health care provider, involving any period of inability to work or perform regular daily activities for more than three consecutive days.
- Any period of incapacity due to pregnancy
- Chronic serious health conditions or conditions which require multiple treatments

V. COMPLIANCE

Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS

LOA Process Guide

VII. OTHER RESOURCES

Bargaining unit employees should refer to their Bargaining Unit Agreement (union contract) for information on other related leave benefits.

Personal Leave of Absence Policy RH-HR-HR-60-06-08
Extended Sick Leave Policy RH-HR-HR-60-02-07
PTO Policy RH-HR-HR-60-02-09

VIII. APPROVAL(S)

Beth Heinz
Vice President, Human Resources

IX. ENDORSEMENT

Human Resources Leadership Team

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

Attachment

REGIONS HOSPITAL LEAVE OF ABSENCE (LOA) EMPLOYEE PROCESS GUIDE

This document provides an overview of the leave of absence process, important contact information, and other information relating to leaves of absence.

Section 1 – Tips for a successful Leave of Absence

- Request your leave well in advance so your department management has time to plan for your absence and so that you have time to complete all necessary paperwork. A minimum of 30 days advance notice is required unless it is an emergency or unforeseen event.
- Be sure you turn your paperwork in by the stated deadlines.
- Stay in touch with your department management at intervals during your leave. This is a courtesy to your supervisor/manager and helps ensure a smooth transition back into the workplace when the leave ends.
- About two weeks prior to your expected return to work you should:
    - Contact your department management to make arrangements. This ensures you are worked back into the schedule in a timely way.
    - Ask your physician to complete your Return to Work Clearance form (if you have been on a medical leave). This form is required in order to return to work after a medical leave and requesting it in advance ensures there is no delay in your return to work.
- If your leave is intermittent FMLA leave, be sure to identify any time off as FMLA or non-FMLA time off.
- Communicate with your department management and Human Resources Benefits any changes to your leave dates, intentions, needs, etc. As with any situation, the clearer the communication lines are, the better the outcomes.

Section 2 - General Process Overview

1. Obtain leave request form from Benefits in the HR Service Center. Requests for leave of absence should be made within 30 days of planned leave unless it is an emergency or otherwise unforeseen incident.
2. Obtain department management's approval and/or signature on Employee Request for Leave of Absence form.
3. If request is for a medical reason, have physician complete certification of health care provider form.
4. Return signed request form and physician certification form to Benefits in the HR Service Center within 15 calendar days.
5. Two weeks prior to expected return to work date, contact manager to discuss return to work/schedule.

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

6. Have physician complete the Return to Work Form.
7. Bring completed Return to Work Form to HR Benefits prior to or on first day of return to work (or fax form to HR Service Center at 651-254-2984).

Note: *It is your responsibility to make sure your health care provider returns the completed forms to the HR Service Center by the deadline.*

Section 3 - Contact Information

Via US Mail: Human Resources Benefits
Regions Hospital
Mail Stop 11502J
640 Jackson Street
St Paul, MN 55101

Via interoffice mail: Human Resources Benefits, Mail Stop 11502J

Or by fax: (651) 254-2984

The HR Service Center is located in the North Building, room C214, and is open Monday through Friday, 7:00 a.m. - 5:00 p.m., 651-254-3284

Section 4 – Family Medical Leave

If the request for leave is due to your own medical condition, a family member with a health condition that requires you to care for them, or the birth or adoption of a child, you may qualify for a Family Medical Leave in accordance with the Family Medical Leave Act (FMLA). FMLA leaves are protected leaves that allow you to take up to 12 weeks of leave while retaining rights back to your current position. To qualify, you must have one year of employment and have worked a minimum of 1250 hours in the past year and must have a qualifying serious health condition. For more information on serious health condition see section 12. When you request a leave of absence, the HR Benefits Administrator will talk with you to determine if you qualify for an FMLA leave. Refer to the Regions Hospital FMLA policy (RH-HR-HR-60-06-11) for more information. FMLA Leaves related to the adoption of a child will require completion of the Certification of Adoption/Foster Care Placement form obtained from Benefits in the HR Service Center.

Section 5 – Personal Leave

Personal leaves of absence are typically leaves for something other than medical conditions, such as taking time off for extended continuing education, travel, etc. However, if your need is a medical condition and you do not qualify for a FMLA leave (see Section 4), your request then becomes a request for a personal leave. Personal Leaves of absence are granted at the discretion of your department management. For more information, please read the Regions Hospital Personal Leave of Absence Policy (RH-HR-HR-60-06-08).

Section 6 - Certification of Health Care Provider

Leaves to care for a seriously ill immediate family member (see Section 12) or due to the employee's own serious health condition, require that certification of medical condition be provided to HR Benefits. Human Resources may require re-certification every 30 days. Completed Certification of Health Care Provider forms are to be sent to the address listed (see Section 3).

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

Section 7 - Pay While on Leave

You are required to use any available accrued benefit hours (see Section 12) when absent from work, due to any reason. If all accrued benefit hours are exhausted while on leave, the remainder of the leave is unpaid.

Section 8 - Short Term Disability (STD)

Leaves of absence due to pregnancy or to your own medical condition when you are also enrolled in the Short-Term Disability plan, requires completion of the Assurant (Assurant Benefits Insurance Company) claim form. Once completed, the form is to be mailed by you **directly to Assurant.** If you are eligible to receive claim benefits from Assurant, and you are being paid for accrued time off hours from Regions Hospital, you may be receiving pay from both Assurant and Regions at the same time.

Section 9 - Long Term Disability (LTD)

If you are a regularly scheduled employee working .5 FTE or above at the onset of disability, you are eligible to receive LTD benefits after being disabled for six months regardless if enrolled in STD or not. Payment is 50% of pay while on LTD. Please direct questions regarding LTD, to Regions Hospital Human Resources Benefits at 651-254-0957.

Section 10 - Insurance Benefits While on Leave

You are responsible for your regular benefits premium payments that are typically payroll deducted while you are on leave of absence. As long as you are receiving pay for any accrued benefit hours, the regularly scheduled premiums will continue to be deducted from payments received from Regions Hospital.

If you are no longer receiving funds from Regions Hospital while on a leave, your regularly scheduled premiums will go into arrears and be deducted from your paycheck upon returning to work from a leave of absence. If you fail to return from your leave of absence, you will be expected to reimburse Regions Hospital for the premiums due. If the group health plan coverage is dropped, you will be required to wait until the next open enrollment period to re-enroll in the plans.

Section 11 - Return to Work

It is your responsibility, while on leave, to contact Human Resources Benefits **and** your department management informing both of your intent to return to work, two weeks prior to the conclusion of your leave.

If you are returning to work after being on leave due to your own health condition, you are required to provide a Return to Work Clearance from your health care provider. The clearance is to provide any restrictions that may prohibit you from returning to full duty.

The right to return to work may be denied until a clearance has been provided and a determination has been made as to whether your department can accommodate your health care provider's statement of restrictions. Regions may request an examination by another health care provider.

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

Section 12- Definitions

Arrears

Accumulated benefit premiums that are due to Regions Hospital as a result of payroll deductions not available. Arrears are typically collected on the next available check payments upon return from leave of absence. Premium payments are only doubled until arrear is paid off. For example, if 6 pay cycles are missed for benefit deductions, upon return from LOA, the next 6 pay checks will have double benefit deductions for the arrears balance to reduce to zero. If benefit premiums are not collected, the benefit coverage is cancelled.

Benefit Hours

Accrued balances of time off hours, including: PTO; holiday; old or frozen vacation; extended or frozen sick leave

Immediate Family Members

- Domestic Partner: An individual who is not married and sole partner to an unmarried employee, at least 18 years of age or older and lives in the same residence with an employee with the intent to reside together permanently. A domestic partner may be of the same or opposite sex.
- Parent: A biological parent or an individual who acted in the place of a parent (“in loco parentis”) when the employee was a child. This term does not include parents-in-law.
- Spouse: A husband or wife as defined or recognized by state law.
- Son or Daughter (Child): A biological, adopted, foster child, stepchild, legal ward, or child of a person who acted in the place of a parent (“in loco parentis”) who is under 18, or if the child is over age 18 the child must be incapable of self-care or the child must have a mental or physical disability as defined by the Americans with Disabilities Act.

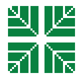
Serious Health Condition - an illness, injury, impairment or mental or physical condition that involves:

- Inpatient care in a medical care facility, including any period of inability to work or perform other regular daily activities due to the serious health condition, or any subsequent treatment in connection with such inpatient care.
- Continuing treatment by a health care provider, involving any period of inability to work or perform regular daily activities for more than three consecutive days.
- Any period of incapacity due to pregnancy.
- Chronic serious health conditions (e.g., asthma and diabetes) or conditions which require multiple treatments (e.g., dialysis and chemotherapy).

Absences which do not require inpatient care and are not chronic serious health conditions must generally be for more than three consecutive days. In the absence of complications, routine treatments and short term conditions ordinarily do not constitute a serious health condition

+++

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

 **HealthPartners/GHI**

Subject **The HIPAA Security Rule**	**Attachments** ☐ Yes ☒ No
Key words Computers, PC, E-Mail, Internet, Intranet, Passwords, Data, Information, Confidentiality, Availability, Integrity, Viruses, Education, Access, Use, PHI, e-PHI, Identifying Information, Privacy, Social Media	**Number** GHI-HR-HR-C206
Category Human Resources	**Effective Date** 4-21-05
Manual HealthPartners/GHI Human Resources Policy Manual	**Last Review Date** 4-12-2012
Issued By Human Resources and IS&T Security Management	**Next Review Date** 2-2013
Applicable All employees, officers, board members, vendors, contractors, residents, interns, trainees, temporary workers, volunteers, and other members of the workforce.	**Origination Date** 4-21-05 **Retired Date** N/A
Review Responsibility Human Resources and IS&T Security Management	**Contact** Human Resources or IS&T Security Management

I. PURPOSE

The purpose of this Policy is to ensure that the organization is in compliance with the security requirements under the Health Insurance Portability and Accountability Act (HIPAA) Security Rule. The HIPAA Security Rule specifically focuses on the safeguarding of electronic protected health information (e-PHI). It is designed to protect confidential healthcare information through security standards. There are 18 information security standards in three areas that must be met to ensure compliance with the HIPAA Security Rule:

Administrative Safeguards: Documented policies and procedures for day-to-day operations; managing the conduct of employees with e-PHI; and managing the selection, development and use of security controls.
Physical Safeguards: Security measures meant to protect an organization's electronic information systems, as well as related buildings and equipment, from natural hazards, environmental hazards and unauthorized intrusion.
Technical Safeguards: Security measures that specify how to use technology to protect e-PHI, particularly controlling access to it.

II. POLICY

The organization values their Patients and Members' privacy and security, recognizing that safeguarding information is important to establishing and maintaining trust. The organization wants to ensure Patients and Members feel safe sharing the personal details about their lives and health with the organization. Patients and Members trust the organization to keep their personal information safe, which enables the organization to provide them with the best health plan and healthcare services.

Group Health, Inc. management retains the right to interpret and/or change current policies and procedures as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

This Policy describes the expectations of employees, providers, agents and Business Associates regarding the protection of Member and Patient information. It also provides a framework for the organization and its business units to develop maintain and adhere to written policies, standards and procedures to prevent inappropriate access, misuse and compromise of Member and Patient information consistent with applicable laws and accreditation standards. All security policies and standards are located on the organization's intranet.

III. PROCEDURE(S)

BUSINESS UNITS RESPONSIBILITES

Business units will adopt written procedures and operational practices to implement the requirements of this Policy and the HIPAA Security Standards. Business units are expected to establish security controls and procedures that are in compliance with the organization's security policies and standards.

Administrative Safeguards

1.0 Security Management Process. The organization will identify and analyze potential risks to e-PHI and implement security measures to reduce risks and vulnerabilities to a reasonable and appropriate level. The measures include: an inventory of e-PHI systems and owners, conducting risk assessments, implementing a risk management program, deploying security policies and procedures, implementing a sanction policy, implementing a review and audit process for system activity, and standard operating procedures.

2.0 Security Personnel. The organization will designate its Senior Vice President and CIO of Information Services and Technology as its Security Official. The Security Official is responsible for the development and implementation of the security policies and procedures. The Security Official may delegate these responsibilities to appropriate personnel or to other committees, as deemed appropriate, so long as the Security Officer retains ultimate accountability for his/her delegated actions. Oversight is provided by the Senior Management Privacy and Security Review Group.

3.0 Workforce Training and Management. The organization will provide appropriate authorizations and supervision of workforce members who work with e-PHI. Workforce members will receive training on security policies and procedures. Appropriate sanctions will be applied against workforce members who violate the policies and procedures.

4.0 Information Access Management. The organization will implement policies and procedures for authorizing access to e-PHI only when access is appropriate based on the user or recipient's role (role-based access).

5.0 Security Awareness and Training. The organization will implement a security awareness and training program for members of its workforce (including management). The program will include: training needs assessment, training strategy and program management plan, development of program content, materials and methods, implementing security reminders, training workforce members on procedures for protection against viruses and malware, password management, monitoring log-in attempts, reporting discrepancies, and applicable security topics to protect e-PHI.

6.0 Security Incident Procedures. The organization will implement policies and procedures to address

Group Health, Inc. management retains the right to interpret and/or change current policies and procedures as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

security incidents. This will be accomplished by implementing incident response processes and procedures, deploying an Incident Response Team, identifying and responding to suspected or known security incidents and mitigating harmful effects of known security incidents.

7.0 Contingency Planning. The organization will establish policies and procedures for responding to an emergency or other occurrence (e.g., fire, vandalism, system failure, and natural disaster) that damages systems that contain e-PHI. This will be accomplished by developing contingency planning policy, conducting an applications and data criticality analysis, identifying preventive measures to avoid loss of critical service operations, develop recovery strategy, data backup plan and disaster recovery plan, and an emergency mode operation plan.

8.0 Evaluation. The organization will perform a periodic technical and nontechnical assessment of how well its security policies and procedures meet the requirements of the Security Rule. This includes determining whether to engage internal or external evaluation resources for examining security controls of e-PHI, use an evaluation strategy and tool that considers all elements of the HIPAA Security Rule and the level of compliance, integrations and maturity of the security safeguards to protect e-PHI, conduct, document and repeat evaluations periodically.

9.0 Business Associate Contracts and Other Arrangements. The organization may permit a Business Associate to create, receive, maintain, or transmit e-PHI on the organization's behalf only if the organization obtains satisfactory assurances that the Business Associate will appropriately safeguard the information. The organization will ensure Business Associate Agreements and other contracts include language to the effect that the Business Associate will appropriately safeguard e-PHI in accordance with the HIPAA Security Rule.

Physical Safeguards

10.0 Facility Access Controls. The organization will limit physical access to its electronic information systems and facilities in which they are housed, while ensuring that authorized access is allowed. This will be accomplished by implementing policies and procedures for a facility security plan, access control and validation, and maintenance records.

11.0 Workstation Use. The organization will implement policies and procedures to protect its workstations (computers). This includes an inventory of workstations and computing devices, the proper use and performance of workstations and analysis of the physical surroundings to prevent unauthorized access.

12.0 Workstation Security. The organization will implement physical safeguards for all workstations that access e-PHI, to restrict access to authorized users. This includes identifying all methods of physical access to workstations, how they are accessed by employees and nonemployees (locations, public areas, laptops, etc.), analysis of areas that are more vulnerable to unauthorized use and theft, and physical safeguards to limit access (locked doors, screen barriers, cable locks, cameras, guards).

13.0 Device and Media Controls. The organization will apply procedures regarding the transfer, removal, disposal, and re-use of electronic media, to ensure the appropriate protection of e-PHI. This includes the receipt and removal of hardware and electronic media that contain e-PHI into and out of its facilities and the movement of these items within the facility.

Technical Safeguards

14.0 Access Controls. The organization will implement technical policies and procedures that allow only authorized persons and authorized software programs, access to e-PHI. This will be accomplished by implementing controls to network and system resources for unique user identification to identify and track user identities. This includes defining user roles, where the e-PHI data is housed, remote access, a formal policy and procedure for access control, an emergency access procedure, automatic logoff for systems, encryption of mobile devices and stored e-PHI.

15.0 Audit Controls. The organization will implement hardware, software, and/or procedural mechanisms to record and examine access and other activity in information systems that contain or use e-PHI. This includes determining the activities that will be monitored and how they will be monitored: what to record and examination of significant activity on information systems that contain or use e-PHI. This will occur through reports, reviews, logs and a formal process to address misuse, abuse and fraudulent activity.

16.0 Integrity Controls. The organization will establish policies and procedures to ensure that e-PHI is not improperly altered or destroyed, put electronic measures into place to confirm e-PHI has not been altered or destroyed: audit, logging, quality control processes, and access control techniques. This includes identifying all users with authorized access to e-PHI with the ability to alter or destroy data and scenarios that may result in modification to e-PHI, plus possible unauthorized sources that may be able to intercept and modify data.

17.0 Person or Entity Authentication. The organization will implement procedures to verify that a person or entity seeking access to e-PHI is the one claimed; are appropriately authenticated before access is granted, including establishing the validity of a transmission source and/or verifying an individual's claim that they are authorized for specific access privileges to e-PHI and systems.

18.0 Transmission Security. The organization will implement technical security measures that guard against unauthorized access to e-PHI being transmitted over an electronic communications network. This includes implementing encryption mechanisms to protect e-PHI in transmission across the internet.

The organization will take appropriate disciplinary action against Personnel who breach this Policy, the Security Policies and Standards and other organizational policies and procedures. Such disciplinary action will be imposed fairly and consistently.

IV. DEFINITIONS

For purposes of this Policy, the following definitions apply:

"Business Associate" means a third party that performs services on behalf of, or provides services to, the organization that involve the disclosure of Protected Information to the Business Associate for that Business Associate's use or further disclosure in connection with those services. "Business Associate" does not include health care providers who receive or use Protected Information in order to treat an individual. "Business Associate" also does not include other third parties described in HIPAA.

"Controls" or "Security Controls" means a combination of policies, standards, procedures and technical

controls to achieve confidentiality, integrity, availability and physical security of e-PHI.

"Electronic Protected Health Information (EPHI)," "Protected Information," "Protected Health Information (PHI)," "Identifying Information," "Sensitive Information," "Health Record," and "Non-Public Personal Information (NPI)," means health information in electronic form variously identified in law or regulation as Protected Information. Accordingly, Protected Information includes information, including demographic, health or financial information, regardless of format that:

(1) (a) identifies (or could reasonably be used to identify) a Patient or Member; and
(b) is not generally known by or made available to the public;

and

(2) (a) is collected or received by or on behalf of the organization from
(i) a Member (or his/her authorized representative);
(ii) a Patient (or his/her authorized representative);
(iii) a Member's or Patient's health care provider or his/her agents; or
(iv) a Member's or Patient's third party payor or health plan sponsor or his/her agents;

and

(b) relates to or facilitates the past, present or future physical or mental health condition of the Member or Patient, payment, or the past, present or future provision of health care to the Member or Patient.

"HealthPartners" means: Group Health Plan, Inc. (d/b/a HealthPartners Medical Group and Clinics); HealthPartners Administrators, Inc.; HealthPartners Insurance Company; HealthPartners Institute for Medical Education; HealthPartners Research Foundation; and their respective related organizations and operating units.

"HIPAA" means the Security Regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, including The Health Information Technology for Economic and Clinical Health Act (HITECH) enacted as part of the American Recovery and Reinvestment Act of 2009.

"Member" means an individual who is enrolled in, or who has applied to be enrolled in, a health plan underwritten or administered by HealthPartners, including, without limitation, fully-insured, self-insured and government-sponsored health benefit plans.

"Patient" means an individual who has received (or has an appointment to receive) health care treatment from HealthPartners, or whose treating physician has sought a professional consult from HealthPartners regarding that individual.

"Personnel" or "staff" means anyone employed by the organization or under contract or other arrangement with the organization to act on its behalf. This includes union and non-union employees, officers, physicians, Board members and volunteers, and any student, resident or intern under the supervision of the foregoing.

"Security Officer" means the individual with assigned responsibility for the development, approval and implementation of this Policy.

"Security Standards" or "Standards" means approved and written business standards adopted by the Security Council to support this Policy.

V. COMPLIANCE

Failure by an individual to comply with this Policy or with the Security Policies and Standards will

result in appropriate disciplinary action, up to and including dismissal.

VI. OTHER RESOURCES

The HIPAA Security Rule, 45 CFR Part 160 and Subparts A and C of Part 164

Privacy Policy CI-002
Records Retention Policy CI-10
Security Policies and Standards located on the intranet: ERIC and myPartner via Compliance 360
Backup and Offsite Storage Policy GHI-SEC-100-45
E-Commerce Policy GHI-SEC-100-4
Electronic Data Classification Policy GHI-SEC-100-10
Electronic Media Handling Policy GHI-SEC-100-24
Encryption Policy GHI-SEC-100-7
Information Risk Management Policy GHI-SEC-100-17
Information Security Policy GHI-SEC-100-1
Logging and Monitoring Policy GHI-SEC-100-22
Management Commitment to Security Policy GHI-SEC-100-9
Security Awareness Education and Training Policy GHI-SEC-100-12
Information Security Incident Reporting Policy GHI-SEC-100-28
User Access Management Policy GHI-SEC-100-5
User Responsibilities Policy GHI-SEC-100-25

VII. APPROVAL(S)

Human Resources Leadership Team and IS&T

Group Health, Inc. management retains the right to interpret and/or change current policies and procedures as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

+++

THE 18 HIPAA IDENTIFIERS

If information about a patient or member **contains *none* of these 18 identifiers,** then the remaining information is considered de-identified; unless the Covered Entity is aware that the remaining information could be used alone or in combination with other information to identify the individual.

1) Name
2) Any geographic subdivision smaller than a state, including street address, city, county, precinct or zip code. (In some circumstances, first 3 digits of the zip can be retained.)
3) All elements of dates (except year) that relate directly to an individual, including birth date, admission or discharge date, date of service, date of death. Also, all ages over 89 and all elements of dates (including year) indicating such age, unless aggregated into a single category of age 90 and over.
4) Telephone numbers (home, work, cell, etc.)
5) Fax numbers
6) Email addresses
7) Social Security Numbers
8) Medical record numbers
9) Health plan beneficiary (member) numbers
10) Account numbers
11) Certificate/license numbers
12) Vehicle identifiers and serial numbers, including license plate numbers
13) Device identifiers and serial numbers
14) Web addresses/URLs
15) Internet Protocol (IP) address numbers
16) Biometric identifiers, including fingerprints, iris images and voice prints
17) Full face photographic images and any comparable images; and
18) Any other unique identifying number, characteristic or code (except re-identification code, so long as the re-identification code is not derived from the identifiable information and the decoding information is not disclosed)

+++

Regions Hospital

Subject	Attachments
Injuries While On Duty	☐ Yes ☒ No
Key words injuries, duty	**Number** RH-SF:30
Category Environment of Care,Service & Work (EC)	**Effective Date** December 31, 2010
Manual Safety & Security	**Last Review Date** December 31, 2010
Issued By Environment of Care	**Next Review Date** December 31, 2013
Applicable	**Origination Date** August 1, 2005
	Retired Date
Review Responsibility Environment of Care Committee	**Contact** Safety Department

I. POLICY

It is the policy of Regions Hospital to be actively involved in assisting the employee during the term of inability to work and to assist all injured employees in returning to productive work. This policy reduces overall workers' compensation costs and helps the injured employee to once again become a productive worker.

Applies to all Regions Hospital, and through contractual agreement, Integrated Home Care and Transitional Care employees.

1. A Regions Hospital Employee/Injury/Illness/Blood and Body Fluid Exposure Report Form must be completed by supervisor/designee and employee jointly. This form must be completed within 24 hours of the injury and sent to Employee Health Service immediately. Copies will be sent to the Workers' Compensation office and to the injured individual's department.

2. If the injury requires medical attention or advice, the Nurse Careline is the first contact point. All work injuries/illnesses/blood and body fluid exposures requiring medical attention must be channeled through the Nurse Careline: (952) 883-5484, available 24 hours a day, 7 days a week.

Failure to comply with the requirement of contacting the Nurse Careline when medical attention or advice is deemed necessary can result in the employee's department being responsible for costs incurred for unauthorized visits to the Emergency Room. Emergency visits will be reviewed regarding necessity.

Note: Even though the employee has the option of seeking treatment from their regular treating doctor, they must follow the above procedure and must submit themselves to examination by Occupational Medicine/ Employee Health physician or other designated physician if requested by the Workers' Compensation staff and at reasonable times thereafter for follow up.

All work-related injuries involving lost work time must be reported to the Workers' Compensation office immediately by calling (651) 254-2273.

3. An active role will be taken by the Workers' Compensation Coordinator, the supervisor, the physicians and the employee to implement a return-to-work program as quickly as possible. Light duty assignments and job modification will be provided to help and support the returning employee when needed and when possible.

4. When appropriate, the Workers' Compensation Coordinator in conjunction with our third party administrator (TPA) will assign a Qualified Rehabilitation Consultant (QRC) to assist with a return to work program.

5. Administering the Workers' Compensation program will be done by the Workers' Compensation Coordinator.

6. Guidelines for lost time and status:

   a. Lost time will be paid in Workers' Compensation benefits as mandated by the State of Minnesota.

   b. Employees may choose to supplement the Workers' Compensation benefit with accrued time (PTO or Extended Sick Leave) in an amount that combined with the Workers' Compensation benefit would be equal to the regular weekly wage. Employees who choose not to use accrued time to supplement Workers' Compensation benefits will not otherwise be eligible to use accrued time until they return to work at Regions.

   c. During the entire period that an employee is off work due to a work comp injury, the Hospital will maintain and contribute to the employee's coverage under the Hospital's group health, dental and life insurance plans in the same manner as before the injury. The employee remains responsible for their portion of the insurance premiums.

      If the employee is working light duty and receiving a paycheck from Regions Hospital, the employee's share of the insurance premiums will be deducted from the employee's paycheck. If the employee is on total disability due to the work comp injury, the Hospital will bill the employee for their share of the premiums.

   d. Employees who are receiving Workers' Compensation benefits and working in a light duty assignment, will accrue PTO if they meet the same timecard hours threshold as for active employees.

   e. Employees will accrue credited service hours only for time worked or for accrued time used.

   f. In the event an employee absence due to a work related injury does not qualify for Workers' Compensation solely because of a statutory waiting period (currently three (3) days), the employee may use their accrued PTO and/or Extended Sick Leave up to a maximum of the statutory waiting period.

   g. As with all Personnel policies, the Hospital reserves the right to modify, revoke, suspend, terminate, or change this policy/procedure in whole or in part, at any time, with or without notice; however, no change will be made that conflicts with mandated state workers' compensation laws.

<u>APPROVAL(S)</u> Environment of Care Committee

+++

Regions Hospital®

Subject **Mobile Computing and Storage Devices Policy**	**Attachments** ☐ Yes ☒ No
Key words Mobile, laptop, cameras, smartphones, portable, USB/flashdrives, CD-ROM, tele-work, handheld, PDA, remote access	**Number** **REG-SEC-100-6**
Category Management of Information (MI)	**Effective Date** **October 1, 2009**
Manual Information Security Policy	**Last Review Date** **February 21, 2011**
Issued By IS&T Security Management	**Next Review Date** **February 21, 2012**
Scope This policy applies to Regions Hospital and all of its operating units and related organizations (collectively, "HealthPartners /REG").	**Implementation Date** **October 1, 2009** **Retired Date**
Roles and Responsibilities Owner: IS&T Security Management Reviewer: IS&T Sr. Vice President and CIO	

I. PURPOSE

The purpose of this policy is to establish an authorized method of controlling mobile computing and storage devices that contain or connect to information resources on the HealthPartners/REG network.

II. POLICY

Approved Devices
Mobile computing and storage devices containing or accessing HealthPartners/REG information must be approved prior to connecting to the HealthPartners/REG network or related systems. This pertains to all devices connecting to the HealthPartners/REG network, regardless of ownership.

- Mobile computing and storage devices include, but are not limited to: laptop computers, tablet computers, smartphones, pagers, cameras, personal digital assistants (PDAs), Universal Serial Bus (USB) storage devices, key fobs (hard tokens), Compact Discs (CDs), Digital Versatile Discs (DVDs), flash drives, handheld wireless devices, camera memory sticks/cards, and any other existing or future mobile computing or storage device owned by HealthPartners and/or may connect or access HealthPartners/REG applications and the network. Includes devices that store or access sensitive data: patient, member, employee, and company confidential data.

- A risk analysis for each new media type shall be conducted and documented prior to its use or connection to the HealthPartners/REG network unless the media type has already been

approved by the COS Standards Committee. The COS Standards Committee will maintain a list of approved mobile computing and storage devices.

- Teleworking activities conducted on personal computers must maintain protections when connecting to the organizations' network: physically secured, up-to-date anti-virus software, firewall protection, operating system patches and remote access only by authorized personnel. Reference the Remote Access Policy, REG-SEC-100-60, the Network Access Control Policy, REG-SEC-100-26 and User Responsibilities Policy, REG-SEC-100-25.

- Only HealthPartners approved mobile storage devices with encryption enabled will be allowed to write back to the mobile storage device. All other mobile storage devices will only be allowed to read from the mobile storage device. Real-time virus scanning of the mobile storage device will be enabled to further mitigate any malicious code threats.

- Patient images must only be taken with approved HealthPartners cameras. Patient photos should not be taken with personal smartphones, personal cameras or any other personal device. Reference the User Responsibilities Policy REG-SEC-100-25 and the Organizational Privacy Standard for Photography, Videotaping and Other Recordings of Patients and Members.

- Corporate e-mail can only be synched to a HealthPartners approved phone or PDA and only with approved Wireless E-mail Access software from the Desktop Standards list (GoodLink or ActiveSync). It is prohibited to synch a HealthPartners approved phone to another phone or to synch to your personal accounts (i.e. personal folders, email, contacts, & calendars) and/or to use unapproved Wireless E-mail Access software for data synchronization to the HealthPartners network (MobileMe). Please note, it is acceptable to view your personal e-mail from your phone, but prohibited to synch your HealthPartners e-mail to your personal e-mail account via your phone.

- Some smartphones and PDA devices have the ability to function as a personal Wi-Fi or hotspot. This capability is not allowed on or at any HealthPartners facilities and should be disabled. These radio frequencies can interfere with other equipment in use at HealthPartners facilities.

Data Storage

Mobile computing devices and portable storage devices that contain any protected HealthPartners/REG information must be encrypted to protect the data while it is being stored. Individuals or their legal representative can consent to receiving their own information in an unencrypted format (i.e. unencrypted CD).

- Data must be saved on the HealthPartners/REG network, i.e. on a share drive and not the device. For example, save a spreadsheet containing patient data on the HealthPartners' share drive and not on a laptop's desktop.
- Cameras containing patient images must not be used as a data store device; the photo must be immediately downloaded and saved to the patient's record, then deleted from the camera's memory and/or the memory stick/card.
- The only exception is for the use of USBs or flash drives, wherein the primary storage remains the HealthPartners/REG network and the data is deleted from the devices when the business purpose is not needed anymore.

Employee / Contractor / Consultant Responsibilities
Users of mobile computing and storage devices must diligently protect such devices from loss of equipment and disclosure of Protected Information belonging to or maintained by HealthPartners / REG.

- Keep mobile computing and storage devices secure by keeping on you or stored in a locked drawer. Keep laptops cable-locked to workstations or secure in a locked drawer.
- Notify the IS&T support center immediately when a mobile computing or storage device may have been lost or stolen.
- While incidental personal use is allowed; HealthPartners owned mobile computing and storage devices should be used only for HealthPartners business.

HealthPartners/REG Responsibilities
IS&T Security Management is responsible for the mobile computing and storage device policy at HealthPartners and shall conduct a risk analysis to document safeguards for each device to be used on the network or on equipment owned by HealthPartners / REG. IS&T Security Management is responsible for developing any related standards and procedures for implementing this policy.

The COS Standards Committee will maintain a list of approved mobile computing and storage devices and will make the list available on the Employee Resource & Information Center at ERIC > Work Tools > Phone Skills, Tools and Standards > Smartphones > Smartphone Models.

III. PROCEDURE(S)

N/A

IV. RISK

Adherence to HealthPartners' policies and procedures reduces the risk of exposure of HealthPartners/REG information assets.

V. DEFINITIONS

CD - A compact disc (disk) is a small, portable, round medium made of molded polymer for electronically recording, storing, and playing back audio, video, text, and other information in digital form.

DVD - The digital versatile disc stores much more information than a CD and is used for playing back or recording movies. The audio quality of a DVD is comparable to that of current audio compact discs. A DVD can also be used as a backup media because of its large storage capacity.

Email - The electronic transmission of information through a electronic mail protocol such as SMTP or IMAP. HealthPartners/REG has standardized on Microsoft Outlook email client.

Flash Drive - A plug-in-play portable storage device that uses flash memory and is lightweight enough to attach to a key chain. The computer automatically recognizes the removable drive when the device is plugged into its USB port. A flash drive is also known as

thumb or USB drive. A flash drive can be used in place of a floppy disk, Zip disk, CD, or DVD.

Handheld Wireless Device – A communication device small enough to be carried in the hand or pocket and is also known as a personal digital assistant (PDA). Various brands are available, and each performs some similar or some distinct functions. It can provide access to other internet services, can be centrally managed by a server, and can be configured for use as a phone or pager. In addition, it can include software for transferring files and maintaining a built-in or synchronized address book and personal schedule.

Media Type - For the purposes of this policy, the term “media type” is interchangeable with “mobile device”. Not to be confused with media makes, models, or brands.

Media Type Model – Refers to the brand of media device such as Treo, Palm, or Blackberry.

Mobile Devices – Mobile media devices include, but are not limited to: PDAs, USB port devices, CDs, DVDs, flash drives, handheld wireless devices, and any other existing or future media device.

PDA - The personal digital assistant is also known as a handheld. It is any small mobile hand-held device that provides computing and information storage and retrieval capabilities for personal or business use, often for keeping schedule calendars and address book information.

VI. COMPLIANCE

Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VII. MONITORING AND MEASUREMENT

This policy will be reviewed annually to determine its timeliness and relevance.

VIII. ATTACHMENTS

N/A

IX. OTHER RESOURCES

ISO 27002:2005 Section 11.7.1, Mobile Computing and Communications
REG-SEC-200-6-1-Cell Phone - PDA devices standard
REG-SEC-100-60, Remote Access Policy
REG-SEC-100-26, Network Access Control Policy
REG-SEC-100-25, User Responsibilities Policy

+++

HealthPartners®

ORGANIZATIONAL PRIVACY STANDARDS:

Photography, Videotaping and Other Recordings of Patients and Members

Definitions:

Recording and **Record** means photographing, videotaping, audiotaping or otherwise capturing a patient or member's image or voice on film or in digital format.

Recording Authorization means a document signed by a patient or member giving the organization permission to Record the patient or member.

Basic Rules:

1. A Recording Authorization, signed by the patient or member (or the patient or member's legal representative) must be obtained before we can Record the patient or member's voice or full or partial image for any purpose, including, without limitation:
   - **Treatment or healthcare operations, such as:**
     - Medical assessment
     - Performance evaluation and improvement
     - Workforce (internal) education
   - **Other activities of the organization, such as:**
     - Community (external) education
     - Promotion, marketing, public relations or advertising
   - **Activities of a third party, including those done:**
     - At the request of media
     - At the request of any other third party, including the patient or his or her family

2. The Authorization must fully describe how the Recording will be used by the organization and whether, and for what purpose, the Recording will be used or disclosed for external purposes.

3. If the organization subsequently wishes to use or disclose a Recording for a particular purpose not described in a previously-signed Authorization, an additional Recording Authorization must be obtained from the patient or member.

4. Recordings of patients or members made for treatment, healthcare operations or other activities of the organization may only be made with cameras or other equipment owned by the organization. No personal cameras, cellphones or other Recording equipment may be used for Recordings.

5. Whenever possible, Recordings should not include identifiable information or characteristics (such as tattoos, jewelry or identifiable body images).

6. A Recording belongs either to the organization or the member or patient and may be used only for Authorized purposes.

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

7. All Recordings must be stored securely, either in the patient's or member's record or in another secure manner.

Exceptions:

1. If a patient (or his or her legal representative) is unable to sign a Recording Authorization at the time the organization wishes to make a Recording for purposes of treatment of the patient or the organization's healthcare operations, a Recording may be made, so long as:
   - The Recording remains in the control of the organization, and
   - The organization obtains the patient's (or legal representative's) written Recording Authorization prior to the organization's use of the Recording.

   Note: This exception is not available for Recordings to be made for any non-treatment or non-healthcare operations purpose.

2. Authorization prior to diagnostic imaging or audiology testing should be obtained through the informed consent process.

3. A Recording Authorization is not required prior to Recording a patient or member for facility security purposes.

Examples:

1. Physician wishes to photograph cosmetic surgery patient for before/after images to show other patients. Patient must first sign written Recording Authorization that describes this purpose. Photographs must be taken only with camera owned by the organization and securely maintained by the organization.

2. Patient brought in to Emergency Department with severe trauma. Due to nature of unusual trauma, trauma team wishes to Record certain procedures for workforce training, but due to his condition, patient is unable to sign Recording Authorization. Recording may be made without patient's Authorization. However, prior to use of the Recording in training, the hospital must obtain the signed Recording Authorization of the patient or his or her legal representative.

3. The organization wishes to photograph several members for use in a new marketing campaign. Before taking these photographs, the organization must have each member sign a Recording Authorization form that explains the purpose of the Recording and how it will be disclosed.

4. Upon admission to the hospital, a patient signs a Recording Authorization form giving the organization permission to use her photograph for professional education of our employed physicians and our residents. If one of the residents then wants to prepare and present a case study at a national conference using the patient's photograph, an additional Recording Authorization describing this expanded use and disclosure must be obtained from the patient.

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

ORGANIZATIONAL PRIVACY STANDARDS:

Photography, Videotaping and Other Recordings of Patients and Members

Important Reminder:

These are important standards for you to follow. If you don't follow them, you may be subject to discipline.

Other Resources:

Forms:

- *Recording Authorization* (Consent for Photography, Videotaping and Audiotaping for Medical Evaluation, Education or Performance Improvement)
- *Recording Authorization* (Consent for Photography, Videotaping and Audiotaping at the Request of Patient or Another External Party)
- *Recording Authorization* (Consent for Photography, Videotaping and Audiotaping at the Request of Media)

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

+++

Regions Hospital®

Subject Privacy Policy	Attachments ☐ Yes ☒ No
Key words Confidentiality, HIPAA, Security, Covered Entity, ACE, Notice of Privacy Practices, PHI, EPHI, Protected Information, Health Record, NPI, Identifying Information	**Number**
Category Management of Information (MI)	**Effective Date** **January 1, 2009**
Manual Health Information Management Manual	**Last Review Date** **2008**
Issued By Office of Integrity and Compliance	**Next Review Date** **2010**
Applicable All employees, officers, board members, contractors, volunteers of Regions Hospital, RHSC, Inc. and other designated individuals.	**Origination Date** **2003** **Retired Date**
Review Responsibility Privacy Official, Regions Hospital Compliance Committee	**Contact** Office of Integrity and Compliance

I. **PURPOSE** At Regions our ability to deliver and finance high quality care and service requires that we collect and generate many different kinds of information. Each time a person enrolls in one of our health plans or receives care from one of our clinicians, he or she is entrusting us with extremely sensitive information. The purpose of this Policy is to ensure that we deserve each Patient's trust by protecting their personal information form improper use and disclosure.

This Policy describes the expectations we have of our employees, providers, agents and business associates regarding the protection of Patient information. It also provides a framework for the organization and its business units to develop, maintain and adhere to written standards and procedures as needed for the appropriate access, use and disclosure of Patient information consistent with applicable laws and accreditation standards.

II. **POLICY**

1.0 Regions is committed to safeguarding the privacy of our Patients and others who have entrusted us with their Protected Information. We handle Protected Information in accordance with applicable legal, and accreditation standards. We ensure that we maintain appropriate oversight of our privacy practices, and we adopt consistent and clear disciplinary measures for breaches of this Policy.

Business units will adopt written procedures, as appropriate, to implement the requirements of

this Policy and the Privacy Standards.

2.0 Notice of Privacy Practices. Regions will notify Patients, and others as required of its practices regarding the access, use and disclosure of Protected Information through its Notice of Privacy Practices. The Notice of Privacy Practices contains three sections: Summary Notice, Member Notice (applicable to HealthPartners/health plan activity) and Patient Notice, each of which may be distributed separately, as appropriate.

2.1 Notice to Patients ("Patient Notice"). Regions will routinely, in accordance with applicable laws, notify Patients of the ways in which its Care Delivery Functions and Health Research Functions use and disclose Protected Information, as well as Patients' individual rights with respect to such information.

2.2 Notice to Others. Where appropriate, Regions will notify providers, practitioners, and other interested parties, whether employed or under contract, of its policies and expectations regarding appropriate uses of, access to and amendment of Protected Information.

3.0 Consents, Authorizations and Opt-Outs. Regions will obtain consent or authorization from the Patient for the use and disclosure of Protected Information in accordance with applicable law, accreditation standards and the Privacy Standards.

3.1 Use of Information. In accordance with applicable law and this Policy, Regions may use Protected Information for purposes of Treatment, Payment and Health Care Operations without Patient Consent. However, Regions will first obtain Patient Authorization prior to using Protected information for purposes other than Treatment, Payment or Health Care Operations, unless otherwise permitted by law.

3.2 Disclosure of Information. Regions may disclose Protected Information as follows:

3.2.1 With Consent. Regions may disclose Protected Information in connection with Care Delivery Functions and Health Research Functions, so long as Consent, as required by law, is obtained, and the Notice of Privacy Practices is made available, in accordance with applicable law the Privacy Standards.

3.2.2 With Authorization. Regions will obtain Patients' Authorization when required by law, in accordance with the Privacy Standards, prior to using or disclosing Protected Information for purposes other than Treatment, Payment or Health Care Operations.

3.3 Option to Opt Out of Certain Disclosures. Patients may notify Regions that they do not wish Regions to share certain Protected Information with non-affiliated parties for particular activities, as required by law or otherwise identified by Regions. The Privacy Standards must be followed to ensure that Patients are appropriately informed of their "opt out" rights and how those rights, when applicable, may be exercised.

4.0 Minimum Necessary Standard. Personnel are permitted to access, use and disclose only the minimum amount of Protected Information that is reasonably necessary to accomplish the

authorized task. Under this standard, Personnel are prohibited from using their positions to gain access to the Protected Information of their friends, family members or coworkers, unless there is a work-related need to know, exercised in accordance with organizational policies and procedures. In addition, where information need not be identified to a particular Patient to accomplish a task, and where feasible, Regions will de-identify Protected Information. Business units will develop and implement written procedures and operational practices as appropriate to ensure that the minimum necessary standard is met.

5.0 Business Associates. Regions will execute written Business Associate Agreements that require third parties to, among other things, safeguard the confidentiality of all Protected Information, use Protected Information solely for the purpose and within the scope of the engagement, and, if appropriate, indemnify Regions against any damages resulting from the third party's inappropriate use of Protected Information.

6.0 Individual Rights. Regions will ensure that Patients are informed of their individual rights with respect to their Protected Information, as described by HIPAA and other applicable laws, and that the organization establishes standards and procedures to allow Patients to exercise those rights. Such rights include, but are not necessarily limited to, the right to access one's Protected Information, the right to request an amendment of one's Protected Information, the right to request alternative means of communication and special restrictions on the handling of one's Protected Information, and the right to complain to the organization and to appropriate regulatory authorities about Regions' privacy practices.

7.0 Documentation. Regions will appropriately document its activities related to the protection of Patient privacy and its compliance with applicable privacy laws. Such documentation will be retained in accordance with applicable law.

8.0 Discipline. Regions will take appropriate disciplinary action against Personnel who breach this Policy, the Privacy Standards and other organizational policies and procedures. Such disciplinary action will be imposed fairly and consistently.

9.0 Security. In addition to the protections identified in the preceding sections, Regions will safeguard Protected Information by adopting and implementing appropriate policies and procedures to ensure the security of Protected Information, including its transmission, storage and destruction.

10.0 Oversight and Compliance. The Regions Hospital Compliance Committee (the "Committee") will function as the privacy oversight committee for Regions Hospital, while the Enterprise Integrity Steering Committee will function as the privacy oversight committee for the ACE overall. The Committee's responsibilities will include:

- Supporting Regions' ongoing compliance with this policy;
- Advising, assisting and supporting the Privacy Official;
- Assessing Regions' privacy environment, understanding applicable privacy requirements, approving enterprise-wide privacy-related policies, and assessing privacy-related risk areas;
- Reviewing, as requested by the Privacy Officer, the need for appropriate corrective and/or disciplinary action for noncompliance with this policy;
- Ensuring that Committee members' respective areas of responsibility are effectively

implementing this policy, including, without limitation any identified corrective and disciplinary action;

- Reviewing this policy periodically and supporting any necessary improvements or modifications to help ensure Regions' compliance with applicable privacy-related laws, regulations and policies;
- Promoting privacy as an essential component of a culture of ethics and integrity in the organization.

11.0 Privacy Official. Regions has designated its Compliance Officer as its Privacy Official. The Privacy Official is responsible for the development and implementation of this Policy, the Privacy Standards and other privacy-related policies and procedures of the Regions ACE.

III. PROCEDURE(S) In addition to this Policy, the Regions ACE will adopt Privacy Standards that provide more detailed information about the privacy obligations of the organization and its Personnel. Likewise, the ACE, and its constituent organizations, may adopt specific written policies and procedures that describe how to carry out this Policy and the Privacy Standards. Individual business units may also, as appropriate, adopt additional written procedures to assist with implementation and compliance.

IV. DEFINITIONS For purposes of this Policy, the following definitions will apply:

"ACE" or "Affiliated Covered Entity" means legally separate Covered Entities that are affiliated and have designated themselves as a single Covered Entity for purposes of compliance with HIPAA. Regions and several of its affiliated organizations have designated themselves as an ACE through actions of their respective Boards of Directors.

"Authorization" means a Patient's specific permission to disclose their Protected Information to third parties for purposes other than treatment, payment or health care operations.

"Business Associate" means a third party that performs services on behalf of, or provides services to, Regions that involve the disclosure of Protected Information to the Business Associate for that Business Associate's use or further disclosure in connection with those services. "Business Associate" does not include health care providers who receive or use Protected Information in order to treat an individual. "Business Associate" also does not include other third parties described in HIPAA.

"Care Delivery Functions" means activities undertaken by Regions in order to provide and coordinate treatment to Patients.

"Consent" means a Patient's general permission for Regions to disclose their Protected Information to third parties for purposes of treatment, payment and health care operations.

"Covered Entity" means an entity subject to HIPAA.

"Health Research Functions" means activities undertaken by Regions in order to systematically evaluate and examine medical information, the results of which are intended to be shared in the public domain.

"HIPAA" means the Privacy Regulations promulgated under the Health Insurance Portability and

Accountability Act of 1996.

"Notice of Privacy Practices" means the written Notice of Privacy Practices provided to Patients.

"Patient" means an individual who has received (or has an appointment to receive) health care treatment from Regions, or whose treating physician has sought a professional consult from Regions regarding that individual.

"Patient Notice" means the portion of the Notice of Privacy Practices provided to Patients pursuant to Section 2.2 of this Policy.

"Personnel" means anyone employed by Regions or under contract or other arrangement with Regions to act on its behalf. "Personnel" includes union and non-union employees, officers, physicians, Board Members and volunteers, and any student, resident or intern under the supervision of the foregoing.

"Privacy Standards" means the standards attached to this Policy to assist Regions business units with developing, maintaining and adhering to written procedures and operational practices that conform to this Policy, as updated from time to time.

"Protected Information" means, for purposes of this Policy and the Privacy Standards, information variously identified in law or regulation as "Protected Health Information (PHI)," "Electronic PHI (EPHI)," "Identifying Information," "Health Record," "Non-Public Personal Information (NPI)." Accordingly, Protected Information includes information, including demographic, health or financial information, regardless of format, that

(1) (a) identifies (or could reasonably be used to identify) a Patient; and
(b) is not generally known by or made available to the public;

and

(2) (a) is collected or received by or on behalf of Regions from
- (i) a Patient (or his or her authorized representative);
- (ii) a Patient's health care provider or their agents; or
- (iii) a Patient's third party payor or health plan sponsor or their agents

and

(b) relates to or facilitates the past, present or future physical or mental health condition of the Patient, payment, or the past, present or future provision of health care to the Patient.

"Regions" means, for purposes of this policy: Regions Hospital, RHSC, Inc. and their related organizations.

V. <u>COMPLIANCE</u> Failure by an individual to comply with this Policy or with the Privacy Standards will result in appropriate disciplinary action, up to and including dismissal.

VI. <u>REFERENCES</u>
Health Plan Privacy Standards
Care Delivery Privacy Standards

Health Research Privacy Standards
Corporate Privacy Standards
Discipline for Breaches of Privacy and Privacy Policies - C211
Confidentiality of Patient/Member Information Policy -- Employee Access and Use - C201
HIPAA Security Policy (GHI) - C206
Record Retention Policy

VII. OTHER RESOURCES

Minn. Stat. §144.291-293
45 CFR 160 and 164 (Health Insurance Portability and Accountability Act of 1996)
15 USC 6801-6809 (Gramm Leach Bliley Act)
Minn. Stat. Chapter 13 (Minn. Data Practices Act)
Minn. Stat. §§ 62D.145; 62M.08; 62Q.021; 72A.497; 72A.499; 72A.502 (Laws governing HMOs, health plans, health insurers and UROs)
15 USC 1681-1681u (Fair Credit Reporting Act)
Minn. Stat. § 325L.01-19 (Minnesota's Electronic Signatures Act)
15 USC 7001 (Federal Electronic Signatures Act)
45 CFR 46 (Federal Research and IRB Regulations)

VIII. APPROVAL(S)

Tobi Tanzer
Vice President of Integrity and Compliance and
Chief Compliance Officer and Privacy Officer

IX. ENDORSEMENT

Enterprise Integrity Steering Committee
Regions Hospital Compliance Committee

+++

Caller Is:	Identity Verification &Authorization Requirements	Exceptions
Member	• Identity must be verified and documented in the member's record. (See requirements below.)	
Parent for Minor Child (Up to age 18)	• Identity must be verified and documented in the member's record. (See requirements below.) • No authorization is required to share member PI.	• An authorization is required to share member PI, if the child is an emancipated minor. • No claims information related to sensitive diagnosis will be disclosed without an authorization, according to Minnesota State Law on minor consent. Minnesota Statutes 2002, 144.343
Other Family Members or Friends	• Identity must be verified and documented in the member's record. (See requirements below.) • Verbal or Written authorization is required to share member PI. Verbal consents will remain in force for 14 calendar days, or the time it takes to resolve the specific issue. The Member's response should be documented in the notes of their record.	• If it is not possible to contact the Member, judgment should be used to determine if it is an emergency. If not, disclosure should be denied and it should be documented in their record. • The language line should be used for non-English speaking members or to receive verbal authorizations from the member to speak with the caller. If a member's English is difficult to understand, due to a language barrier, the language line should be provided as an option.
Calling regarding a deceased Member	• Identity must be verified and documented in the member's record. (See requirements below.) • Obtain a copy of the death certificate. • Confirm that we have a copy of the appropriate legal documentation (issued by probate court – called Letter of Administration or Letters Testamentary) and verify that the caller's name matches the representative's name on record.	• If the member does not date the authorization, it expires 2 years after the coverage terms, including death.
Provider, Physician, or Delegated Entities (i.e. ChiroCare)	• Identity must be verified. (See requirements below.) • No authorization is required to share PI for that provider's members.	• Only PI related to claims and authorizations for that provider may be disclosed or discussed.

Government or Enforcement Officials Seeking Mandated Release (i.e. police officers, CMS employees, fraud investigators, county social workers)	• Identity must be verified and documented in the member's record. (See requirements below.) • Verify that the caller is who they say they are by either (1) asking the caller to fax the request on official letterhead, (2) calling them back at a number provided, ensuring the number matches a listed phone number for the agency, or (3) documenting the caller and his/her supervisor's name and numbers in the member's record • The basis for confirming the caller's identity must be documented in the member's record. • Confirm that we have the written authorization or a copy of the appropriate legal documentation (i.e. subpoena, warrant) on file before we disclose.	• Tracking of disclosures is required.
Legal Representatives (including attorneys)	• Identity must be verified and documented in the member's record. (See requirements below.) • Confirm that we have a copy of the appropriate legal documentation on file and verify that the caller's name matches the representative's name on record.	
Other Insurers	• Identity must be verified and documented in the member's record. (See requirements below.) • No authorization is required if both insurers have a relationship (past or present) with the member, and the data is used for payment or health care operations functions.	
County Workers, Foster Care, Advocacy Groups, or Ombudsmen	• Identity must be verified and documented in the member's record. (See requirements below.) • An authorization is required to discuss member specific health information with county advocates or social workers.	• No authorization is required to discuss health plan administration activities, such as claim denials or authorizations.

Collection Agency	• Identity must be verified and documented in the member's record. (See requirements below.) • No authorization is required to share the PI because the agency is the business associate of the provider. We are not required to verify this. • We only confirm the data they have; we don't give out additional PI.	
Government Officials (i.e. Attorney General, Legislators) and Regulatory Agencies	• Identity must be verified and documented in the member's record. (See requirements below.) • Verbal or Written authorization is required to share member PI. Verbal consents will remain in force for 14 calendar days, or the time it takes to resolve the specific issue. The Member's response should be documented in the notes of their record.	• Authorizations are not required for Regulatory Agencies for an audit or fraud investigation.
Employers	• Identity must be verified. (See requirements below.) • Verbal or Written authorization is required to share member PI, when the employer is acting as the member's advocate. Verbal consents will remain in force for 14 calendar days, or the time it takes to resolve the specific issue. The Member's response should be documented in the notes of their record.	• Certification is required to get identifiable, non-aggregated employer reports and to handle appeals, but an authorization is not required to share that data. • An authorization is not required to share enrollment data about a member, but ID verification is.
Brokers	• Identity must be verified. (See requirements below.) • Brokers will be treated as Business Associates, and therefore, no authorization is required.	• Until a signed BA agreement is received, we cannot disclose any PHI but can only confirm the data they already have, unless we obtain an authorization from the member.
Media	N/A	• We never give out any information to the media. It is referred to Corporate Communications.

What information is required to verify Caller Identification?

Identity Verification Requirements (If identity is incorrect or cannot be verified, document that in the member's record. Apologize to the caller and explain that the information is being withheld for the protection of the member.)	Must Provide Full Name and at least 2 of the following: • Member ID Number; • PMI Number; • Patient Account Number; • Employer Group Name; • Employer Group Number • Contract Number; • Claim Number; or • Date of Birth (2 yr tolerance). If necessary, the caller should be asked to provide one additional piece of information, such as address, phone number, or coverage date. Parents need not verify the last name for their children if it is the same as their own. If the child's last name is different from the parent's, we must verify both first and last name. This also applies to spouses on a policy identifying each other. **Note: While HealthPartners cannot ask for SSN, if the caller provides it correctly, it can be used for identity verification purposes.**

What PI can be disclosed with and without an Authorization?

Have Member Authorization	No Member Authorization but Caller has EOB or Premium Bill	No Member Authorization or EOB or Premium Bill
Can disclose any member information, unless specifically restricted by the member's authorization.	Can disclose general coverage and benefits information Can disclose claims or premium payment information only, no diagnosis data can be shared.	Can disclose general coverage and benefits information only.

Privacy Project: Customer Service Work Group Policy Recommendation FINAL
(Updated 01/09/04)

NOTE:
This policy was developed according to state & federal regulations, as well as CMS guidelines and practices.

+++

Regions Hospital

Subject PROCEDURE FOR HEALTH SCREENING OF NEW EMPLOYEES	Attachments ☐ Yes ☒ No
Key words HEALTH, HEALTH SCREENING, NEW EMPLOYEES	**Number** **RH-HR-60-05-07**
Category Human Resources (HR)	**Effective Date** **October 1998**
Manual Human Resources	**Last Review Date** **July 2010**
Issued By Human Resources	**Next Review Date** **May 2013**
Applicable This policy applies to all employees at Regions Hospital.	**Origination Date** **March 1986**
	Retired Date **Not Applicable**
Review Responsibility Human Resources and EHS	**Contact** Human Resources

I. PURPOSE

This policy is established in order to ensure that all employees are cleared medically to perform the essential functions of the job for which they were hired prior to the time they begin work.

II. POLICY

All new Regions Hospital employees must complete the Health Screening Questionnaire and other necessary forms and receive tentative health clearance by the Employee Health Service prior to the time the employee begins work.

III. PROCEDURE(S)

To assure that required health screening is completed in a timely manner prior to the time the new employee begins work, the following procedure will be in effect:

1. A prospective employee will be sent Employee Health Service (EHS) paperwork to complete at the time a hiring commitment is made and an EHS appointment will be scheduled for the prospective employee by the Human Resources department.

2. The prospective employee will bring his/her completed EHS paperwork to his/her EHS appointment.

3. Employee Health Service will review all health questionnaires to determine acceptability for employment with or without further medical follow-up. One or more of the following will occur:
   - Medical Clearance is granted
   - Further information is requested before medical clearance

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

- Further evaluation is required before medical clearance
- Medical clearance is granted with work modifications
- Tentative clearance is granted pending further evaluation and/or information
- Medical clearance is granted for this position only, with medical re-evaluation required before a change of position
- Statutory disability is identified and Human Resources notified for accommodation, if indicated
- Medical clearance is not granted

4. Employees designated unacceptable will be scheduled to see the Employee Health Service physician and/or provide further information as necessary.

5. If the Employee Health Services determines that the prospective employee is unable to perform the essential job functions, the Health Service will so notify both the Human Resources Department, and the prospective employee. The Human Resources Department will determine if a reasonable accommodation, in conjunction with EHS and the hiring department, can be made. If a reasonable accommodation cannot be made, then the offer of employment will be withdrawn.

6. The prospective employee can only begin work at the Hospital when he/she has been cleared by the Employee Health Service prior to beginning work.

IV. DEFINITIONS
NOT APPLICABLE

V. COMPLIANCE
Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS
NOT APPLICABLE

VII. OTHER RESOURCES
Employment Requirements for New Employees #RH-HR-60:05:05

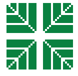
VIII. APPROVAL(S)

Beth Heinz, Vice President

IX. ENDORSEMENT
Human Resources Leadership Team

+++

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

 **Regions Hospital**

Subject PROFESSIONAL BOUNDARIES	**Attachments** ☐ Yes X No
Key words Patient Rights, Relationships, Vulnerable Adults	**Number** RH-HR-HR-60-10-28
Category Human Resources (HR)	**Effective Date** **6/11/2002**
Manual Human Resources	**Last Review Date** **July 2010**
Issued By Human Resources	**Next Review Date** **July 2013**
Applicable All Regions Hospital employees	**Origination Date** **6/11/2002** **Retired Date** **Not Applicable**
Review Responsibility Human Resources	**Contact** Human Resources

I. PURPOSE

To support the establishment and maintenance of therapeutic relationships between Regions Hospital staff and patients and to insure the patient's rights to privacy and confidentiality.

II. Policy

I. Regions Hospital staff who work with patients are prohibited from having relationships of a personal nature with patients during the patient's hospital stay.

A. Staff are to explain to the patient any physical contact prior to making the physical contact except in emergency situations.

B. Staff may only touch the patient as appropriate to job responsibilities.

II. Regions Hospital staff who work with psychiatry and/or chemical dependency patients are prohibited from having relationships of a personal nature with patients.

A. Staff are not to make personal contacts with patients after discharge.

B. Staff are prohibited from having contacts of an intimate nature with patients during their hospital stay or after discharge.

C. Staff are to explain to the patient any physical contact prior to making the physical contact except in emergency situations.

D. Staff may only touch the patient as appropriate to job responsibilities.

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

E. Any staff person already having a personal relationship with a patient prior to that person's admission will be reassigned to another area/unit until that patient is discharged.

III. PROCEDURE(S)

All Employees must complete a training packet at least once during their course of employment. Employees will revisit the policy annually when completing the annual code of conduct when they are required to verify their understanding of and compliance with the policy.

IV. DEFINITIONS

Vulnerable Adult: Any Person 18 years of age or older who is an inpatient in this facility per MN Statute 626.557 Reporting of Maltreatment of Vulnerable Adults. Violation of statute requires reporting to police, central intake office of the Office of Health Facility Complaints, Vulnerable Adult Department or State Ombudsman Office.

Child Protection Act Statute 626.556 covers people under 18 years of age.

V. COMPLIANCE

Employees who violate this policy will be subject to disciplinary action up to and including termination of employment, or possible criminal penalties.

VI. ATTACHMENTS

Not Applicable

VII. OTHER RESOURCES

NONE

VIII. APPROVAL(S)

Beth Heinz, Vice President

IX. ENDORSEMENT

Human Resources Leadership Team

+++

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

Regions Hospital

Subject REQUESTS NOT TO PARTICIPATE IN AN ASPECT OF PATIENT CARE	Attachments ☐ Yes ☒ No
Key words Ethics, Religious Beliefs, Values	**Number** **RH-HR-HR-60-05-31**
Category Human Resources (HR)	**Effective Date** **October 1998**
Manual Human Resources	**Last Review Date** **July 2010**
Issued By Human Resources	**Next Review Date** **August 2013**
Applicable All Regions Employees	**Origination Date** **July 1996** **Retired Date** **Not applicable**
Review Responsibility Human Resources Department	**Contact** Human Resources Department

I. PURPOSE

To establish a mechanism by which an employee may request to be excused from participating in an aspect of a patient's care or treatment in situations where the prescribed care or treatment presents a conflict with the employee's values, sense of ethics, or religious beliefs. In no instance will the mission of the hospital be compromised. Medically related treatment and care will be provided to all persons in need regardless of race, color, creed, religion, national origin, sex, sexual or affectional orientation, marital status, status with regard to public assistance, membership or activity in a local commission, disability, age, political affiliation or place of residence.

II. POLICY

1. It is understood that situations may arise in which the prescribed course of treatment or care for a patient may be in conflict with the personal values or religious beliefs of a staff member. In such situations, it is the responsibility of the employee to immediately notify his/her supervisor or department head of his/her concerns and to request that he/she be excused from participating in a particular aspect of treatment or care of the patient. The supervisor or department head will make a decision on the request. As permitted by the situation, this request must be committed to writing as soon as reasonably possible and must include the specific aspects of care from which the employee is requesting to be excused and the reasons for making the request.

In no circumstances will a request be granted if it is felt that doing so would negatively affect the care of the patient. The requesting employee is responsible for providing appropriate patient care until alternate arrangements can be made. Refusal to provide care may result in disciplinary action up to and including termination.

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

It must be realized that for reasons of minimal staffing and unavailability of other staff, requests may not be granted. Employees may request a transfer to a department or position in which conflict of care issues are less likely to occur. Requests will not be honored if they are premised on actions or positions which would constitute a violation of the Minnesota Human Rights Act or any similar federal or local law.

2. If an employee feels he/she cannot morally assist with an abortion, he/she should notify his/her supervisor as soon as he/she is aware of this situation in which he/she cannot participate. Notwithstanding, the provisions of paragraph 1. above, any employee has an absolute right, pursuant to Minnesota Statutes, Section 145.42, to refuse to perform or assist in the performance of an abortion.

3. Requests for accommodations in the delivery of patient care as a result of an employee's personal values and/or beliefs are to be first presented to the employee's supervisor. If the employee is not satisfied with the supervisor's response, the employee may present the request to the respective vice president in writing. The decision of the vice president shall be final.

4. The hospital will attempt to make reasonable accommodations for all justified employee requests for exclusion from patient care or treatment resulting from a conflict with the employee's personal values or beliefs.

III. PROCEDURE(S)
NOT APPLICABLE

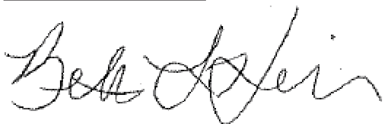
IV. DEFINITIONS
NOT APPLICABLE

V. COMPLIANCE
Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS
NOT APPLICABLE

VII OTHER RESOURCES
NOT APPLICABLE

VIII. APPROVAL(S)



Beth Heinz, Vice President

IX. ENDORSEMENT
Human Resources Leadership Team

+++

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

HealthPartners®

ORGANIZATIONAL PRIVACY STANDARDS:

Sending Protected Information Securely

Definitions:

De-Identified Information means information about a member or patient that is not Protected Information because it does not identify the individual and does not contain sufficient information to reasonably allow someone to figure out who the patient or member is. For information to be considered De-Identified, it must follow the standards for de-identification established in HIPAA. You should not assume that just because a name is not attached to the information that it is De-Identified Information. To determine if information is truly, legally De-Identified, consult with the Law Department or the Office of Integrity and Compliance.

Encrypted Information means Protected Information that has been electronically masked or otherwise made unviewable and unalterable by anyone who does not have a code, key, password or decryption technology to allow viewing.

Basic Rules:

1. All Protected Information must be transmitted (sent outside the organization) in accordance with the organization's Privacy and Security Policies and Privacy and Security Standards.

2. Whenever possible to accomplish the assigned task, transmit De-Identified Information.

3. If any of the data elements listed below are associated with the information you are transmitting, then it is *highly* likely that the information is Protected Information and so subject to specific transmission requirements discussed below:
   - Name
   - Address
   - Five-digit zip codes
   - Telephone or fax number
   - Email address
   - Social security number
   - Medical record or insurance ID number
   - Driver's license number or other vehicle or professional license number
   - Medical device identifier or serial number
   - Biometric identifiers, including fingerprints, voice codes, retinal scans or DNA
   - Photographic images that contain identifying marks or characteristics
   - Date of Birth

4. When transmitting Protected Information outside the organization, you are permitted to transmit only the amount and kind of Protected Information that is reasonably required to accomplish the assigned task. That means:

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

- To support **treatment**, use your best professional judgment as to what kind and how much of the patient's information you need to transmit;

- To support **payment-related activities** or **health care operations,** start with De-Identified information and piece by piece add identifiable information until you have the information you actually need to accomplish the task – and then transmit only that information.

5. When transmitting electronic Protected Information outside the organization, you must use one of the five (5) **secure transmission methods** listed below.

6. **Secure Transmission Methods**: The table below identifies secure methods for transmitting electronic Protected Information that conform to the organization's Privacy and Security Policies and Standards. For assistance accessing or using any of these options, contact IS&T Security Management.

Method	Description	Limitations	User Guidance
1. Secure Mail	• Point-to-point email distribution • Secure envelope mail delivery	• Would not prevent unauthorized disclosure if email sent to wrong address • 10MB maximum file size	• Use for small files that will typically only be sent to one recipient and contain limited Protected Information. • **Always** verify the recipient email address before sending the message.
2. E-Transfer	• Encrypts data • Handles larger files	• Requires separate communication of User ID and Password • 200MB maximum file size	• Use for medium sized files that will typically only be sent to one recipient. • **Always** send the User ID and Password to the recipient via a separate transmission method. • **Always** verify the recipient email address before sending the messages.

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

Sending Protected Information Securely

Method	Description	Limitations	User Guidance
3. PointSec Portable Media Encryption	• Encrypts portable media (CDs, flash drives)	• Requires separate communication decryption key	• Use when recipient of the data requires physical media. • **Always** send the decryption key to the recipient via a separate transmission method.
4. Encrypted Processes Employed by the HealthPartners EDI Business Unit	• Encrypts the "envelope" and/or "tunnel" • Set-up is tested to ensure the connection is correct • Handles any size files • Transmission can be scheduled	• Requires coordination of audit process to ensure data is not sent in the incorrect "envelope" • Requires lead time to set-up connections • Requires coordination with our customers	• Recommended for files that are sent on a routine schedule. • Business units and IS&T should coordinate an automated audit function that validates and ensures that the correct data is entered into the correct "envelope." • For ad hoc or urgent requests, incorporate additional validation points.
5. Portals	• Encrypts the "tunnel" • Set-up is tested to ensure the connection is correct • Handles large files • IS&T can configure so that recipient "pulls" data from a secure web environment. • Examples include Provider Portal, Online Patient Services and HealthPartners.com Secure Messaging.	• Requires coordination with our customers • Requires lead time to set-up connections • Requires modification to current reporting methods	• Modify reporting process so that customer "pulls" data, rather than our pushing the information to a mailbox. • Use whenever possible for sharing Protected Information with employers, brokers and providers.

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

Exceptions:

There are only limited exceptions to the requirements for transmitting Protected Information outside the organization as described in this standard, and those will depend on the circumstances. If you are considering transmitting Protected Information in a manner that is not described in this standard, you must first consult with IS&T Security Management.

Important Reminder:

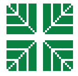
These are important standards for you to follow. If you don't follow them, you may be subject to discipline.

Resources:

Organizational Privacy Standards: Minimum Necessary
Organizational Privacy Standards: Protected Information, De-Identified Information and Encrypted Information
Organizational Privacy Standards: Using E-Mail to Communicate With and About Patients and Members
Organizational Privacy Standards: Business Associates and Business Associate Agreements

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

+++

 **Regions Hospital**

Subject Social Media Use and Behavior	Attachments ☐ Yes ☒ No
Key words Social Networking, Facebook, YouTube, Internet e-mail, blog, online manners, netiquette, Twitter, web mail	**Number** **RH-HR-HR 60:10:34**
Category Human Resources (HR)	**Effective Date** **January 2010**
Manual Human Resources	**Last Review Date** **September 2010**
Issued By Human Resources	**Next Review Date** **January 2012**
Applicable All Regions Hospital staff.	**Origination Date** **January 11, 2010** **Retired Date** **N/A**
Review Responsibility Human Resources	**Contact** Human Resources

I. PURPOSE

The purpose of this policy is to establish clear expectations for the use of online networking or "social media" (see definition on page 4) and staff behavior in the social media environment.

This policy applies whenever you reference or allude to Regions Hospital (or a related organization), its people, patients, services, customers or business in the Social Media environment, regardless of whether you are doing so as part of your work or for personal reasons. This policy also applies when you are using Social Media via a company-owned computer or other device (such as a smart phone), when you are using a personally-owned computer or device in a facility owned or operated by Regions Hospital or a related organization and when you are using a company-owned or personally-owned computer or device during working hours, as well as during "off hours" and/or when using your own computer, device or system.

II. POLICY

In general, Regions Hospital does not prohibit you from using Social Media at work and as part of your work. But in order to protect the privacy of the people we serve, preserve the reputation of the organization and promote a respectful and productive work environment, there are important rules that you must follow when using Social Media for personal or work-related reasons. These rules are described in this policy.

A. Using Social Media as Part of Your Work

Social Media can be an important tool in the work we do. It can help us communicate with our patients, customers and each other. It can help us improve service, respond to concerns and identify care and business opportunities. But like all tools, Social Media must be used properly.

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

1. **When Is It Appropriate to Use Social Media as Part of Your Work?**
   There are so many possible ways we could use Social Media to help with our work, but that doesn't mean that we should be using it for everything. In general, you may use Social Media as part of your work if:

   - The activity fills legitimate need related to marketing, patient care, employee engagement or community benefit;
   - The activity is consistent with the Mission, Vision and Values of the organization: and
   - The organization will have the ability to regularly monitor the proposed site and content, and to edit or remove content in its discretion.

   If employees have an idea for using social media to help achieve the work of the organization -- for example, a work-related blog, Facebook page, a virtual meeting or other online content sharing -- the employee must first work with his/her leader to gain their initial approval. After the leader's approval, you must follow the instructions on the Social Media Approval Process Form on Brand Central then work with Brand Team to determine appropriate use, content and administration. **All requests must be reviewed and approved by Brand Team PRIOR to implementation.**

2. **How Should Staff Behave when Using Social Media for Work-Related Reasons?**
   It might seem a little strange to talk about "behavior" in the online world, but just as we behave in the "real" world, we also behave in the "virtual" world. In general, all organizational policies that govern your "real world" behavior also govern your behavior in the Social Media world. This means, for example, that when using Social Media you must follow the organization's:

   - Code of Conduct
   - Privacy Policy, Standards and Guidelines
   - Security Policy and Standards
   - Internet Use and Email Use Policies
   - Human Resources Policies

   But there are some unique aspects of the "virtual" world that are in fact different from the "real" world. For example, it can be difficult to determine the true identity of an online user. Also, online postings are generally considered public, can be disseminated easily and rapidly, and often cannot be deleted – ever. For these reasons, Regions Hospital requires you to follow some additional rules when using Social Media:

   a. **Represent Yourself and Regions Hospital Honestly**.
      When using Social Media for work-related reasons, you must:

      - Use your real name and disclose that you are a Regions Hospital employee (or consultant, resident, volunteer, Medical Staff member, etc.); be clear about which part of the organization you work for and what your general role and responsibilities are.
      - Disclose only information that is already available to the public. You may not post or comment on confidential Regions Hospital information, such as patient information, financial information, business performance, business plans, legally protected information or employee or staffing information. *If you have any question about what is considered confidential Regions Hospital information, or what is or is not already available to the public, you must get guidance from your supervisor; supervisors, in turn, are responsible for consulting with Corporate Communications, Legal, Human Resources, Corporate Integrity and Finance, as*

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

appropriate.

- When you post any content, make sure that you do not claim or imply that you speak for Regions Hospital or any of its related organizations unless you have been expressly authorized by your leader to do so.

b. **Be Responsible**.
When using Social Media for work-related reasons, you must:

- Make sure that anything you post or publish is factually accurate and complies with all related organizational policies, such as Code of Conduct and privacy-related policies.
- Not make any announcements or statements about Regions Hospital or a related organization unless you have received the specific authorization of the Corporate Communications Department to do so.
- Only offer opinions, support or guidance about matters that fall within your area of responsibility at Regions Hospital. If you become aware of an opportunity to engage in a Social Media interaction related to the work of Regions Hospital or a related organization that falls outside your area of responsibility, bring this to the attention of a leader in the relevant area so that they can evaluate the matter and follow up as appropriate.
- Not disclose other people's personal information in Social Media (or any other format) and that you comply with the organization's privacy-related policies, guidelines and standards and expectations related to caregiver professionalism. This includes (but is not limited to) not discussing specific patients or discussing, displaying or posting their information or images on Social Media, even if you do not refer to the patient by name or other details.
- Obey copyright, privacy and other applicable laws when using Social Media. Seek advice from the Law Department if you are not certain about what you are permitted to post or publish on a Social Media platform.
- Observe standards of professionalism and professional boundaries.

c. **Be Respectful.**
When using Social Media for work-related reasons, you must:

- Be respectful of all individuals and communities with which you interact.
- Be polite and respectful of others' opinions, even if you disagree in the midst of heated debate and discussion.
- Obey the Terms of Use and the cultural and behavioral norms of the Social Media platform being used.
- Make sure that you do not post any material that is obscene, defamatory, threatening, harassing, discriminatory or hateful to another person or organization, including Regions Hospital, its staff, its competitors or its customers, or patients.

B. Using Social Media for Personal Purposes

When you choose to use Social Media for non-work-related reasons, ***the requirements described above continue to apply.*** In addition, you must follow ***several additional rules****:*

1. If using Social Media while at work, on work time or using a device or system that belongs to Regions Hospital, you must:
   - You may only access social media while on a defined break and must limit your use to occasional & incidental use
   - Your use MUST not interfere with the organization's business activities or your job performance or productivity
   - You may not use computers or devices located in a direct patient care area to access social media. This includes inpatient, outpatients, ED, Surgical Services and other

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

diagnostic or procedural areas. You may use computers located in break rooms, offices, the Health Resource Center and the cafeteria

- Not pursue or promote any outside job or business activity not associated with the organization
- Not make any statements, post any material or act in any way that could embarrass or potentially embarrass Regions Hospital including its staff, patients or visitors, or its related organizations
- Make sure that your use does not violate the Code of Conduct, this Policy or any other organizational policy.

2. In addition, whether using the organization's or your own devices or systems, and whether you are using Social Media on work time or your own personal time, you must also follow these rules:

   - If you refer to Regions Hospital, a related organization, our people, services, business partners or competitors, identify yourself as an employee (or consultant, resident, volunteer, Medical Staff member, etc.).
   - Do not imply in any way that you are authorized to speak for or on behalf of Regions Hospital or a related organization.
   - Do not use or co-opt the identity of any patient or member or any other employee (or consultant, resident, volunteer, etc.) of Regions Hospital, a related organization, a business partner or a competitor.
   - Do not use any logos, signage or trademarks of Regions Hospital or a related organization in your personal Social Media interactions, unless Regions Hospital has specifically authorized that use.
   - Make it clear that any opinions you express are your personal opinions. If you are commenting or offering your personal opinion about a work-related matter, make sure that your comments and opinions do not cause damage to Regions Hospital, its related organizations, our people, services, business partners or competitors.
   - If you regularly refer to your work or the activities of Regions Hospital or a related organization (for example, if you maintain a personal blog about your profession), include a permanent disclaimer that your comments and opinions are your own and not those of Regions Hospital or its related organizations.
   - Refrain from commenting about our patients, members or other customers, even if you do not identify them by name. All of the people we serve deserve to be treated with dignity and respect; negative or disrespectful comments about them will not be tolerated.

III. PROCEDURE(S)

Regions Hospital reserves the right to monitor and review Staff's use of Social Media in a Regions Hospital facility or through a Regions Hospital owned or issued device or system. In the event Regions Hospital identifies any content posted by or at the request of a person subject to this policy that it deems inappropriate under this policy, Regions Hospital may demand the removal of such content.

Business unit leaders may adopt more restrictive policies and procedures relating to Staff's use of Social Media in order to protect the organization or its patients, members or customers.

IV. DEFINITIONS

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

"Social Media" means the use of web-based or other electronic technology for the purpose of interacting and communicating with people, companies and communities.
Examples of Social Media include, but are not limited to:

- Social networking sites, such as Facebook, LinkedIn and MySpace
- Video, photo and audio sharing sites, such as YouTube and Flickr
- Blogs and blogging tools, such as Blogger and WordPress
- Micro-blogging tools, such as Twitter and Yammer
- Collaborative forums (open or closed), such as Yahoo!Groups, SharePoint and SecondLife
- Interactive encyclopedias, such as Wikipedia
- Comment-enabled online tools on webzines, online news sites and listserves
- Personal web mail accounts, such as Yahoo or gmail
- And any other web sites or electronic media that allow individual users or companies to publish or post content

"Staff" means any person who works for or represents Regions Hosptial, or who works in a facility owned or operated by Regions Hospital or a related organization. This includes, but is not limited to, employees, privileged medical staff, residents, students, volunteers, temporary employees, consultants, board members.

V. COMPLIANCE

If you do not comply with this policy you may be disciplined, which could include suspension or removal of internet or email privileges, and other disciplinary action, up to and including termination. If your violation of this policy results in Regions Hospital or a related organization incurring any cost, we can recover those costs from you. If you break the law, you may also be personally liable.

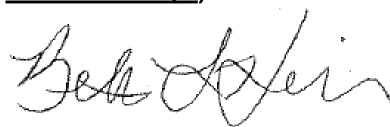
VI. ATTACHMENTS

None

VII. OTHER RESOURCES

- Code of Conduct, other policies (privacy, security, internet, email, etc.)
- Privacy Policy, Standards and Guidelines
- E-mail and Internet Use policy #RH-HR-HR 60-10-25
- Social media tips for appropriate and effective use.

VIII. APPROVAL(S)



Beth L. Heinz
Vice President

IX. ENDORSEMENT

People Council
Corporate Integrity
Human Resources Leadership Team

+++

Regions Hospital management retains the right to interpret and/or change current policies as necessary. These policies and procedures are not an employment contract and should not be interpreted as creating an employment contract or contractual rights.

HealthPartners

ORGANIZATIONAL PRIVACY STANDARDS:

Using E-Mail to Communicate With and About Patients and Members

Definitions:

Internal E-Mail means an e-mail transmitted *from* an @healthpartners.com e-mail address *to* an @healthpartners.com e-mail address.

External E-Mail means e-mail transmitted from an @healthpartners.com e-mail address to an e-mail address that is not an @healthpartners.com e-mail address, even if that e-mail address is part of an e-mail system maintained by a HealthPartners-related organization (for example, an e-mail message from jane.x.doe@healthpartners.com to joe.x.smith@hudsonhospital.org is an External E-mail).

Secure E-Mail means Internal E-mail **or** e-mail transmitted using (1) Online Patient Services; (2) the Secure Mail tool installed by IS&T as a software add-on to a regular Outlook e-mail account; or (3) another secure e-mail method arranged through IS&T.

Basic Rules:

1. These standards apply to any e-mail used to communicate with or about patients or members, or about any other matter related to HealthPartners' business.

2. Use only Secure E-Mail when sending an External E-Mail.

3. Do not send Protected Information via e-mail using personal or web e-mail programs (for example, Gmail, Hotmail, Yahoo or Comcast accounts).

4. Do not send Protected Information via e-mail to your personal e-mail account(s).

5. Make sure Internal *and* External E-mail conform to the following requirements:

   - **Subject line:** Do not include any Protected Information, any identifying information about a member, patient or research study participant in the Subject line of an e-mail. For example, do not include patient or member names or identification numbers, but you may include patient or member initials.
   - **Recipients:** Send e-mail only to those people who need the information to do their work.
   - **Distribution list:** If using a distribution list, make sure all members of the list actually need to receive the information and then make sure you're using the correct list.
   - **Content:** The content of the e-mail and any attachments should follow the Minimum Necessary Rule.
   - **Header/Footer:** The following text must be included in all e-mails that contain Protected Information or other sensitive information:

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

ORGANIZATIONAL PRIVACY STANDARDS:

Using E-Mail to Communicate With and About Patients and Members

THIS E-MAIL CONTAINS SENSITIVE AND CONFIDENTIAL INFORMATION. DO NOT FORWARD WITHOUT THE PERMISSION OF THE ORIGINAL SENDER. IF YOU BELIEVE YOU HAVE RECEIVED THIS E-MAIL IN ERROR, INFORM THE ORIGINAL SENDER IMMEDIATELY.

Exceptions:

1. If a member, patient or research study participant initiates e-mail communication via our HealthPartners website to your healthpartners.com address, you may send an External E-mail using your healthpartners.com account to acknowledge its receipt. But the response should (a) include no additional Protected Information, and (b) notify the sender that future e-mail communication with the sender will need to be conducted only through Secure E-Mail.

2. There are only limited additional exceptions to the e-mail communication requirements described in this standard, and whether they apply will depend on the individual circumstances. If you are considering using e-mail in a manner other than permitted under this standard, you must first consult with IS&T Security Management.

Examples:

1. Patient sends an e-mail to provider's healthpartners.com e-mail address. Provider should not use his or her healthpartners.com account to reply to patient's e-mail. Instead, the provider should use Secure Messaging through Online Patient Services. If the patient does not have an Online Patient Services account, the provider may:
   - Call the patient;
   - Send an e-mail to the patient via the HealthPartners.com account that only acknowledges the patient's e-mail and encourages the patient to sign up for Online Patient Services.

2. Employer requests a monthly claims report. Before sending the report, the HealthPartners claims staff must coordinate with the employer to establish an agreed upon secure transmission method: Secure E-mail, E-transfer, TLS, or transmission by the IS&T EDI team.

3. Employee receives an Internal E-mail containing Protected Information that the employee does not need for his or her work. Employee should reply only to the sender to report that the e-mail was sent to him or her in error, and then delete the e-mail.

4. You send a Secure E-Mail containing Protected Information to an external party. After sending, it comes to your attention that either the wrong recipient received it or the content of the e-mail was the wrong content. You should report the problem immediately to the Office of Integrity and Compliance.

Practical Tips:

1. If you receive an e-mail where you are one of many recipients and the e-mail requires your response, do not automatically use the "reply all" function. Instead carefully consider who needs the information you will provide in response and send your response only to those individuals.

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

Using E-Mail to Communicate With and About Patients and Members

2. If you receive an e-mail in error, respond only to the sender (not the entire recipient list) to inform the sender of the mistake.

3. Be aware that most e-mail is not secure, and therefore it is easily hacked or intercepted. E-mail is not private like a telephone.

4. Keep in mind that e-mail systems such as Microsoft Outlook often have automated features that make it extremely easy to put in the wrong addressee or distribution list by mistake.

5. Remember, once you send an e-mail to someone within or outside the organization, they can easily forward it to someone else – or to hundreds of other people! Once you hit "send," you have lost control of the information in that e-mail forever.

Important Reminder:
These are important standards for you to follow. If you don't, you may be subject to discipline.

Other Resources:
Security and Electronic Messaging Policy (C100-2)
Organizational Privacy Standards: Minimum Necessary
Organizational Privacy Standards: Sending Protected Information Securely
Organizational Privacy Standards: Sharing Protected Information with Employer Groups and Brokers

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

+++

REGIONS HOSPITAL

POLICY/PROCEDURE		Page 1 of 2
Subject Use of Facsimile Transmissions to Communicate Patient and Member Information		No. 50:05:13 Effective Date 4/15/03 Supersedes No:
ISSUED BY: Administration	Date: April 15, 2003	Dated:

PURPOSE:
The purpose of these procedures is to establish standards for using faxes to communicate with or about patients or research study participants. Although faxing can be a convenient and efficient form of communication, it is important to recognize that it can also pose some risks on the privacy of Protected Information. For that reason, HealthPartners/Regions Hospital –as a provider and as a health researcher – must weigh these risks against the benefits when deciding whether, when and how to communicate via fax. By following these procedures, the risks inherent in the use of faxes will be minimized, although not necessarily eliminated.

POLICY:
All Facsimile (fax) transmittals generated or received by Regions Hospital personnel, that contain personal health or other Protected Information must follow established procedures to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements. All supervisors are responsible for enforcing these guidelines. Failure to comply with this procedure will result in appropriate disciplinary action, up to and including dismissal.

PROCEDURE:

1. *General Considerations*
   a. *All faxes sent by Regions Hospital personnel – whether intended to be communicated only internally or also externally – should follow these procedures. Likewise, Regions Hospital personnel who expect to receive Protected Information via fax should also follow these procedures.* There may be times when even following these procedures might not offer appropriate protection for the information included in fax transmissions. Conversely, there may be times when following these procedures might unduly interfere with providing quality care and service. Accordingly, personnel should not rely solely on these procedures when deciding whether and how to communicate sensitive information via fax.
   b. Due to the nature of fax technology, the possibility of transmission errors and the frequency, with which fax machines may be accessed by multiple people, special precautions must be taken to protect the confidentiality of Protected Information.
   c. Providers, health plans and researchers must weigh these risks against the benefits when deciding whether to communicate Protected Information via fax. (Consult *the Privacy Policy* or *Privacy Guidelines* to determine what is considered "Protected Information.")

2. *Fax Cover Sheet*
   a. **Standard Cover Sheet Template** – All business units must use the standard fax cover sheet components for faxes that contain Protected Information. The standard cover sheet template may be found on the Corporate Integrity section of ERIC (HealthPartners Intranet) in the Privacy link http://intranet.healthpartners.com/. The standard template contains a confidentiality heading that has been approved by HealthPartners legal counsel. See attachment A.
   b. **Fax Cover Sheet Components include**:
      i. – **Confidential** – Whenever possible, all pages of all confidential documents to be faxed should be marked "Confidential" before they are transmitted.
      ii. – **Recipient information** – Name, department/company, fax number and phone number of the intended recipient should be included on the fax cover sheet.
      iii. – **Sender information** – Name, department, address, fax number and phone number of the person who sent the fax should be included on the fax cover sheet.
      iv. – **Other information** – Number of pages transmitted, date and time of fax. Whenever possible, the subject line on the fax cover sheet should not contain any information that identifies the person who is the subject of the fax (e.g., no patient or member names or ID numbers).

3. *Location and access to fax machines*
    a. If your business unit regularly sends or receives faxes that contain Protected Information, you should take the following precautions:
        i. Place fax machines that are used to transmit Protected Information in areas that are not routinely accessed by people who are not authorized to view the Protected Information.
        ii. Avoid placing fax machines in areas that are accessible by the public (such as reception or waiting areas).
        iii. If possible, avoid sharing fax machines with other departments or business units that do not need to access the Protected Information that you are sending or receiving.

4. *Confirm, Verify, Coordinat*e
    a. One of the most important ways to safeguard the Protected Information contained in faxes is to be extremely cautious about fax numbers, recipients, arrival times and delivery. For example:
        i. If you regularly send faxes to certain people, consider programming their fax numbers into the fax machine and prominently display the name of the programmed recipient.
        ii. If possible, configure the fax machine so it routinely prints a confirmation of each outgoing transaction. In addition, consider attaching this printout to a copy of the document that was faxed and keep both in your files.
        iii. If you expect to receive a fax that contains Protected Information, try to coordinate its arrival with the sender. Likewise, if you are sending a fax, attempt to coordinate its arrival with the receiver. If this approach is not feasible within your area, it is recommended that an in-box be placed next to the fax machine to store received faxes.
        iv. Destroy, or follow sender's instructions for information faxed in error and immediately inform the sender.

5. Use Common Sense
    a. Don't assume that faxing is a secure mode of communication. Limit the Protected Information you fax (or agree to receive by fax) to the following circumstances:
        i. Communications that are time-sensitive or non-routine, when mail or courier is not feasible. For example, personnel may transmit proetected information by facsimile when urgently needed for patient care or required by a third-party payor for payment of a patient's claim.
        ii. Information transmitted must be limited to the minimum necessary to meet the requestor's needs.

6. Train fax users
    a. All personnel should be trained and periodically updated on the fax procedures and safeguards that are in place in their departments.

7. Report problems or suspected problems promptly
    a. If you suspect that fax procedures have been violated or an individual's privacy has otherwise been compromised follow the procedure for misdirected faxes below.

8. Procedures for Misdirected Faxes
    a. If a fax transmission containing Protected Information is not received by the intended recipient because of a misdial, check the internal logging system of the fax machine to obtain the misdialed number.
    b. If possible, a phone call (supplemented by a note referencing the conversation) should be made to the recipient of the misdirected fax requesting that the entire content of the misdirected fax be destroyed. If the recipient cannot be reached by phone, a fax should be sent to the recipient requesting that the entire content of the misdirected fax be destroyed.
    c. The fax confirmation sheet or activity report should be sent along with the misdirected fax cover letter to Corporate Integrity. It is the responsibility of the department sending the misdirected fax to forward this information to Corporate Integrity.

+++

Regions Hospital®

Subject **User Responsibilities Policy**	**Attachments** ☐ Yes ☒ No
Key words passwords, computer equipment, locking, mobile and storage devices, clear desk, cameras, printers, fax machines	**Number** **REG-SEC-100-25**
Category Management of Information (MI)	**Effective Date** **04-November-2008**
Manual Information Security Policy	**Last Review Date** **07-May-2012**
Issued By IS&T Security Management	**Next Review Date** **07-May-2013**
Scope This policy applies to Regions Hospital and all of its operating units and related organizations (collectively, "HealthPartners/ REG").	**Implementation Date** **04-November-2008**
	Retired Date
Roles and Responsibilities Owner: IS&T Security Management Reviewer: IS&T Sr. Vice President & CIO	

I. PURPOSE

The purpose of this policy is to establish HealthPartners / REG employee, consultant, and agent user responsibilities in the use and protection of HealthPartners / REG information and assets.

II. POLICY

Passwords

Employees, consultants, and agents will be required to follow good security practices in their selection and use of passwords. All employees, consultants, and agents are required to:

- Keep passwords confidential. Do not share or ask someone for their passwords.
- Avoid keeping a record of passwords, unless they are stored securely by one of the approved methods: on paper in a locked cabinet/drawer or an encrypted flash drive.
- Change passwords whenever there is any indication of possible system or password compromise.
- Select strong passwords which are:
  - ✓ Easy to remember; select a phrase that means something only to you.
  - ✓ Not based on anything somebody else could easily guess or obtain using your personal information, i.e. names, telephone numbers, date of birth, etc.
  - ✓ Do not consist of dictionary words included in dictionaries.
  - ✓ Free of consecutive identical, all-numeric or all alphabetic characters.
- Change passwords at regular intervals and avoid re-using of passwords.
- Privileged accounts (accounts with more access rights) should be changed more frequently.

- Change temporary passwords at the first log-on.
- Do not include passwords in any automated log-on process, i.e. stored in a macro or function key.
- Do not share individual user passwords, this includes indirect sharing of passwords by logging in for someone with your password and allowing them to use your access (i.e. logging in for them but not actually providing them with your user ID and password).
- Do not use the same password for business and non-business purposes.
- Employees, consultants, and agents must not use identical passwords for different systems in which they have access.

Protecting computers, laptops, cameras, mobile computing and storage devices

- All employees, consultants, and agents are required to:
  - ✓ Terminate active sessions when finished, unless they can be secured by an appropriate locking mechanism (i.e. a password protected screen saver).
  - ✓ Log-off applications when the session is finished (i.e. turning off a computer screen is not sufficient).
  - ✓ Secure computers and terminals from unauthorized access by locking the computer when not in use or stepping away (i.e. pressing Ctrl+Alt+Delete and then Enter).
  - ✓ Cable-lock laptops to workstations or secure in a locked drawer.
  - ✓ Keep electronic devices and equipment secure by keeping on you or stored in a locked drawer when not in use. This includes digital cameras and memory sticks/cards used to capture patient images (see Mobile Computing and Storage Devices Policy REG-SEC-100-6).
  - ✓ Must not leave laptops unattended in a car, take it with you.
- A password protected screensaver will be implemented to automatically lock systems that are unattended. Exceptions to this requirement will be documented using the Workstation Exception Request process.

Clear desk and clear screen

- HealthPartners / REG confidential or PHI information, i.e. on paper or electronic storage media, should be locked away (ideally in a safe or locked cabinet) when not required, especially when the office is vacated.
- Computers and terminals should be left logged off or protected with a screen and keyboard locking mechanism controlled by a password, token or similar user authentication mechanism. When equipment is unattended it must be protected by a key lock, password, or other control when not in use.
- Incoming and outgoing mail points and unattended facsimile machines must be protected.
- Documents containing HealthPartners / REG confidential or PHI information must be removed from printers, fax machines, copiers, etc. immediately when not in use.

Suspicious Activity

All HealthPartners / REG employees, consultants and agents are responsible for securing day to day operations. If any HealthPartners / REG employees, consultants, and agents witness any suspicious activity they should inform IS&T Security Management immediately.

III. **PROCEDURE(S)**

N/A

IV. **RISK**

Adherence to HealthPartners policies and procedures reduces the risk of exposure of HealthPartners / REG information assets.

V. **DEFINITIONS**

Mobile Computing and Storage Devices include, but are not limited to: laptop computers, tablet computers, smartphones, pagers, cameras, keyfobs (hard tokens), personal digital assistants (PDAs), Universal Serial Bus (USB) storage devices, Compact Discs (CDs), Digital Versatile Discs (DVDs), flash drives, handheld wireless devices, memory sticks/cards and any other existing or future mobile computing or storage device owned by HealthPartners and/or may connect or access HealthPartners/REG applications and the network. Includes devices that store or access sensitive data: patient, member, employee, and company confidential data.

VI. **COMPLIANCE**

Failure to comply with this policy or the associated standards and procedures may result in disciplinary action, up to and including termination.

VII. **MONITORING AND MEASUREMENT**

This policy will be reviewed annually to determine its timeliness and relevance.

VIII. **ATTACHMENTS**

N/A

IX. **OTHER RESOURCES**

ISO 27002:2005 Section 11.3., User Responsibilities
Mobile Computing and Storage Devices Policy REG-SEC-100-6

+++

HealthPartners®

ORGANIZATIONAL PRIVACY STANDARDS:

Verifying Patient & Member Identity Over the Phone

Definitions:

Caller means a person who calls HealthPartners or whom HealthPartners calls on the telephone to communicate Protected Information.

Basic Rules:

1. Protected Information may only be given over the phone if (A) the person receiving the information has a right to receive it, and (B) the identity of the person receiving the information has been verified. The standards described in *both* (A) *and* (B), below, must be met.

   (A) Callers only have a right to receive Protected Information if:
   - The Caller is the **patient or member** who is the subject of the information;
   - The Caller is an **authorized legal representative** of the person who is the subject of the information;
   - The patient or member has **specifically authorized** the disclosure of the information to the Caller; or
   - HealthPartners is otherwise **authorized by law** to release the information to the Caller.

   (B) No Protected Information may be released to a Caller without first verifying the identity of the Caller by requesting the full name of the patient or member, plus *at least two (2)* of the following pieces of information:
   - Membership/insurance ID number
   - Patient account number or medical record number
   - Claim number or Authorization number
   - Employer/group name
   - Name of research study (if applicable)
   - Date of birth (correct month, day and year)
   - One other piece of information that exists in our system, such as current address or phone number.

2. When you verify a Caller's identity, ask the Caller for the information you need; DO NOT tell the Caller the information and ask the Caller to confirm. Instead, compare the information the Caller reports with the information you have on record.

3. If the information provided by the Caller does not match the information in our records, then the requested Protected Information should not be given to the Caller. Staff and providers should express an apology to the Caller and explain that that our privacy standards do not allow release of

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

information if we are not able to verify the Caller's identity – and explain that this is for the protection of our patients and members. If a Caller gives you verification information that is almost – but not quite – correct, you may give the Caller an opportunity to correct the mistake, but do not suggest what the error is (for example, if a person seems to have transposed digits in an identification number, you can tell the Caller that the number is not correct and ask the Caller to read it again).

4. **SPECIAL NOTE FOR MINORS:** If the Caller is the parent or Guardian of a Minor and the Protected Information relates to the Minor's reproductive health (including contraception, pregnancy, STDs), Hepatitis B or chemical dependency, the Protected Information must not be disclosed without the Minor patient or member's written Authorization – *even if the caller provides the appropriate verification information*.

Exceptions:

1. If the Caller is personally known to a caregiver or business leader (supervisor or manager), and the caregiver or business leader believes, in his or her professional judgment, that the Caller is who they say they are, and is authorized to receive the Protected Information, the caregiver or business leader may disclose the information, subject to the following:

   - The caregiver or business leader must inform the Caller that caller verification information will be required in the future; and
   - Disclosure must be documented in the member or patient's record, including name of Caller, what information was disclosed, purpose of disclosure, and the fact that caller verification information will be required in the future.

2. If the Caller requests general information that is not specific to a particular patient or member, we can give that information to the Caller without verifying his or her identity (for example, clinic hours or days of the week a particular provider works).

Examples:

1. Member calls Member Services and asks for additional information on a claim received in the mail. The Member Services Representative should ask the member for her name and two additional pieces of identifying information (see list under *Basic Rules*).

2. Medical Office Assistant (MOA) calls patient's home to leave an appointment reminder. When someone at the house picks up the phone, the MOA asks for the patient. The person who picked up the phone asks who is calling, and the MOA says that he is calling for [patient name] with an appointment reminder from HealthPartners. If that person then begins to ask questions about the type of appointment, the MOA may not provide any information about the kind or location of the

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

appointment. MOA should only leave his name and a call-back number. If the person who answered the phone claims to be the patient, MOA should get at least two pieces of identifying information (see list).

3. Nurse leaves a voicemail for a 16-year-old patient requesting a call back; parent calls back – identifies herself as the patient's mother and provides two correct pieces of identifying information for the patient. If the information relates to a "sensitive service" (such as reproductive health or chemical health), the nurse must refrain from providing any information to the parent. If the information does not relate to a "sensitive service," the nurse may provide the information to the parent.

Practical Tips:

1. There is no need to be shy about asking the Caller for their verification information. If you are polite but firm, most people will understand that we are doing this for the protection of our members and patients.

2. If a Caller is reluctant to provide the information, it is important to clarify why you are asking: To protect the patient or member's privacy.

3. If you have left a message for a patient or member to call you, make sure to ask for the Caller verification information when the call is returned.

4. If you are concerned that the Caller is not who they say they are, even if they provide accurate verification information, you have a couple of good options:
   - Politely place the Caller on hold, explain your concerns to your supervisor and ask your supervisor to resume the call, or
   - Politely tell the Caller that you will call them back shortly and call back at a number we already have documented for that person in our system.

Important Reminder:

These are important standards for you to follow. If you don't follow them, you may be subject to discipline.

Other Resources:

Organizational Privacy Standards: Special Privacy Considerations for Adolescents and Other Minors
Organizational Privacy Standards: Using and Releasing Protected Information (Consent/Authorization)

For help, contact your supervisor or the Office of Integrity and Compliance at privacy@healthpartners.com or 952-883-5124.

+++