RULES & REGULATIONS OF THE MEDICAL STAFF

85202

Medical Staff Services
May 30, 2017

Banner
Behavioral Health
Hospital – Scottsdale

BANNER BEHAVIORAL HEALTH HOSPITAL
MEDICAL STAFF RULES and REGULATIONS

TABLE OF CONTENTS

BANNER BEHAVIORAL HEALTH HOSPITAL
MEDICAL STAFF RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles of conduct found in the Medical Staff Bylaws. Rules and Regulations shall set standards of practice that are to be required of each physician and other practitioners privileged to practice in the hospital, and shall aid in evaluating performance under the compliance with these standards. Rules and Regulations shall have the same force and effect as the Medical Staff Bylaws.

I. GENERAL RULES REGARDING PRACTICE IN THE HOSPITAL

1.1 Each patient will be under the care of an attending physician. The attending physician will be responsible for the care of each patient for whom they have established an attending relationship.

1.2 Transfer of care to one attending physician to another physician who has agreed to accept the patient shall be entered on the patient's chart by order of transfer by the admitting physician.

1.3 Each member of the Medical Staff shall be responsible for providing the hospital with current information as to the address and telephone numbers where he/she can be reached, and the names of any other members of the Medical Staff who are to be contacted in the event of his/her unavailability.

1.4 The Emergency Management Plan shall be rehearsed twice a year by key hospital personnel, including members of the Medical Staff. Each member of the staff shall be responsible for familiarizing him/herself with the plan, a copy of which is available through the Administrative Office. In cases of evacuation of patients from one section of the hospital to another or evacuation from hospital premises, the Chief Medical Officer or Chief of Staff, in conjunction with the Chief Executive Officer, will authorize the movement of patients. All physicians on the Medical Staff specifically agree to relinquish direction of the professional care of their patients to the Chief Medical Officer, Chief of Staff or their respective designee in cases of such emergency.

1.5 Consulting (non-psychiatric) staff members may evaluate and examine patients; write orders and make recommendations for patient care to the attending physician.

1.6 The attending physician is expected to attend patient case conferences (staffings) and participate in multidisciplinary treatment planning.

1.7 Disclosure of Unanticipated Outcomes - It is the policy of Banner Health that patients, their legally authorized representative, and when appropriate, their families be informed about the outcomes of care including unanticipated outcomes. The responsibility for disclosure is a collaborative effort between the physician, Administration, Quality Management and Risk Management. Disclosure shall be made in accordance with the Banner Health Disclosure of Unanticipated Outcomes Policy.

II. ADMISSION

2.1 Each patient shall be admitted by a member of the Medical Staff with admitting privileges and with appropriate privileges to manage and coordinate the patient's care, treatment and services.

2.2 No patient shall be admitted to the Hospital until a provisional diagnosis has been stated.

2.3 Patients will not be discriminated against on the basis of race, creed, color, age, sex, national origin, religion or disability.

2.4 If there is a conflict concerning the suitability of the admission of a patient, the Chief Medical Officer or his/her designee shall determine the necessity for, or deferment of, the admission.

2.5 Patients shall be admitted only for the treatment of conditions and diseases for which the hospital has facilities and personnel.

2.6 On admission, and as necessary, the physician is responsible for writing or phoning orders appropriate to the care of the patient for initial treatment to include unit, meds, program, diet, laboratory tests, x-rays, special precautions, or assessments.

2.7 A medical history and physical examination must be entered into the medical record within 24 hours of admission to the BBHH. Physicians will co-sign the medical history and physical if delegated to a family nurse practitioner.

2.8 Medical histories and physicals may also be accepted from physicians, nurse practitioners or physician assistants who are not members of the medical staff, if they are complete, legible, and if they were completed in the last 30 days prior to the hospital admission. However, an assessment and update must be performed within 24 hours after the admission or prior to an ECT procedure by a member of the Medical Staff. This assessment and update shall include any components of the patient's current medical status that may have changed since the prior history and physical or will address any areas where more current data is needed, and it will confirm that the necessity for the care and/or procedure is still present. This update must be authenticated.

2.9 A medical history and physical examination is not required for patients in the Intensive Outpatient Program (IOP).

2.10 Pelvic, rectal and breast examinations are not required to be conducted as part of the physical examination, absent a clinical indication.

2.11 Where any portion of the physical examination is not performed because it is contraindicated, such contraindication will be properly documented and specific to the case. In each such case, upon discharge, appropriate referrals will be made for follow-up as indicated.

2.12 A comprehensive psychiatric evaluation and preliminary treatment plan exam must be completed within 24 hours of admission to the BPC and within 24 hours of admission to BBHH.

III. TREATMENT

3.1 Members of the Medical Staff shall have the authority to write orders, and all orders must be legibly entered in the patient's record, dated**,** timed and signed by the responsible physician. Members of the Psychology Staff shall have authority to write those orders for which privileges are granted; all orders must be entered in the patient's record and authenticated.

3.2 Patients, including outpatients, shall be treated only by physicians, psychologists and allied health professionals who have been granted privileges in conformity with the Medical Staff Bylaws**,** or by allied health professionals who are employed by the Hospital.

3.3 Telephone orders may be given only to a registered nurse**,** licensed practical nurse, or pharmacist, must be dated, timed and signed by the nurse/pharmacist per the attending physician and countersigned as soon as possible by the acting or responsible physician for all

acute care and residential treatment patients, but will be considered delinquent if not signed within 72 hours.

3.4 Physicians or psychiatric nurse practitioners are required to visit acute care patients at least five days per week. Progress notes must be written at the time of each patient visit by the physician or psychiatric nurse practitioner.

3.5 Physicians are required to visit patients in residential treatment units at least one time per week. Progress notes must be written at the time of each physician visit.

3.6 All orders for x-ray examination shall contain a concise statement of the reason for the examination.

3.7 Therapeutic diets may be prescribed by the dietician, with approval of the attending physician.

3.8 Practitioners shall be responsible to use only approved symbols or abbreviations in the medical record. See Banner Health's policy "Medical Record Abbreviations and Symbols".

3.9 Patient treatment provided shall be consistent with hospital Medical Staff Bylaws, Rules and Regulations and policies.

3.10 Consultation shall be required in all non-emergency cases in which, in the judgment of the attending physician, specific skills of other practitioners may be indicated.

3.11 Consultation or a second opinion will be sought when requested by the patient or his/her family.

3.12 Consultation must be rendered on a timely basis. Consultants are expected to see patient within 24 hours for situations that are not considered imminently serious or potentially life-threatening. Every effort should be made to coordinate orders between multiple consultants and the attending physician. The attending physician will coordinate orders unless he/she specifies differently.

3.13 It shall be the responsibility of the Medical Staff to obtain informed consents from the patient prior to performing any unusual or high-risk medical procedure, including ECT. Such consent shall be evidenced by the hospital's consent form signed by the patient or his/her representative and responsible physician. Failure to include a completed consent form in the patient's chart prior to the performance of the procedure shall automatically cancel the procedure. Whenever the emergency nature of the case prevents the obtaining of prior consent, every effort shall be made, and documented, to obtain the consent of the patient's legal representative.

IV. DISCHARGE

4.1 The attending physician is responsible to assure a final diagnosis is entered in the medical record at the time of discharge. An attending physician may provide a final discharge order by telephone.

4.2 At the time of discharge, the attending physician shall see that any orders for the continuing care of the patient have been entered in the medical record.

4.3 Should a patient express an intent to leave the hospital, the physician will be contacted to make a determination whether to discharge the patient, discharge the patient against medical advice, or commence the petitioning process.

4.4 If the patient is to be transferred or transported to another health facility, the Medical Staff member or Allied Health Professional shall explain to the patient/legally authorized representative the reasons for and risks and benefits of transfer/transport, write an order for transfer/transport, including the mode of transportation and whether designated staff member will accompany the patient. The Medical Staff member or Allied Health Professional will obtain the patient's consent for transfer or, in an emergency, document why such consent could not be obtained.

V. GENERAL PHARMACY AND THERAPEUTICS POLICIES

5.1 General Information

All medication administered to patients at BBHH will be supplied by the BBHH Department of Pharmacy Services unless otherwise defined by policy or by pharmacy approval. The Department of Pharmacy Services maintains a formulary as authorized by the Medical Executive Committee. The formulary is an established compendium of approved medications available at BBHH for diagnostic, prophylactic, therapeutic or empiric treatment of patients. The pharmacy is not required to stock more than one brand of an individual medication as approved by the Medical Executive Committee. Medications ordered by trade name may not necessarily be filled by that name unless the physician states "do not substitute" within the order. The pharmacy will be permitted to make therapeutic substitutions of medications only within clearly defined parameters established and approved by the Medical Executive Committee. Medication samples shall not be used for patients of the Hospital.

5.2 Medications

Medications brought into the medical center by patients must be specifically ordered by the physician and identified according to approved policy before being administered by the Medical Center personnel. Use of a blanket statement is not allowed. For example, "Use patient's own medications" is not acceptable.

5.2.1 These medications will be kept at the nursing unit. Medications may be kept at the patient's bedside for self-administration only upon specific written orders of the physician.

5.2.2 Medications brought in by the patient that cannot be identified will not be administered to the patient by Medical Center Hospital personnel nor should they be taken by the patient.

5.2.3 Outpatient prescriptions, with the few exceptions defined in Banner policy, will not be filled at BBHH. If a medication is to be sent home with a patient, a prescription must be written.

5.3 Medication Orders

5.3.1 Whenever possible, medication orders must be entered electronically directly into the EMR.

5.3.2 Written orders for medications must be legible, clear and accurate and must be authenticated.

5.3.3 All medication orders must be complete, including patient name (present on order sheet or prescription); age and weight of patient, when applicable; medication name; dosage form, dose, strength, route, frequency, rate and method.

5.3.4 Medications ordered by "PRN" must specify frequency and indication.

5.3.5 The use of abbreviations should be minimized and only standard abbreviations on the Medical Center's approved list can be used.

5.3.6 Medication dosages should be expressed in the metric system and a leading zero must always precede a decimal expression of less than one (i.e., 0.1 mg not .1 mg). A terminal or trailing zero is never to be used after a decimal (e.g., 1 mg never 1.0 mg).

5.3.7 There must be documentation of medical necessity or clinical indications in the medical record for all medication orders.

5.3.8 There will be no automatic stop order except for those medications defined by the Pharmacy and Therapeutics Committee or the medication order indicates the exact number of doses to be administered or an exact period of time of the medication is specified.

5.3.9 All medication orders must be reviewed and updated when a patient is transferred from one medical service to another or from one level of care to another.

5.4 Authorization to Order Medications
Practitioners licensed by the State of Arizona to prescribe medications may write orders for medications, if they satisfy the requirements for privileges on the Medical Staff of BBHH consistent with their scope of practice. Allied Health Professionals as defined in the Bylaws may write orders under the policies outlined in the AHP Rules and Regulations. Registered pharmacists are permitted to order medications under physician ordered pharmacotherapy consults and MEC approved therapeutic guidelines.

5.5 Authorization to Administer Medications
Only appropriately licensed personnel or approved personnel working under the direction of a licensed person may be allowed to administer medications. Administration of medications will be in response to an order by an authorized individual, as set forth above and as directed by applicable Hospital policy.

5.6 Reporting Adverse Drug Events
All adverse drug events shall be reported using the approved system as per BBHH policy.

5.7 ECT and other types of specialized treatment shall be given on signed consent of the patient. Whenever possible, the signed consent of the legal representative or responsible relative should also be obtained.

5.8 ECT therapy in pregnancy shall be given only after psychiatric and obstetrical consultation.

5.9 ECT therapy in adolescents shall be given only after consultation with two qualified child and adolescent psychiatrists who have training or experience in the treatment of adolescents and who are not affiliated with the treatment program and who concur with the decision to administer such therapy. The consultant shall write his findings and recommendations and his report shall be part of the patient's record.

ARTICLE VI. MEDICAL RECORD POLICIES

6.1 General Rules
- 6.1.1 A Medical Record is established and maintained for each patient who has been treated or evaluated at the Medical Center. The Medical Record, including electronic data, medical imaging, pathological specimens and slides, are the property of the Medical Center.
- 6.1.2 For purposes of this Medical Records section, practitioner includes physicians, advanced practice nurses, physician assistants, and other credentialed practitioners to give orders, provide consultations and/or perform procedures.

6.2 Purpose of the Medical Record - The purposes of the medical record are:
- 6.2.1 To serve as a detailed data base for planning patient care by all involved practitioners, nurses and ancillary personnel.
- 6.2.2 To document the patient's medical evaluation, treatment and change in condition during the Medical Center stay or during an ambulatory care, or emergency visit,
- 6.2.3 To allow a determination as to what the patient's condition was at a specific time,
- 6.2.4 To permit review of the diagnostic and therapeutic procedures performed and the patient's response to treatment,
- 6.2.5 To assist in protecting the legal interest of the patient, Medical Center and practitioner responsible for the patient and to provide data for use in the areas of quality and resource management, billing, education, and research.

6.3 Electronic Medical Record (EMR) - Banner Health is a "paper light" organization. As such, physicians need to adhere to record keeping practices that support the electronic environment. As much data as possible will be created electronically and paper-based documentation will be scanned. Records will be accessed by physicians and other users online and the records will not be printed for internal use. Subsequently referred to herein as EMR.

6.4 Use of EMR - All medical record documents created after the patient is admitted will be created utilizing BH approved forms or BH electronic systems to allow for patient information to be exchanged and shared electronically among healthcare providers. This includes Psychiatric Evaluations, Procedure Reports, Consultations, Discharge Summaries, and Progress Notes. The following documents are exceptions:

6.4.1 Documents from contracted/credentialed external sources that pertain to the delivery of patient care, such as radiology and telemedicine reports and select physician orders, with approval by the BH System Forms Committee. These reports must meet the time requirements and contain the data elements specified in the Medical Staff Rules and Regulations.

6.4.2 Banner Health approved forms and templates that are pre-populated and maintained by the provider with physician specific information such as consents and discharge instructions. These forms will be required to meet Banner Health forms template guidelines for bar-coding/scanning purposes and should not be photocopied by the provider. This exception does not apply to pre-populated forms maintained by Standard Register.

6.4.3 Other documents that are created utilizing BH unapproved forms or non-BH electronic systems after the patient is admitted may be accepted only through approval of the BH System Forms Committee.

6.5 Access to the EMR - Access to patient information on the EMR will be made available to Medical Staff and Allied Staff members and their staff through Clinical Connectivity. All access to electronic records is tracked and unauthorized access to a patient's record is not tolerated.

6.6 EMR Training - Practitioners who are appointed to the Medical Staff or Allied Health Staff pending Banner electronic medical record training (EMR) and who have not completed this training within six (6) months of appointment will be considered to have voluntarily resigned from the staff**.** Practitioners will be advised of the training requirement at or prior to appointment and reminded of the requirement five (5) months from the date of appointment. Exceptions will be made on a case by case basis to be determined by the facility CEO.

6.7 Retention - Current and historical medical records are maintained via clinical information systems. The electronic medical record is maintained in accordance with state and federal laws regulatory guidelines and Banner Records Retention Policy.

6.8 Confidentiality of Patients' Medical Records - The medical records are confidential and protected by federal and state law. Medical record access to confidential materials by authorized individuals is only permissible when access is sought for patient care, payment, peer review, risk management, approved research, or other appropriate authorized activity. This requirement applies irrespective of the form in which confidential materials are maintained or stored and applies equally to information stored in hard copy form or electronically stored. In addition, Banner Health safeguards patients' records against unauthorized disclosure and/or use, loss, defacement, and tampering. Unauthorized access or disclosure of confidential patient information or tampering, loss or defacement of medical records constitutes grounds for disciplinary action.

6.9 Release of Patient Information - Banner Health releases patient information only on proper written authorization of the patient or as otherwise authorized by law and Banner policies.

Medical Records may be removed from the Medical Center only in accordance with state and federal law, a court order, or subpoena, the permission of the Medical Center's Chief Executive Officer, or in accordance with Banner Health's policies. Unauthorized removal of an original medical record or any portion thereof from the Medical Center or disclosure of Patient Information constitutes grounds for disciplinary action.

6.10 Passwords - All practitioners must maintain the confidentiality of passwords and may not disclose such password to anyone.

6.11 Information from Outside Sources - Health record information obtained on request from an outside source is placed in the medical record and is available to the professional staff treating the patient. This information will contain the source facility name/address. Results of examination (Laboratory and X-Ray) performed prior to admission of the patient to the Medical Center and that are required for or directly related to the admission are made a part of the patient's Medical Center record.

6.12 Abbreviations - Practitioners shall be responsible to use only approved symbols or abbreviations in the medical record. See Banner Health's policy "Medical Record Abbreviations and Symbols" list.

6.13 Responsibility - The attending physician is responsible for each patient's medical record. The medical record must identify who is primarily responsible for the care of the patient. Transfers of primary responsibility of the patient are not effective until documented in the clinical information system by the transferring physician and accepted on the clinical information system by the accepting physician. All clinical entries in the patient's record must be accurately dated, timed and individually authenticated by the responsible physician; group signing of documentation is not permissible. Authentication means to establish authorship by written or electronic signature and shall consist of the practitioner's name and professional title indicating the professional credential. Electronic signature authentication of medical records is the standard practice.

6.14 Counter-authentication (Endorsement) -

- 6.14.1 Physician Assistants – History and Physical Reports, Operative/Procedural Notes, Psychiatric Evaluations, Consultations and Discharge Summaries must be counter-authenticated timely by the physician according to medical staff policies. Each clinical event must be documented as soon as possible after its occurrence. Requirements for countersignature of Progress Notes will be established and monitored by the supervising physician.
- 6.14.2 Psychiatric Nurse Practitioners – History and Physical Reports, Psychiatric Evaluations, Progress Notes, Consultations, and Discharge Summaries are not required to be counter-authenticated by the physician. Each event must be documented as soon as possible after its occurrence.
- 6.14.3 Family, Acute and Adult Nurse Practitioners – Medical History and Physical Reports and Consultations are not required to be counter-authenticated by the physician. Each clinical event must be documented as soon as possible after its occurrence. Requirements for countersignature of Progress Notes will be established and monitored by the supervising physician.
- 6.14.4 Medical Students - Access to view the patient chart only. May not document in the medical record.
- 6.14.5 House Staff, Resident, and Fellows- Requirements for countersignatures will be established and monitored by specific training programs. Each clinical event must be documented as soon as possible after its occurrence. The Health Information Management Services Department does not monitor countersignatures by House Staff, Resident or Fellows. Appropriate action will be taken by the specific training programs.

6.15 Legibility - All practitioner entries in the record must be legible, pertinent, complete and current.

6.16 Medical Record Documentation and Content
The medical record must identify the patient, support the diagnosis, justify the treatment, and document the course and results of treatment and facilitate continuity of care. The medical record is sufficiently detailed and organized to enable:

6.16.1 The responsible practitioner to provide continuing care, determine later what the patient's condition was at a specified time, and review diagnostic/therapeutic procedures performed and the patient's response to treatment.

6.16.2 A consultant to render an opinion after an examination of the patient and review of the health record.

6.16.3 Another practitioner to assume care of the patient at any time.

6.16.4 Retrieval of pertinent information required for utilization review and/or quality assurance activities.

6.16.5 Accurate coding diagnosis in response to coding queries.

6.17 History and Physical Examination (H &P) - A history and physical examination must be performed within 24 hours after admission or registration for inpatients or observation or prior to any procedure in which IV Moderate Sedation or anesthesia will be administered. The H&P shall be completed by a physician, or Allied Health Professional who is approved by the medical staff to perform admission history and physical examinations, and placed in the patient's medical record. The completed H&P must be on the medical record or the case will be cancelled unless the responsible physician documents in writing that such delay would constitute a hazard to the patient.

6.17.1 A legible office history and physical performed within 30 days prior to admission is acceptable with an updated medical record entry documenting an examination for any changes in the patient's condition. The updated examination must be completed and documented in the patient's medical record within 24 hours after registration or admission but prior to a procedure requiring anesthesia services.

6.17.2 For patients receiving electro-convulsive therapy in a behavioral health unit, a current H&P must be completed prior to each treatment.

6.17.3 If approved by the Medical Staff, the Emergency Room report or Consultation report may be used as the H&P as long as all elements in section 6.19 are included and the document is filed as a History and Physical on the EMR.

6.18 Responsibility for H&P or Comprehensive Psychiatric Evaluation – The attending medical staff or allied health member is responsible for the H&P or Evaluation, unless it was already performed by the admitting provider. H&Ps performed prior to admission by a practitioner not on the medical staff are acceptable provided that they are updated timely by the attending physician or allied health member.

6.19 Contents of a H&P – For all inpatients, observation patients, and for those outpatients having procedures requiring general, spinal or epidural anesthesia, or IV moderate sedation, the H&P must include the following documentation as appropriate:

6.19.1 Medical history

6.19.2 Chief complaint

6.19.3 History of the current illness, including, when appropriate, assessment of emotional, behavioral and social status

6.19.4 Relevant past medical, family and/or social history appropriate to the patient's age.

6.19.5 Review of body systems.

6.19.6 A list of current medications.

6.19.7 Any known allergies including past medication reactions and biological allergies

6.19.8 Existing co-morbid conditions

6.19.9 Physical examination: current physical assessment
6.19.10 Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination
6.19.11 Initial plan: Statement of the course of action planned for the patient while in the Medical Center.
6.19.12 For other outpatient (ambulatory) ECT patients, as necessary for treatment:
6.19.12.1 Indications/symptoms for the procedure.
6.19.12.2 A list of current medications.
6.19.12.3 Any known allergies including past medication reactions.
6.19.12.4 Existing co-morbid conditions.
6.19.12.5 Assessment of mental status.
6.19.12.6 Exam specific to the procedure performed.
6.19.13 IV moderate sedation - For ECT patients receiving IV moderate sedation, all of the above elements in section 7.19.1- 7.19.12, plus the following:
6.19.13.1 Examination of the heart and lungs by auscultation.
6.19.13.2 American Society of Anesthesia (ASA) status.
6.19.13.3 Documentation that patient is appropriate candidate for IV moderate sedation.

6.20 Behavioral Health Documentation
6.20.1 A psychiatric evaluation including an initial plan of treatment, mental status examination, diagnosis and estimated length of stay, shall be completed and documented within 24 hours after admission of the patient. Attending Physicians or Allied Health Professional will be responsible to complete the psychiatric evaluation and the above documentation.
6.20.2 A physical examination shall be performed and documented within 24 hours of admission or registration of the patient. Physical examinations may be used from the previous hospitalization if the examination was within 30 days. Physical examinations may be accepted from a doctor's office if the examination was done within 30 days of admission and meets the standards as defined by hospital policy and procedure. If the patient was transferred from another hospital, the physical examination may be accepted if done within the last 30 days provided they are updated within 24 hours of admission or registration by the attending physician.
6.20.2.1 In the above cases, the attending physician or allied health must validate the physical examination in the medical record (on the physical exam) by noting that there are no significant findings or changes and signs and dates the report.
6.20.3 Pertinent progress notes related to diagnosis and to treatment plan goals and objectives, sufficient to permit continuity of care shall be recorded at the time of observation. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress note and correlated with specific orders, as well as results of tests and treatments. A progress note shall be documented and authenticated after each visit by the attending physician.
6.20.3.1 Physicians shall document abnormal diagnostic values and their response to such;
6.20.3.2 Consultants shall document, authenticate, time, and date all assessments, diagnostic tests, and treatments, etc. whenever they see a patient.
6.20.3.3 All entries must be dated, timed and authenticated by the person making the entry and must include his/her discipline.
6.20.4 Therapeutic Leaves of Absences (Passes) the attending physician shall write an order specifying date and length of the pass, therapeutic goals and the identity of any person to accompany the patient. The attending physician or allied health will indicate any medication to be taken by the patient during the pass by a specific order.
6.20.5 Discharge Documentation
6.20.5.1 Patients shall be discharged only on given order of the discharging physician.

6.20.5.2 AMA discharge orders must be given by the attending physician or his/her designee. Exceptions may only be made by the Medical Director who has the authority to discharge a patient for administrative reasons.

6.20.5.3 At the time of discharge, but no later than 24 hours after, the attending physician shall complete the discharge summary according to the approved guidelines and state final diagnoses according to DSM-5 terminology OR according to current psychiatry diagnostic terminology**.**

6.20.5.4 A category of disposition must be included in the discharge summary.

6.20.5.5 Discharge Summaries may be constructed by an approved non-physician. Utilizing a non-physician for medical record analysis, information compilation and discharge summary construction is the prerogative of the attending physician. Physicians who chose this practice must give prior authorization of their intent, obligation and responsibility of their intent, obligation and responsibility to read, review, approve and authenticate every clinical resume.

6.20.5.6 The attending physician ensures that the content of the dictated discharge summaries (M.D. dictated and non-M.D. dictated) is accurate, complete, and meets all pertinent requirements.

6.20.5.7 Against Medical Advice (AMA) Discharged at insistence of self or family when patient is not considered imminently suicidal or homicidal, but is in such a condition that there is serious risk of rapid relapse or other clinical complication.

6.21 Progress Notes - Progress notes should be electronically created that reflects appropriate attending involvement but at least every day. Progress notes should describe not only the patient's condition, but also include response to therapy.

6.22 Admitting Note- The responsible provider must see the patient and document an admitting note (that justifies admission and determines the plan of treatment) within 24 hours of admission.

6.23 Consultation Reports - A satisfactory consultation includes examination of the patient as well as the medical record and should be electronically recorded or dictated within 24 hours. When electro-convulsive therapy procedures are involved, the consultation shall be recorded prior to the procedure (except in an emergency).

6.24 Preoperative, Intraoperative & Post Anesthesia/Sedation Record for General, Regional or Monitored Anesthesia

6.24.1 Preoperative Anesthesia/Sedation Evaluation – A preanesthesia/sedation evaluation must be conducted and documented by an individual qualified to administer anesthesia or conscious sedation within 48 hours prior to the procedure. A preanesthesia/sedation evaluation of the patient must include review of the medical history, including anesthesia, drug and allergy history; review and examination of the patient; notification of anesthesia risk (per ASA classification); identification of potential anesthesia problems, particularly those that suggest potential complications or contraindications; additional pre-anesthesia as applicable; and development of the plan for anesthesia care, including type of medications for induction, maintenance, and post-operative care and discussion with the patient of risks and benefits. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before pre-operative medication has been administered. Immediately prior to the induction of anesthesia while the patient is on the procedural table, the patient's vital signs, airway and response to pre-procedure medication must be assessed and the equipment checked.

6.24.2 Intraoperative Anesthesia/Sedation Record - The intraoperative anesthesia/sedation record will also include the name of the practitioner who administered anesthesia and the name of the supervising anesthesiologist or operating practitioner; techniques used and

patient position(s), including the insertion/use of any intravascular or airway devices; name and amounts of IV fluids, including blood or blood products if applicable; time-based documentation of vital signs as well as oxygenation and ventilation parameters; and any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

6.24.3 Post Anesthesia Evaluation - The post anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after a procedure requiring anesthesia services and, for outpatients, prior to discharge. The record must include respiratory function, including respiratory rate, airway patency and oxygen saturation; cardiovascular function, including pulse rate and blood pressure; mental status; temperature, pain; nausea and vomiting; and postoperative hydration.

6.25 ECT Treatment Notes – An ECT treatment note is documented upon completion of the ECT procedure and before the patient is transferred to the next level of care.

6.25.1 The ECT treatment note includes the following information:

6.25.1.1 The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)

6.25.1.2 The name of the procedure performed

6.25.1.3 A description of the procedure

6.25.1.4 Findings of the procedure

6.26 Informed Consent - Prior to any invasive procedures or ECT Treatment, the medical record must contain an informed consent. See Section 5.7.

6.27 Special Procedures – EKGs will be interpreted and documented within 24 hours of notice. Notice will be a communication to the physician or agent to inform the provider of the test completion.

6.28 Discharge Documentation A discharge summary must be documented at the time of discharge but no later than 24 hours thereafter by the responsible practitioner on all Inpatient and Observation hospitalizations 48 hours or greater in length.

6.28.1 The discharge summary shall include:

6.28.1.1 Reason for hospitalization

6.28.1.2 Concise summary of diagnoses including any complications or co-morbidity factors

6.28.1.3 Hospital course, including significant findings

6.28.1.4 Procedures performed and treatment rendered

6.28.1.5 Patient's condition on discharge (describing limitations)

6.28.1.6 Patients/Family instructions for continued care and/or follow-up

6.28.2 The final discharge progress note should be documented immediately upon discharge for inpatient stays less than 48 hours, observations, and extended recovery. The discharge progress note will include:

6.28.2.1 Final diagnosis (is)

6.28.2.2 Condition of patient

6.28.2.3 Discharge instructions

6.28.2.4 Follow-up care required

6.29 Documentation of Death - A death summary is required for all deaths regardless of length of stay and must be documented at the time of death but no later than 24 hours thereafter by the responsible practitioner.

6.30 Documentation for Inpatient Transfers to another facility– The transferring physician must dictate or electronically create a transfer summary regardless of length of stay to include documentation

that patient was advised of risks/benefits of transfer at the time of transfer but no later than 24 hours thereafter.

6.31 Amending Medical Record Entries

6.31.1 Electronic Documents (Structured, Text and Images)

6.31.1.1 Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error or omission through the EMR. The EMR will track all changes made to entries.

6.31.1.2 Once an entry has been authenticated and an error is found, the EMR will force the author to record his/her comments in the form of an electronic addendum in which the individual will document the erroneous information, authenticate the entry and the system will be date and time stamp the entry.

6.31.1.3 If information is found to be recorded on the wrong patient, regardless of the status of the entry, the EMR will not allow deletion of any entries. The entry recorded in error must be documented as such by the author, and re-enter the information on the correct patient.

6.31.2 Paper-Based Documents

6.31.2.1 Any individual who discovers his/her own error or omission prior to the authentication of the entry shall immediately, upon discovery, correct the error by drawing a single line through the erroneous entry, but not obliterating it, and initialing and dating the error.

6.31.2.2 Errors or omissions discovered at a later time shall be corrected by the individual with a new entry. The person making the change shall sign and note the date of the change and reason for the change. The new entry shall also state who was notified of the change and the date of such notification. The individual must notify the HIMS Department to permit a review of the erroneous documentation for recording in-error criteria within the EMR.

6.31.2.3 Any physician who discovers a possible error made by another individual should immediately upon discovery notify the supervisor of that clinical or ancillary area.

6.31.2.4 Upon confirmation of the error, the patient's attending physician and any other practitioners, nurses or other individuals who may have relied upon the original entry shall be notified as appropriate.

6.32 Complete Medical Record - The Medical Record is not considered complete until all its essential elements are documented and authenticated, and all final diagnoses and any complications are recorded, consistent with these Rules.

6.33 Timely Completion of Medical Record Documents - All medical record documents shall be completed within time frames defined below:

Documentation Requirement	Timeframe	Exclusions
Admitting Progress Note	Documented within 24 hours of admission	
History & Physical	Documented within 24 hours of admission and before invasive procedure	
Consultation Reports	Documented within 24 hours of notice.	
Provider Coding Clarification	Documented response no later than 7 days post notification to the provider	

Procedure Report	Documented immediately after procedure and no later than 24 hours after the procedure	
Discharge Summary Report	Documented at the time of discharge but no later than 24 hours	Not required on all admissions less than 48 hours
Discharge Progress Note	Documented at the time of discharge but no later than 24 hours after discharge for all admissions less than 48 hours	
Death Summary Death Pronouncement Note	Documented at the time of death/disposition but no later than 24 hours after death Completed at the time the patient is pronounced within 24 hours	
Transfer Summary	Documented at the time of transfer no later than 24 hours	
Signatures	Authentication of transcribed or scanned reports and progress notes, within 7 days from date of notice	
Verbal Orders	Date, time, and authenticated within timeframe specified by AZ regulations – within 72 hours	
Psychiatric Evaluation	Documented within 24 hours for Banner Psychiatric Center (BPC) patient and within 24 hours of hospital admission	

6.34 Copying and Pasting – Medical Staff members and Allied Health Professionals may not indiscriminately copy and paste documentation from other parts of the applicable patient's records. If copying a template, the practitioner shall make modifications appropriate for the patient. If copying a prior entry, the practitioner shall make appropriate modification based upon the patient's current status and condition. The practitioner must reference the date of the prior note as appropriate. When copying patient data into the medical record from another provider, the practitioner must attribute the information to the person who performed the task unless it is readily apparent, based upon the nature of the information copied, that the data was entered by another provider. If referencing a form within the record, the form must be referenced with sufficient detail to identify the source. Example: "for review of systems, see form dates 6/1/10."

6.35 Medical Record Deficiencies

6.35.1 Physicians and Allied Health Professionals are advised of incomplete documentation via the physician inbox. The Health Information Management Services Department shall advise physicians, by fax, mail or electronic notice of incomplete medical records. Notice of Incomplete Records will be sent after a qualifying deficiency has met or exceeded the timeframes in section 6.33. The notice will include a due date and a list of all incomplete and delinquent medical records.

6.35.2 If a vacation prevents the practitioner from completing his/her medical records the physician must notify the Health Information Services Department in advance of the vacation; otherwise the suspension/sanction will remain in effect until the documentation

is completed. If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the physician or the physician's office must notify the Health Information Management Services Department.

6.36 Medical Record Suspensions/Sanctions

6.36.1 A medical record is considered eligible for suspension/sanction based on the timeframes in section 6.33.

6.36.2 If the delinquent records are not completed based on the timeframes in section 6.33, providers will receive a notice and their admitting, procedure scheduling and consultative privileges will be temporarily suspended until all medical records are completed as outlined in section 6.37 and Medical Staff Bylaws 6.6.3, Automatic Suspension or Limitation, Medical Records.

6.36.3 A suspension/sanction list will be generated weekly and made available to the Executive Committee, Administration, Medical Staff Services, Patient Registration, Patient Placement, and appropriate patient care units.

6.36.4 Continuous Temporary Suspension – The Medical Staff shall institute a process to address chronic medical record delinquency and temporary suspension of privileges or sanction.

6.36.5 For new facilities or facilities implementing new EMR software, Medical Executive Committee may choose not to take action regarding delinquent medical records during the Medical Center's first 180 days of operation, or initial phase of implementation.

6.37 Continuous Temporary Suspension/Automatic Termination of Privileges for Delinquent Medical Records

6.37.1 Temporary suspension shall become automatic permanent suspension following 60 cumulative days of temporary suspension within any consecutive 12 month period. At that time, the practitioner's privileges will automatically move to permanent suspension for failure to complete medical records. Affected practitioners may request reinstatement during a period of 30 calendar days following permanent suspension if all incomplete and delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the staff. In order to reinstate their staff privileges following such action, the physician will be required to re-apply for medical staff membership, including the reapplication fee.

6.37.2 Neither temporary nor permanent suspension of privileges or revocation of membership and privileges under this Section entitles a staff member to rights pursuant to the Fair Hearing Plan. Physicians may submit evidence demonstrating why the suspension/revocation is unwarranted to the Medical Executive Committee pursuant to Article 6.3 of the Bylaws.

6.38 Confidentiality of Patients' Medical Records

6.38.1 General. Patients' medical records are the property of the Hospital. Because they are confidential, the Hospital releases the information contained in them only on proper written authorization of the patient. In addition, the Hospital safeguards patients' records (whether hard copy, microfilm or computerized) against unauthorized disclosure and/or use, loss, defacement, and tampering. The Medical Records Department keeps a log of all requests for and of specified persons gaining physical access to patients' Medical Records.

6.38.2 Medical Staff Member Responsibility. Medical Staff Members must:

a. Use and Disclose patient health information only as necessary for treatment, payment or health care operations and authorized research. Health care operations include activities such as peer review, quality assessment and performance improvement.

b. Otherwise obtain patient consent.
c. Protect access codes and computer passwords to protect confidential information.

6.38.3 Extremely Sensitive Patient Information. Certain information in the Medical Record (e.g., drug and alcohol treatment, psychiatric, communicable disease and HIV-related information) requires additional protection, because of potential criminal and civil penalties associated with their improper disclosure. Hospital procedures prevent such sensitive information from being released on a general consent. Note: "HIV-related" and "communicable disease related" information means positive and negative information.

6.38.4 Faxing Medical Records. Before transmission, the fax number and the name of the recipient are verified. The cover sheet warns about the confidential nature of the fax. After transmission, proper receipt is verified by phone. The Medical Record documents: fax date, phone number, persons sending and receiving.

ARTICLE VII. ORDERS

7.1 GENERAL INFORMATION

7.1.1 A physician order is required to admit a patient, place a patient in observation or extended recovery, and to transfer a patient to another physician. A physician or physician extender (provider) order is required to discharge or transfer a patient for all tests, services, therapy and procedures. Exceptions may be made through a Medical Staff approved Standing Order or Protocol.

7.1.2 All orders will be entered and authenticated within the prescribed time frames.

7.1.3 Whenever possible, orders will be entered directly into the electronic medical record (EMR.) When the EMR is unavailable, orders should be documented on Banner Health Order form(s).

7.1.4 If physicians or providers do not have the ability to access the EMR to input orders themselves, or if a delay in accepting the order could adversely affect patient care, telephone/verbal orders may be accepted by appropriate facility personnel. (Faxed orders are acceptable provided that they are signed (timed exceptions exist for certain outpatient diagnostic orders.)

7.1.5 All orders should be reviewed and continued or discontinued when a patient is transferred from one level of care to another (e.g., from the Emergency Department to an inpatient unit, to or from intensive care units, and/or pre and post-surgery). An order entered into Cerner will be continued until such time as the order is discontinued or modified.

7.1.6 Orders as originally written cannot be changed or added to at some future time. When it is necessary to change an order, it must be rewritten with the current date.

7.1.7 Nurses have the responsibility of questioning any order that they feel might harm the patient.

7.1.8 Orders which are not legible will be clarified with the responsible physician or provider before they are carried out.

7.2 Verbal and Telephone Orders

7.2.1 Verbal (face to face) orders are discouraged except in the case of emergency. Verbal orders will be accepted only by a registered nurse (RN) or licensed practical nurse (LPN). Licensed Respiratory Care Practitioners (RCP) and registered pharmacists can accept verbal orders provided the orders are directly related to their specialized discipline.

7.2.2 Only physicians and authorized allied health professionals are permitted to give telephone orders for inpatient services. Office staff are not permitted to give telephone orders.

7.2.3 Registered pharmacists are permitted to give telephone orders under physician ordered pharmacotherapy consultation.

7.2.4 RNs or LPNs are permitted to accept telephone orders on nursing units. Registered pharmacists, Occupational Therapists, Physical Therapists, Registered Dietitians, Speech Therapists and Respiratory Care Practitioners (RCPs) can accept telephone orders pertaining to their specialty. All telephone orders will be written by the person receiving the order or entered into the EMR then the entire order must be read back to verify accuracy and signed by the receiving individual. Telephone orders will be authenticated by the responsible physician or provider.

7.2.5 In areas other than nursing units, certain telephone orders may be taken by the personnel in each department most qualified to accept them. The director of the department will be responsible for the acceptance of such orders, and for the designation, if necessary, of personnel with the appropriate skills to accept telephone orders. All such orders will be strictly limited to the area of expertise of the department. Bed placement, registration staff and unit secretaries may accept admission orders from physicians only related to the type of bed needed (telemetry vs ICU, etc.) and specifying the reason for the admission.

VIII. PSYCHOLOGY STAFF

8.1 The work of the Psychology Staff member within the hospital must be under the supervision of a staff physician with admitting privileges.

8.1.1 The attending physician may delegate his/her supervision of a particular Psychology Staff member to another physician on the staff by mutual agreement.

8.1.2 The attending physician must define, in the medical record (order sheet) what function the Psychology Staff member is to perform in the therapy of the patient.

8.1.3 The attending physician will write orders on the patient, including admission and discharge orders, and make regular progress notes regarding the treatment of the patient.

8.1.4 Responsibility for the maintenance and completion of the medical record of the patient is that of the attending physician.

8.2 Psychology Staff members are encouraged to attend all meetings of the committees of the Medical Staff to which they have been appointed and the Annual Medical Staff meeting.

8.3 Members of the Psychology Staff have order writing privileges, as described in their delineation of privileges and approved by the Governing Board.

8.4 Psychology Staff members may perform seclusion and/or assessments and may write orders to extend seclusion and/or restraints.

8.5 Psychology Staff members will utilize the patient's EMR for recommendations, comments, and progress reports, and when they are functioning as primary therapist, this must be done at least twice weekly.

8.6 A preliminary report of psychological testing results (to date) must be on the chart in the progress notes within 24 hours from the date of order. A full report must be dictated (in house/or on chart) within 24 hours of completion of testing.

ARTICLE IX. RESTRAINTS

9.1 Behavior Restraint – Medical staff members will utilize restraints according to the current Banner Health policy governing such use. The Banner policy governing use of restraints will be attached as an addendum to these Rules and Regulations.

ARTICLE X. RESIDENT AND FELLOW ROTATIONS

10.1 Supervision of Residents and Fellows - Professional Graduate Medical Education Programs wishing to rotate 2nd through 4th Year Residents or Fellows through Banner Behavioral Health Hospital will require approval by the Medical Executive Committee and Chief Executive Officer. This approval will be based upon information provided by the GME training program. Once approved, the professional liability coverage and competencies of each resident or fellow will be confirmed. Successful completion of Banner's electronic medical record/computer assisted order entry training (CPOE training) is required before start of the assigned rotation. Residents and Fellows will be oriented to Banner Health policies, programs, and channels of communication.

10.2 Residents and Fellows shall function within the Hospital under an approved job description and must be supervised by an attending or supervising physician with appropriate clinical privileges. The Supervising Physician, who is a member in good standing of the BBHH Medical Staff, shall communicate information to the graduate medical education (GME) training program about the quality of care, treatment, and services and educational needs of the participants he/she supervises.

10.3 The Supervising Physician must:

- 10.3.1 within 24 hours of admission, write an admission note that he/she has examined the patient, state his findings and whether he/she concurs with the assessment and treatment plan developed by the resident, and that he/she has discussed the case with the resident;
- 10.3.2 document supervision of the resident by progress notes at least once weekly; and
- 10.3.3 not supervise more than two residents at one time.

10.4 Residents and Fellows are not members of the Medical Staff and therefore may not admit patients, hold elected office or vote, and are not required to pay staff dues. They may attend meetings or serve on committees if invited by the organized medical staff. They are not entitled to the rights outlined in Article III, Section 3.2 of the Medical Staff Bylaws.

10.5 Documentation By Interns, Residents And Fellows - The attending physician shall be responsible for each patient's medical record. When residents or fellows are involved in patient care at Banner Behavioral, sufficient evidence is documented in the health record to substantiate active participation and supervision of the patient's care by the attending physician. The teaching physician must personally document his/her participation in three (3) key components of the service provided by residents or fellows, ie. history, exam, and medical decision making.

10.6 Orders - Residents and Fellows approved for rotation through Banner Behavioral, who are appropriately registered with the Arizona Medical Board and who are participants in an accredited training program, may enter patient care orders as determined by the supervising physician and the training program.

10.7 Other Documentation – Residents and Fellows may write progress notes, history and physical exam and discharge summary.

10.8 The attending/supervising physician will be notified of incomplete or delinquent records assigned to residents, or fellows he/she supervises. Final responsibility for care of the patient rests with the attending physician or his/her designee.

ARTICLE XI. NURSE PRACTIONER AND MEDICAL STUDENTS

11.1 Student Level of Participation

10.1.1 Medical Student Rotations through Banner Behavioral Health Hospital will be in accordance with the Banner Health Clinical Education Rotation Agreement.

10.1.1 Students will work under the direct supervision of a college participating teaching Medical Staff member (preceptor), according to specific clinical goals and objectives developed by the college for each rotation.

10.1.2 Clinical goals and objectives will be reviewed, in advance, by the Graduate Medical Education Committee at Banner Good Samaritan Medical Center or a subcommittee to include interested BBHH medical staff members. The Banner RN Professional Practice team will review clinical goals and objectives for nurse practitioner students.

10.1.3 The MEC will determine the scope of the clinical rotations permitted within the facility. The number of students participating will be reevaluated periodically and subject to change. Specific Medical Student Activities

11.2.1 Year one and two medical students may observe only.

11.2.2 Year three and four medical students may participate in care and management of patients.

11.2.3 Year three and four medical students may review EMR, perform medical history and physical and comprehensive psychiatric evaluation.

11.2.4 Medical Students are not permitted to document in the patient's permanent medical record.

11.2.5 Medical Students are not permitted to create orders nor accept verbal or telephone orders.

11.2.6 Medical Students may not be given responsibility for obtaining informed consent for procedures independently.

11.2.7 Medical Students may not provide disclosure for unanticipated outcomes to patients or family.

11.2.8 All activities are under the direction of and in the presence of the physician preceptor(s).The only portion of a student's assessment that may be incorporated in a note by the preceptor is the review of systems and past family/social history. The preceptor may not refer to a student's documentation of physical exam findings or medical decision-making in his or her personal note. The preceptor must verify and re-document the history or present illness as well as perform and re-document the physical exam and medical decision making activities.

11.3 Specific Nurse Practitioner Student Activities

11.3.1 NP students may participate in care and management of patients.

11.3.2 At the discretion of the preceptor, NP students may obtain EMR training and document in the electronic medical record. Otherwise, they will be granted view-only training and access.

11.3.3 Documentation is countersigned by preceptor promptly. Preceptors are ultimately responsible for all required components of the medical record.
11.3.4 NP students may not dictate.
11.3.5 All activities are under the direct guidance and supervision of preceptor.

11.4 Student Responsibilities
11.4.1 Students are required to comply with all BBHH policies and procedures during the clinical experience.
11.4.2 Students shall have access only to patient information that is a necessary part of the approved rotation.
11.4.3 Students, as participants in an educational program, must at all times wear a Student Identification Badge issued by Medical Staff Services.
11.4.4 Students must complete the Banner Online Compliance Training prior to beginning their rotation.

11.5 Application and Approval Process
11.5.1 A request for approval for medical student rotation at BBHH must be submitted to the Medical Staff Services Department for processing at least two weeks in advance of the rotation.
11.5.2 NP student applications will be processed by the RN Clinical Educator and forwarded to Medical Staff Services for tracking.
11.5.3 Students, with the assistance of their school, will supply documentation as required by the affiliation Clinical Education Rotation Agreement prior to starting the clinical experience. Once a specific program has received approval from the BGSMC GME Committee and the BBHH Medical Executive Committee, individual students may be accepted for rotation upon successful completion of the above application process.

11.6 Orientation – Nurse Practitioner and Medical Students will be oriented to Banner Health policies, programs, and channels of communication.

11.7 Fees and Services - A facility stipend will apply, in the amount provided in the Clinical Education Rotation Agreement, to offset expenses involved in the student rotation for those core rotations and other rotations in which the student spends a substantial amount of their time in the hospital. This fee covers services provided by BBHH including access to: patient (with consent); education and teaching areas; computer systems and training, and meals provided in the Cafeteria.

XII. HIPAA (Health Insurance Portability and Accountability Act)

12.1 All members of the medical staff are required to follow the Banner Health Policy as to Protected Health Information (PHI) they generate or receive from Banner Behavioral Health Hospital.

XIII. AMENDMENT AND ADOPTION

13.1 AMENDMENT: These General Rules and Regulations of the Medical Staff may be amended or repealed, in whole or part, by a resolution of the Medical Executive Committee recommended to and adopted by the Board.

DATES OF ADOPTION AND AMENDMENT

Revised:	3/99
Amended by the Executive Committee	03/01
Approved by the Board of Directors	06/01
Amended by the Executive Committee	08/01
Approved by the Board of Directors	10/01
Amended by the Executive Committee	12/01
Approved by the Board of Directors	03/02
Amended by the Executive Committee	08/08/02
Approved by the Board of Directors	09/20/02
Amended by the Executive Committee	09/11/03
Approved by the Board of Directors	10/16/03
Amended by the Executive Committee	10/09/03
Approved by the Board of Directors	11/20/03
Amended by the Executive Committee	04/08/04
Approved by the Board of Directors	05/20/04
Amended by the Executive Committee	04/14/05
Approved by the Board of Directors	05/19/05
Amended by the Executive Committee	07/14/05
Approved by the Board of Directors	08/16/05
Amended by the Executive Committee	03/09/06
Approved by the Board of Directors	04/20/06
Amended by the Executive Committee	04/13/06
Approved by the Board of Directors	05/18/06
Amended by the Executive Committee	12/14/06
Approved by the Board of Directors	01/18/07
Amended by the Executive Committee	02/14/08
Approved by the Board of Directors	03/12/08
Amended by the Executive Committee	08/28/08
Approved by the Board of Directors	09/10/08
Amended by the Executive Committee	01/15/09
Approved by the Board of Directors	02/12/09
Amended by the Executive Committee	11/22/11
Approved by the Board of Directors	12/08/11
Approved by the Executive Committee	08/15/12
Approved by the Board of Directors	09/13/12
Approved by the Executive Committee	10/04/12
Approved by the Board of Directors	10/11/12
Board of Directors	03/14/13
Approved by the Executive Committee	11/07/13
Approved by the Board of Directors	01/09/14
Approved by the Executive Committee	10/15/15
Approved by the Board of Directors	11/12/15
Approved by the Executive Committee	05/30/17
Approved by the Board of Directors	08/10/17