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ADMISSION, TRANSFER AND DISCHARGE

POLICY STATEMENT

It is the policy of the Medical Staff to ensure the following guidelines for admission, transfer and discharge of patients are consistently observed. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. ADMISSION

1.1 Generally
A patient may be admitted to the Medical Center only by a Practitioner who possesses admission privileges. A patient seeking admission to the Medical Center who does not or cannot designate his or her choice of an admitting Practitioner shall be referred to the Medical Staff Member on call who shall then arrange for appropriate care.

1.2 Determination of Admission Status.
Prior to admitting a patient to the Medical Center, the admitting Practitioner must conclude that the admission is medically necessary and determine whether the patient should be admitted as an inpatient or an outpatient. Medicare does not recognize a separate patient status called “observation;” therefore, all Medical Center patients admitted for “observation” services must be admitted as outpatients.

1.3 Behavioral Health Patients
For each Medical Center patient being admitted to Behavioral Health Services, a medical clearance examination shall be performed.

1.4 Admission Order.
All Medical Center inpatients must be admitted upon the recommendation of a Physician, Dentist, Oral Surgeon or Podiatrist. The admitting Practitioner must enter an admission order that includes the following:

(a) admission diagnosis(es) and reason(s) for admission;
(b) admission status (inpatient or outpatient)
(c) name of the admitting Practitioner;
(d) name of the attending Physician (as applicable); and
(e) if the admitting Practitioner is a Dentist, Oral Surgeon, or Podiatrist, the name of the Medical Staff Physician who will be responsible for the medical aspects of care for such patient during the inpatient stay.

1 Wis. Admin. Code DHS § 124.05(2)(g)1 (2016).
2 Wis. Admin. Code DHS § 124.05(2)(g)1 (2016).
1.5 Admission Note.
For each Medical Center inpatient, within twenty-four (24) hours of admission, the admitting or attending Practitioner shall complete an admission note which includes:

(a) a concise statement of the patient’s complaints, including the chief complaint, and the date of onset and duration of each;¹

(b) the reason(s) for admission for care, treatment, and services, including the patient’s initial diagnosis(es), diagnostic impression(s), or condition(s);⁴

(c) treatment goals and the plan of care (plans of care and discharge plans should be initiated immediately upon admission and be modified in the progress notes as patient care needs change);

(d) any information related to the patient’s condition, including but not limited to alcohol or drug use or mental illness, as may be necessary to assure the protection of other patients, Medical Center personnel and Medical Staff Members from patients who maybe a source of danger to themselves or others; and

(e) if the admitting Practitioner is a Dentist, Oral Surgeon, or Podiatrist, the name of the Physician Medical Staff Member who will be responsible for the medical aspects of care for such patient during the inpatient stay.⁵

If an admission note is entered by an Advanced Practice Professional, refer to Aurora’s Hospital Co-Signature Requirements Chart for applicable co-signature requirements.

1.6 Responsibility of the Admitting Practitioner.
Unless care is transferred to an attending or alternate Practitioner, the admitting Practitioner shall remain responsible for: (1) the care and treatment of the patient at the Medical Center; (2) the prompt completion and accuracy of those portions of the medical record for which he or she is responsible; (3) the provision of necessary special instructions; (4) and the transmission of reports regarding the patient’s condition to the patient, the referring practitioner (if any), and the patient’s representatives (if any).

1.7 Ongoing Availability; Designation of Alternate Practitioner; Transfer of Care.
Each Practitioner must assure timely, adequate professional care for his or her patients in the Medical Center by being continuously available, or designating a qualified alternate Practitioner with whom prior arrangements have been made to attend to Practitioner’s patients when the Practitioner is unavailable. Transfer of care shall not be effective until the transferring Practitioner has communicated with, and documented in the patient's medical record the acceptance of, the Practitioner assuming responsibility for the patient's care. Refer to the Medical Center’s On-Call and Designation of Alternate Providers policies.

1.8 Frequency of Patient Attendance.

² Wis. Admin. Code DHS § 124.14(3)(a)5 (2009); JCS RC.01.01.01, EPs 5 & 6 (Jul. 2015); JCS RC.02.01.01, EP 2 (Jul. 2015).
⁵ Wis. Admin. Code DHS § 124.05(2)(g)1 (2016).
In order to ensure timely care and treatment of all Medical Center inpatients, the attending Practitioner must come to the Medical Center and evaluate his/her patients as soon as reasonably possible after admission. As a general guideline, for patients admitted from the Emergency Department to an inpatient unit, the attending Practitioner should evaluate the patient within twenty four (24) hours of admission. For patients admitted from the Emergency Department to an Intensive Care Unit, the attending Practitioner should evaluate that patient within six (6) hours of admission. After the initial visit, all Medical Center inpatients should be seen on at least a daily basis by the admitting or attending Practitioner, or his or her designee; provided, however, all behavioral health services patients must be seen by a psychiatrist at least every forty-eight (48) hours. These timeframes are guidelines, and certain circumstances will require greater urgency.

1.9 Continued Stay.
The admitting or attending Practitioner must ensure that the medical record contains documentation explaining the need for ongoing hospitalization in accordance with the Aurora Utilization Review Plan and the Aurora Medical Records Policy.

2. TRANSFER

2.1 Transfer of Care to an Alternate Provider within the Medical Center.
Refer to Section 1.6 above.

2.2 Transfer Between Settings Within the Medical Center.
The transfer of patients from certain Medical Center Departments may require specific documentation in the patient’s medical record to ensure proper continuity of care. For example, if a patient is transferred to a different level of care within the Medical Center and the patient’s caregivers will change, a transfer summary may be required. In addition, a patient may only be transferred from a post-anesthesia recovery unit to another Medical Center department upon the recommendation of an anesthesiologist, another qualified Physician, or a certified registered nurse anesthetist. Refer to appropriate Department policies for specific documentation requirements.

2.3 Transfer to Another Medical Facility.
Refer to Section 3.6 below.

3. DISCHARGE

3.1 Discharge Planning.
The admitting or attending Practitioner’s decisions regarding the provision of ongoing care, treatment, and services, discharge, or transfer of his/her patients must be based on the assessed needs of the patient, regardless of the recommendations of any Medical

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6 JCS PC.04.01.01, EP 2 and JCS PC.02.02.01, EP 1-3) (Jul. 2015).
7 JCS RC.02.04.01, EP 3, Note 2 & JCS PC.04.01.01, EP 2 (Jul. 2015).
8 Wis. Admin. Code DHS § 124.20(2)(a)4 (2016); JCS RC.02.01.03 EP 9 (Jul. 2015).
9 JCS PC.04.01.01, EP 2 and JCS PC.02.02.01, EP 1-3) (Jul. 2015).
Center internal or external review process. The admitting or attending Practitioner may request a discharge planning evaluation, and the Medical Center will perform the evaluation upon request. In addition, the admitting or attending Practitioner shall cooperate with the Medical Center’s discharge planning staff to:

(a) Identify any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer;

(b) Include the patient, the patient’s family, Practitioners, clinical psychologists, and other staff involved in the patient’s care, treatment, and services in planning for the patient’s discharge or transfer;

(c) Assist in arranging the services required by the patient after discharge in order to meet the patient’s ongoing needs for care and services, and

(d) Provide the patient and the patient representative information regarding:

   i. why he or she is being discharged or transferred;

   ii. any alternatives to transfer or discharge;

   iii. the types of continuing care, treatment, and services the patient will need after discharge, and

   iv. how to obtain any continuing care, treatment, and services that the patient will need.

3.2 Discharge Order.

(a) A Medical Center patient may be discharged only after a discharge order from the patient’s attending Practitioner is entered into the medical record.

(b) Discharge from Off Campus Outpatient Surgery Center Location: At off campus Outpatient Surgery Center location, a responsible Practitioner or Advanced Practice Professional remains available on site until all patients are medically cleared for discharge and the last patient has an anticipated discharge within thirty (30) minutes.

3.3 Discharge Instructions.

The admitting or attending Practitioner must ensure that the patient or his/her patient representative receives appropriate written discharge instructions.

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10 JCS LD.04.02.05, EP 1 (Jul. 2015).
11 JCS PC.04.01.03, EP 2 (Jul. 2015).
12 JCS PC.04.01.03, EP 3 (Jul. 2015).
13 JCS PC.04.01.03, EP 4 (Jul. 2015).
14 JCS PC.04.01.05, EP 3 (Jul. 2015).
15 JCS PC.04.01.05, EP 4 (Jul. 2015).
16 JCS PC.04.01.05, EP 5 (Jul. 2015).
17 JCS PC.04.01.05, EP 6 (Jul. 2015).
18 JCS PC.04.01.05, EP 7 (Jul. 2015).
3.4 Discharge Summary.

(a) Generally. The admitting or attending Practitioner is responsible for ensuring that a Discharge Summary (in the form designated by the applicable department or unit) is entered or dictated within three (3) days after discharge. If a Discharge Summary is dictated more than twenty-four (24) hours prior to the patient’s actual discharge, the admitting or attending Practitioner must ensure the Discharge Summary is updated as necessary. The admitting or attending Practitioner may delegate the completion of the Discharge Summary to another qualified Practitioner or an Advanced Practice Professional, if such other Practitioner or Advanced Practice Professional is knowledgeable about the patient’s condition, the patient’s care during hospitalization, and the patient’s discharge plans. If the admitting or attending Practitioner delegates the completion of the Discharge Summary to another qualified Practitioner or Advanced Practice Professional, the admitting or attending Practitioner must verify the content of the Discharge Summary and co-sign and date the Discharge Summary as provided in Aurora’s Hospital Co-Signature Requirements Chart.\(^\text{19}\)

(b) Inpatients (more than 48 hours inpatient stay). The medical record of each Medical Center inpatient who is discharged after an inpatient stay of forty-eight (48) hours or more must contain a Discharge Summary, which includes:\(^\text{20}\)

i. date of discharge;

ii. definitive final diagnosis(es) expressed in the terminology of a recognized system of disease nomenclature;\(^\text{21}\)

iii. reason(s) for the patient’s admission/registration and transfer or discharge;

iv. significant findings and complications (if any);

v. summary of the care, treatment and services provided\(^\text{22}\) (including the procedures performed, treatments rendered, the outcome(s) of such procedures and treatments and progress towards goals\(^\text{23}\));

vi. condition of the patient upon discharge (including the patient’s physician and psychosocial status\(^\text{24}\)) stated in a manner that allows specific comparison to the patient’s condition upon admission/registration;\(^\text{25}\)

vii. the method of transport (if any);

viii. provisions for follow-up care (including any post-hospital appointments, how post-hospital patient care needs are to be met, plans for post-hospital care by providers such as home health, hospice, nursing homes, or assisted

\(^{19}\) CFR § 482.24(c)(2)(vii) (Interpretive Guidelines, effective October 17, 2008).

\(^{20}\) JCS RC.02.04.01 (Jul. 2015).

\(^{21}\) 42 CFR § 482.24(c)(2)(viii) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(3)(a)13 (2016); JCS RC.02.01.01, EP 2 (Jul. 2015).

\(^{22}\) JCS PC.02.04.01, EP 3 (Jul. 2015).

\(^{23}\) JCS PC.04.02.01, EP 1 (Jul. 2015).

\(^{24}\) JCS PC.04.02.01, EP 1 (Jul. 2015).

\(^{25}\) 42 CFR § 482.24(c)(2)(vii) (Interpretive Guidelines, effective October 17, 2008).
living facilities, and community resources or referrals made or provided to the patient; and

ix. any other specific instructions given to the patient and/or the patient’s representatives upon discharge (e.g., activity, diet, medications, follow-up care, etc.). If no discharge instructions were required, the discharge summary shall indicate as such.

(c) **Inpatients (less than 48 hours stay); Outpatients Requiring Anesthesia Services.** The medical record of each Medical Center inpatient who is discharged after an inpatient stay of less than forty-eight (48) hours and each Medical Center outpatient who underwent a procedure requiring anesthesia services must include a Discharge Summary. Such Discharge Summary may be abbreviated, but at a minimum must include: (i) the outcome of the treatment(s) or procedure(s) provided; (ii) the disposition of the case, including the patient’s condition; and (iii) any recommended follow-up care or instructions. The final progress note may serve as the Discharge Summary if it contains the elements described in this Section.

(d) **Patient Who Leave Against Medical Advice.** If a patient leaves the Medical Center against medical advice, document the circumstances in the patient’s medical record and refer to the Medical Center’s policy on informed refusal.

(e) **Death.** In the event of a patient’s death, please refer to Aurora’s Autopsy Policy.

### 3.5 Discharge/Transport from the Emergency Department.

For standards and documentation requirements related to Emergency Department patients discharged to home or transported to a non-Medical Center facility, refer to Aurora’s EMTALA Policy.

### 3.6 Discharge/Transport from Medical Center Inpatient/Outpatient Departments.

Medical Center patients may be discharged from any Medical Center inpatient or outpatient department and transported to another non-Medical Center facility if the Practitioner ensures that:

(a) the receiving facility has the capability to manage the patient’s condition;

(b) the receiving facility has consented to the admission and appropriate transfer arrangements have been made;

(c) the patient is considered sufficiently stabilized for transport; and

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26 JCS PC.04.02.01, EP 1 (Jul. 2015).
28 42 CFR § 482.24(c)(2)(vii) (Interpretive Guidelines, effective October 17, 2008); JCS RC.02.04.01 (Jul. 2015) (A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.)
29 JCS PC.04.01.01, EP (Jul. 2015).
(d) All pertinent medical information necessary to ensure continuity of care accompanies the patient to the receiving facility (including a Discharge Summary that includes the elements set forth in Section 3.4). 30

3.7 Discharge of Infants. 31
An infant may be discharged only to a parent who has lawful custody of the infant, or to an individual who is legally authorized to receive the infant. If the infant is discharged to a legally authorized individual, that individual shall provide identification and, if applicable, the identification of the agency the individual represents. The medical record must include the identity of the legally authorized individual who receives the infant. Refer to applicable departmental policies to identify specific documentation requirements.

3.8 Objections to Discharge.
Medicare patients have the right to appeal a discharge that the patient considers premature. 32 If a patient objects to discharge from the Medical Center, contact Case Management.

REFERENCES:

Federal Regulations
• 42 CFR § 482.13 (a) (Interpretive Guidelines, effective October 17, 2008).
• 42 CFR § 482.24(c)(2)(viii) (Interpretive Guidelines, effective October 17, 2008).

Wisconsin Statutes
• Wis. Stat § 146.37 (2016).

Wisconsin Administrative Code
• Wis. Admin. Code DHS § 124.05 (2016).

Joint Commission Standards
• JCS LD.04.02.05 (Jul. 2015).
• JCS PC.02.02.01 (Jul. 2015).
• JCS PC.02.04.01 (Jul. 2015).
• JCS PC.04.01.01 (Jul. 2015).
• JCS PC.04.01.03 (Jul. 2015).
• JCS PC.04.01.05 (Jul. 2015).
• JCS PC.04.02.01 (Jul. 2015).
• JCS RC.01.01.01 (Jul. 2015).
• JCS RC.02.01.01 (Jul. 2015).
• JCS RC.02.01.03 (Jul. 2015).

30 JCS PC.04.02.01, EP 1 (Jul. 2015).
32 42 CFR § 482.13 (a) (Interpretive Guidelines, effective October 17, 2008).
• JCS RC.02.04.01 (Jul. 2015)

FORM(S):  None

MEDICAL EXECUTIVE COMMITTEE APPROVAL:  3/19/2013, 7/23/13, 9/26/17

BOARD OF DIRECTORS APPROVAL:  4/18/2013, 8/12/13, 12/18/17

POLICY STEERING COMMITTEE APPROVAL:  10/25/17
ADVANCED PRACTICE PROFESSIONALS

POLICY STATEMENT

Advanced Practice Professionals may come to the Medical Center and provide direct patient care services in certain circumstances. This Policy describes the necessary qualifications of such providers, how such providers are granted the authority to perform direct patient care services at the Medical Center, the supervising and collaborating relationships that are required, how the competency of such providers will be assessed, and the process for revoking such providers’ authority to perform services at the Medical Center. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. STAFF MEMBERSHIP

1.1. Advanced Practice Professionals.
An Advanced Practice Professional is an individual, other than a Practitioner, who meets the qualifications for Staff Membership and Clinical Privileges, as set forth in the Medical Staff Bylaws, and has been appointed to the Advanced Practice Professional Staff.

1.2. Qualifications.
An Advanced Practice Professional must meet the qualifications for Staff Membership as set forth in the Medical Staff Bylaws.

1.3. Application, Staff Membership and Clinical Privileges.
An Advanced Practice Professional must submit a complete application for Staff Membership to Medical Staff Services and shall be credentialed, privileged, and re-privileged through the Medical Staff process, as set forth in the Medical Staff Bylaws.1 An Advanced Practice Professional shall only be entitled to exercise those Clinical Privileges specifically granted to the Advanced Practice Professional in accordance with the credentialing and privileging process set forth in the Medical Staff Bylaws.

1.4. Compliance with Bylaws and Policies.
Prior to the exercise of Clinical Privileges, each Advanced Practice Professional must acknowledge in writing that he or she shall be bound by and is obligated to comply with the Medical Staff Bylaws, the Policies Governing Medical Practices, and all other applicable Medical Center policies

1.5. Suspension or Termination of Clinical Privileges.
An Advanced Practice Professional’s Clinical Privileges may be suspended or terminated as set forth in the Medical Staff Bylaws. Advanced Practice Professionals are subject to the corrective action process set forth in the Medical Staff Bylaws and are entitled to the rights applicable to Advanced Practice Professionals as set forth therein.

1 JCS HR.01.02.05, EP 10 (Jan. 2016).
2. **SUPERVISORY AND COLLABORATIVE RELATIONSHIPS**

2.1. **Advanced Practice Nurse (APN).**

(a) An APN must have a current written collaborative agreement with one or more Physicians appointed to the Medical Staff and shall work in a collaborative relationship with such Physician(s). The collaborative agreement must be in a form acceptable to Medical Staff Services.

(b) The APN and the collaborating Physician(s) shall comply with the collaborative agreement and all other applicable requirements set forth by the Wisconsin Department of Regulation and Licensing and the Medical Center, and shall work in each other's presence whenever necessary to deliver health care services within the scope of the APN’s professional expertise. Collaborating Physician(s) shall co-sign the APN’s medical record entries in accordance with Aurora’s Hospital Co-Signature Requirements Chart.

(c) It is the responsibility of both the APN and the collaborating Physician(s) to provide prior written notice to and receive prior approval from Medical Staff Services of any changes to the collaborative agreement or relationship.

2.2. **Physician Assistant (PA).**

(a) A PA must have a current written supervision agreement with one or more Physicians appointed to the Medical Staff who will act as the PA’s supervising Physician(s). If the PA intends to prescribe medications, the PA must also have a PA prescription authorization form signed by a supervising Physician and evidence of annual written reviews of the PA's prescriptive practices by a Physician providing supervision. Both the supervision agreement and the prescription authorization form must be in a form acceptable to Medical Staff Services.

(b) The PA and the supervising Physician(s) shall comply with the supervisory and all other applicable requirements set forth by the Wisconsin Department of Regulation and Licensing and the Medical Center, and shall work in each other's presence whenever necessary to deliver health care services within the scope of the PA’s professional expertise. Supervising Physician(s) shall co-sign the PA’s medical record entries in accordance with Aurora’s Hospital Co-Signature Requirements Chart.

(c) No Physician may concurrently supervise more than four (4) PAs unless the physician submits a written plan for the supervision of more than four (4) PAs and

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2 Wis. Adm. Code N § 8.10(7).
3 Wis. Adm. Code Med §§ 8.07(1) and 8.10(1).
the Wisconsin Medical Examining Board and the Medical Executive Committee approves the plan.\textsuperscript{5}

(d) The supervising Physician may designate another Physician to supervise the PA only if: (i) such designation is made in writing, and (ii) at all times the PA is able to readily identify the Physician currently providing supervision.\textsuperscript{6}

(e) Supervising Physicians shall be available to the PA at all times for consultation either in person or within fifteen (15) minutes of contact by telecommunications or other electronic means.\textsuperscript{7}

(f) It is the responsibility of both the PA and the supervising physician(s) to provide prior written notice to and receive prior approval from Medical Staff Services of any changes to the supervision agreement or relationship.

2.3. \textbf{Psychologist}.
Psychologists shall coordinate care with each patient’s attending Physician, consulting Physicians, and other Medical Center staff caring for the patient. There are no specific supervision or collaboration requirements for Psychologists, however, certain medical record entries made by a Psychologist must be co-signed. Refer to Aurora’s Hospital Co-Signature Requirements Chart.

2.4. \textbf{Chiropractor}.
Chiropractors shall coordinate care with each patient’s attending Physician, consulting Physicians, and other Medical Center staff caring for the patient. There are no specific supervision or collaboration requirements for Chiropractors, however, certain medical record entries made by a Chiropractor must be co-signed. Refer to Aurora’s Hospital Co-Signature Requirements Chart.

2.5. \textbf{Optometrists}.
Optometrists shall coordinate care with each patient’s attending Physician, consulting Physicians, and other Medical Center staff caring for the patient. There are no specific supervision or collaboration requirements for Optometrists, however, certain medical record entries made by an Optometrist must be co-signed. Refer to Aurora’s Hospital Co-Signature Requirements Chart.

2.6. \textbf{Scope and Standards of Practice}.
An Advanced Practice Professional’s practice may not exceed his or her educational training or experience and may not exceed the scope of practice of the collaborating or supervising Physician(s) (if any).\textsuperscript{8} In addition, an Advanced Practice Professional may provide services only within the scope of the Clinical Privileges granted to such Advanced Practice Professional in accordance with the Medical Staff Bylaws. Such

\textsuperscript{5} Wis. Adm. Code Med § 8.10(1).
\textsuperscript{6} Wis. Adm. Code Med § 8.07(3).
\textsuperscript{7} Wis. Adm. Code Med § 8.10(2).
\textsuperscript{8} Wis. Adm. Code Med § 8.07(1).
Clinical Privileges shall not exceed those granted to the collaborating or supervising Physician(s) (if any).

2.7. **Competency Assessment / Performance Evaluation.**
Advanced Practice Professionals shall be subject to the credentialing recredentialing, Focused Professional Practice Evaluation, and the Ongoing Professional Practice Evaluation processes set forth in the Medical Staff Bylaws and the Peer Review Policy.

2.8. **Failure to Maintain Appropriate Relationship.**
The failure to maintain appropriate collaborative or supervisory relationships, complete necessary evaluations in a timely manner, or otherwise comply with this Policy, may serve as the basis for corrective action against the Advanced Practice Professional and any collaborating or supervising Physician(s) in accordance with the Medical Staff Bylaws.

**REFERENCES:**

**Wisconsin Statutes & Administrative Code**

**Code of Federal Regulations**
- None

**Joint Commission Standards**
- JCS HR.01.02.05 (Jul. 2015).

**FORM(s):**

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 3/19/13; 7/22/14, 9/26/17

**BOARD OF DIRECTORS APPROVAL:** 4/18/13; 8/18/14, 12/18/17

**POLICY STEERING COMMITTEE APPROVAL:** 10/25/17
CODE OF CONDUCT

POLICY STATEMENT

All individuals within Medical Center facilities shall be treated courteously, respectfully and with dignity. To that end, the Governing Body requires all individuals, including without limitation, Medical Staff Members, Advanced Practice Professional Staff Members, Medical Center employees, independent practitioners, volunteers, and vendors to conduct themselves in a professional and cooperative manner at all times. This Code of Conduct describes minimum expectations regarding the conduct of Staff Members and defines acceptable behavior and behaviors that undermine a culture of safety.1 The process for evaluating and addressing concerns related to a Staff Member’s conduct is set forth in the Peer Review Policy. The processes for evaluating and addressing concerns related to a non-Staff Member’s conduct are set forth in other Medical Center or Aurora administrative policies. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. MINIMUM EXPECTATIONS

At a minimum, all Staff Members are expected to:

1.1 Treat all individuals with courtesy, dignity and respect;

1.2 Comply with all Aurora and Medical Center policies and the Medical Staff Policies Governing Medical Practices;

1.3 Address concerns about clinical and non-clinical judgments with fellow Staff Members directly and professionally;

1.4 Address dissatisfaction with Medical Center policies, the Medical Staff Policies Governing Medical Practices, or the services provided by Medical Center staff, vendors, and volunteers, through appropriate grievance channels;

1.5 Work together as a team;

1.6 Be fair and honest;

1.7 Cooperate with patients in their care and with colleagues at all levels, recognizing that we need one another to reach our goals;

1.8 Support an environment in which ideas and concerns may be expressed freely;

1.9 Value differences of opinion, and when conflicts occur, deal with them directly and constructively;

1 JCS LD.03.01.01, EP 4 (Jul. 2015).
1.10 Offer criticism in a constructive manner and accept constructive criticism; and

1.11 Demonstrate behaviors that support the Aurora Service Commitment Standards.

2. **UNACCEPTABLE CONDUCT**

Unacceptable conduct includes, but is not limited to the following:

2.1 Any behavior that endangers the safety of anyone in the Medical Center, including patients, Staff Members and Aurora employees;

2.2 Any behavior that is inconsistent with applicable laws, regulations, or ethical standards;

2.3 Disruptive Conduct, including:

   (a) Verbal, written or physical behavior that a reasonable person would consider intimidating, hostile, or otherwise unprofessional, whether directed at Staff Members, Medical Center/Aurora employees, patients, family members, visitors, or others encountered as a result of the Staff Member’s association with the Medical Center; and

   (b) Any other conduct (including without limitation behavior that is inconsistent with the Medical Center’s policy on sexual harassment) that indicates the Staff Member is unable to work harmoniously with others in a manner that does not interfere with the orderly operation of the Medical Center.

2.4 Impertinent or inappropriate comments (or illustrations) made in a patient medical record or other official document;

2.5 Use of foul language (verbal or written) or non-constructive criticism that intimidates, undermines confidence, belittles or implies stupidity or incompetence;

2.6 Willful damage to or theft of Medical Center or Aurora property;

2.7 Willful disregard of Medical Center or Aurora policies or the Medical Staff Policies Governing Medical Practices;

2.8 Unauthorized use, possession, or ingestion of mood altering substances while providing services or during a period in which the Staff Member is on-call to provide services;

2.9 Threats, reprisals, or any other aggressive, intimidating, or discriminatory behavior that could be considered retaliatory, against individuals who express professional practice or conduct concerns; and
2.10 Dishonesty in communications with peer reviewers, Medical Center/Aurora employees, personnel, patients, or family members of patients.

3. ADDRESSING PRACTICE AND CONDUCT CONCERNS

Questions or concerns regarding an individual Staff Member’s professional practice or conduct shall be addressed in accordance with the Communication of Practice and Conduct Concerns Policy, the Focused Professional Practice Evaluation process set forth in the Peer Review Policy, the Corrective Action process set forth in the Medical Staff Bylaws, and the Impaired Practitioner Policy (as applicable).²

REFERENCES:

Joint Commission Standards

- JCS LD.03.01.01 (Jul. 2015)

FORM(S): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/22/16

BOARD OF DIRECTORS APPROVAL: 5/16/16

POLICY STEERING COMMITTEE: 4/27/16

² JCS LD.03.01.01, EP 5 (Jul. 2015).
COMMUNICATION OF PRACTICE AND CONDUCT CONCERNS

POLICY STATEMENT

The organized Medical Staff is accountable to the Governing Body for the quality of medical care provided to Medical Center’s patients, assists the Governing Body by serving as a professional review body, and monitors and evaluates the professional practice and conduct of individuals with Clinical Privileges in order to make recommendations regarding such individuals’ continued Staff Membership and Clinical Privileges. In order to fulfill these obligations and ensure that the professional practice and conduct of Staff Members are consistent with the highest standards of safety, quality and collegiality, the Medical Staff and the Medical Center strongly encourage all individuals who have concerns related to the practice or conduct of a Staff Member to promptly communicate such concerns. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. IDENTIFICATION AND COMMUNICATION

1.1 Identification of Practice and Conduct Concerns.

Individual practice or conduct concerns may arise from:

(a) Information obtained through the Ongoing Professional Practice Evaluation (OPPE) process;

(b) Information from other Staff Members, Medical Center staff, patients/families, and/or regulatory or other agencies related to specific incidents, complaints, grievances, or concerns relating to quality patient care;

(c) Recommendations from Risk Management or Utilization Review; and/or

(d) Other relevant information.

1.2 Communication of Practice and Conduct Concerns.

The Medical Staff actively encourages any individual (including a Staff Member, Medical Center employee, patient, visitor, vendor or other person) who has or becomes aware of a question or concern related to the professional practice or conduct of any individual Staff Member, to promptly communicate such question or concern to any one or more of the following persons:

(a) Director of Quality;

(b) Applicable Clinical Chairperson;

(c) Chief of Staff;

(d) Chief Medical Officer;

(e) Administrator;

(f) Any member of the Practitioner Wellness Committee;

(g) Any member of the Practice Evaluation Committee;
(h) Any member of the Credentials Committee;
(i) Any member of the Medical Executive Committee; or
(j) Any member of the Governing Body.

A Medical Center employee may also communicate questions or concerns to his/her immediate supervisor and/or a representative from human resources. To the extent possible and appropriate, the identity of an individual who communicates his or her concerns shall be kept confidential.

2. **Preliminary Evaluation and Review**¹

2.1 **Preliminary Evaluation and Documentation.**
The individual who receives the concern shall consider whether the information provided indicates an **imminent danger to the health, safety or welfare of any individual**. If so, the individual who receives the concern shall immediately contact any individual with the authority to impose a summary suspension as set forth in the Medical Staff Bylaws (the individual may also, at any time, refer the matter to an individual with authority to submit a Request for Inquiry or Investigation under the Medical Staff Bylaws if he/she believes the concern warrants a different form of corrective action). If the concern does not indicate an imminent danger, the individual who receives the concern shall refer the matter to the Director of Quality. The Director of Quality will ensure that the concern is properly documented, obtain additional information as necessary, and consult with the applicable Clinical Chairperson.

2.2 **Review by the Clinical Chairperson and Director of Quality.**
The Clinical Chairperson, in consultation with the Director of Quality, shall evaluate the concern as described below and obtain additional information as necessary.

(a) **Imminent Danger.** The Clinical Chairperson, in consultation with the Director of Quality, shall consider whether the concern indicates an **imminent danger to the health, safety or welfare of any individual**. If so, the Clinical Chairperson shall immediately refer the concern to any individual with the authority to impose a summary suspension as set forth in the Medical Staff Bylaws.

(b) **Impaired Practitioner.** The Clinical Chairperson, in consultation with the Director of Quality, shall consider whether the concern is related to a Staff Member who may be impaired. If so, the Clinical Chairperson will notify the Administrator and refer the concern to the Practitioner Wellness Committee, which shall address the concern in accordance with the Impaired Practitioner Policy.

(c) **Allegations of Disruptive Conduct.** The Clinical Chairperson, in consultation with the Director of Quality, shall consider whether concern involves allegations of Disruptive Conduct (as defined in the Medical Center’s Code of Conduct Policy). If so, the Clinical Chairperson will notify the Administrator and refer the concern to the Quality Improvement Committee Chairperson.

¹ JCS LD.03.01.01, EP 5 (Jan. 2010).
(d) **Other Concerns.** If the concern is not referred for further review as provided in subsections (a)-(c) above, the Clinical Chairperson, in consultation with the Director of Quality, will determine whether the issue warrants further attention by the Practice Evaluation Committee. This determination is not intended to be a complete evaluation of the circumstances, but merely a determination whether additional inquiry or review is necessary.

i. **Additional Review Required.** If additional inquiry or review is necessary, the Clinical Chairperson shall forward the applicable documentation to the Practice Evaluation Committee Chairperson.

ii. **Additional Review Not Required.** If additional inquiry or review is not necessary, the Clinical Chairperson shall seek the concurrence of the Chief Medical Officer or Chief of Staff, and forward to the Director of Quality. The Director of Quality shall maintain a confidential record of all concerns that are not referred for further review (i.e., concerns that are not referred for corrective action, to the Committee on Practitioner Wellness, or to the Practice Evaluation Committee Chairperson). All such concerns shall be reviewed by the Chief Medical Officer to determine whether there is a pattern of practice or conduct concerns that needs to be addressed by the Practice Evaluation Committee in accordance with the Peer Review Policy.

(e) **Possible Corrective Action.** The Clinical Chairperson, or any other individual with the authority to submit a Request for Inquiry or Investigation as set forth in the Medical Staff Bylaws, may submit such request at any time. The performance or lack of performance of any step set forth in this Policy shall in no way affect concurrent or subsequent Corrective Action.

3. **NO RETALIATION**

Retaliatory behavior will not be tolerated. Any attempt to confront, intimidate, harass, discriminate, or otherwise retaliate against an individual who reports a concern, or cooperates or assists in the investigation of a concern, is a violation of this Policy. Any individual who engages such retaliatory behavior will be subject to corrective action in accordance with the procedures specified in the Medical Staff Bylaws.

4. **IMMUNITY**

The activities described in this Policy and conducted in good faith, and the individuals or groups that perform or assist in the performance of such activities, are protected by the civil immunity protections of Wisconsin Statute § 146.37 and the Health Care Quality Improvement Act.
5. **CONFIDENTIALITY**

All activities shall be conducted in a manner consistent with applicable confidentiality laws. All OPPE and FPPE records and activities are confidential and shall not be disclosed except as permitted by law.

6. **USE OF FORMS**

Whenever this Policy specifies a form for a particular purpose, no subsequent action shall be deemed invalid merely because other documentation containing substantially similar or all essential information for the purpose is used.

**REFERENCES:**

- **Wisconsin Statutes**
- **Joint Commission Standards**
  - JCS LD.03.01.01 (Jul. 2015).

**FORM(S):**

- 

**MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/22/16**

**BOARD OF DIRECTORS APPROVAL: 5/16/16**

**POLICY STEERING COMMITTEE: 4/27/16**
CONFIDENTIALITY OF MEDICAL STAFF RECORDS

POLICY STATEMENT

It is the policy of the Medical Center to maintain the confidentiality of documents relating to credentialing, peer review and quality improvement activities involving individual Staff members. Such Records shall be maintained and kept confidential in accordance with the Health Care Quality Improvement Act of 1986, Wisconsin Statutes § 146.38, and other applicable State and Federal laws. Records may be accessed or disclosed only as described in this policy and in accordance with applicable law. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. DEFINITIONS

“Authorized Representative” includes the following representatives of the Medical Center:

- Administrator
- Chief of Staff
- Chief of Staff Elect
- Secretary/Treasurer
- Clinical Chairpersons
- Members of the following Medical Staff Committees: Medical Executive Committee Credentials Committee, Practice Evaluation Committee, and Practitioner Wellness Committee
- Medical Staff Services personnel
- Medical Center’s Legal Counsel

“Consultant” means: (1) any person or entity engaged by the Medical Center to assist in peer review and quality assurance activities, or otherwise assist or provide counsel to the Medical Center, including without limitation external peer reviewers or experts; or (2) any authorized representative of a regulatory or accreditation agency acting within the scope of his/her authority.

“Disclose” “Disclosed” or “Disclosure” means to permit a person or entity to access and inspect Records, or to provide a person or entity with copies of Records.

“Records” means all individually identifiable documentation (including notes of discussions and deliberations) relating to focused and ongoing professional practice evaluations, credentialing, peer review and quality improvement activities maintained in a Staff Member’s credentials file and/or quality file.

“Records Subject” means the Medical Staff Member or Advanced Practice Professional Staff Member who is the subject of the Records.

“Third Party” means a person or entity who is not the Records Subject, an Authorized Representative, or a Consultant (e.g., another hospital).
2. **LOCATION AND SECURITY OF RECORDS**

All Records shall be maintained under the care and custody of the Medical Center’s Authorized Representatives. The office where the Records are maintained shall be kept locked, unless an Authorized Representative is present. An Authorized Representative must supervise all access to and disclosure of the Records. Records stored electronically shall be protected by passwords.

3. **REQUESTS FOR DISCLOSURE**

3.1 **Requests for Disclosure.**
All requests for Disclosure of Records to a person/entity other than the Records Subject or an Authorized Representative must be made in writing and presented to the Chief of Staff or his/her designee for approval. The written request must include the following:

(a) name and address of the person making the Disclosure request;
(b) name and address of the person or entity to whom the Records are to be Disclosed;
(c) specific information requested;
(d) purpose of the request; and
(e) if the person/entity to whom the Records are to be Disclosed is a Third Party, a written statement signed by the Records Subject and releasing the Medical Center and its representatives from liability for Disclosure of the Records. (If a form other than the Medical Center’s Authorization and Release Form is used, consult with legal counsel regarding the adequacy of release language, as appropriate.)

The Chief of Staff (or his/her designee), in consultation with Medical Staff Services, will determine whether the Disclosure will be permitted in accordance with Section 4 below.

3.2 **Records of Requests and Permitted Disclosures.**
The Chief of Staff or his/her designee will maintain a record of all requests received, whether such requests were granted or denied, and, if granted, to whom Records were disclosed, and the date of the Disclosure.

4. **PERMITTED ACCESS/DISCLOSURE**

4.1 **Access and Disclosure Generally.**
The original content of Records may not be altered or removed from the Medical Center under any circumstance. An individual permitted access to Records shall be afforded a reasonable opportunity to inspect the Records and to make notes regarding the requested Records. An Authorized Representative must be present at all times during the inspection of Records. Medical Staff Services personnel may make copies of Records to be Disclosed to an Authorized Representative, Consultant, the Records Subject, or a Third Party as set forth below.
4.2 **Authorized Representative.**
Medical Staff Services personnel may Disclose Records to an Authorized Representative as necessary for such Authorized Representative to fulfill his/her Medical Staff responsibilities.

4.3 **Consultant.**
Medical Staff Services personnel may Disclose Records to a Consultant as necessary for such Consultant to fulfill his/her responsibilities, if such Disclosure is authorized by the Records Subject or the Chief of Staff (or his/her designee) in accordance with Section 3.1.

4.4 **Records Subject.**
Medical Staff Services personnel may Disclose Records to the Records Subject if such Disclosure is requested by the Records Subject and authorized by the Chief of Staff (or his/her designee) in accordance with Section 3.1.

4.5 **Third Party.**
Medical Staff Services personnel may Disclose Records to a Third Party if: (1) the Records Subject authorizes such Disclosure in an authorization and release document approved by the Medical Center, and (2) the Disclosure is authorized by the Chief of Staff (or his/her designee) in accordance with Section 3.1. Medical Staff Services personnel must confirm that an authorization and release form approved by the Medical Center and signed by the Records Subject is on file prior to disclosing Records to a Third Party. (If a form other than the Medical Center’s Authorization and Release Form is used, consult with the Medical Center legal counsel regarding the adequacy of release language, as appropriate.)

4.6 **Subpoenas.**
All subpoenas pertaining to Records shall immediately be referred to an Authorized Representative. Before responding to such a subpoena, an Authorized Representative shall consult, as necessary, with the Medical Center’s legal counsel regarding the appropriate response to the subpoena.

4.7 **Costs.**
A Records Subject or Third Party may be charged an administrative fee to reimburse the Medical Center for costs incurred in producing and transmitting copies of Records.

**REFERENCES:**

- **Wisconsin Statutes**

- **Federal Statutes**
  - Health Care Quality Improvement Act of 1986

**FORM(S):**

- Consent and Release from Liability Form

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 3/19/2013, 9/26/17

**BOARD OF DIRECTORS APPROVAL:** 4/18/2013, 12/18/17

**POLICY STEERING COMMITTEE APPROVAL:** 10/25/17
CONFIRMATION OF IDENTITY

POLICY STATEMENT
Consistent with the Medical Staff Bylaws and Joint Commission requirements, it is the policy of the Medical Center to verify that the Applicant applying for Staff Membership and/or Clinical Privileges is the same individual identified in the credentialing documents presented pursuant to such Application.1 All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. DEFINITIONS

“Aurora Affiliate” means any facility or entity owned, controlled, or managed by, or under common ownership, control or management with Aurora Health Care, Inc.

“Authorized Form of Identification” includes the following forms of identification:
- A current picture hospital ID card; or
- A valid picture ID issued by a State or federal agency (for example, a driver's license or passport)

“Confirmation of Identity Process” means the process of confirming an Applicant’s identity as specified in the Medical Staff Bylaws.

2. USE OF CONTRACTORS OR AURORA AFFILIATES FOR VERIFICATION

Medical Staff Services may delegate the Confirmation of Identity Process to an Aurora Affiliate, a Credentials Verification Organization, or a Telemedicine Service Organization (as defined in the Bylaws). In the event of such delegation, the entity performing the Confirmation of Identity Process must meet the requirements of the Bylaws, this Policy, and the Joint Commission requirements.

3. METHOD OF CONFIRMATION

Medical Staff Services (or its designee) may verify an Applicant is the same individual identified in the credentialing documents by using one of the following methods:
(a) comparing the Authorized Form of Identification against the Applicant either (1) in person or (2) via real-time electronic visual communication (for example, Skype or FaceTime), or

1 JCS MS.06.01.03, EP 5 (January 2018)
(b) having the Applicant complete and return the Identification Verification Form attached to this Policy. The completed Identification Verification Form must be submitted via mail. Faxed copies will not be accepted.

REFERENCES:
JCS MS.06.01.03, EP 5 (January 2018)

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 5/22/18

BOARD OF DIRECTORS APPROVAL: 6/18/18
**IDENTIFICATION VERIFICATION FORM (NOTARY ATTESTATION)**

<table>
<thead>
<tr>
<th>SECTION A.</th>
<th>SECTION B. APPLICANT ATTESTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Place a copy of your</strong>&lt;br&gt;Authorized Form of Identification&lt;br&gt;<strong>in this box</strong>&lt;br&gt;<strong>MUST BE LEGIBLE</strong></td>
<td>Please check type of identification copied in Section A.</td>
</tr>
<tr>
<td></td>
<td>□ Hospital Photo ID Card&lt;br&gt;□ Driver’s License&lt;br&gt;□ Passport&lt;br&gt;□ Other Government-issued ID: __________________________</td>
</tr>
</tbody>
</table>

I attest that I, ________________________________, am the person reflected in the above photograph, and I am applying for privileges/scope of practice at a medical center of Aurora Health Care.

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________________________</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

Signature

<table>
<thead>
<tr>
<th>SECTION C. NOTARY ATTESTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sworn to and subscribed before me this _____ day of ________ 20____ in the State of ______________________ and County of ______________________.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Notary Public’s Printed Name</td>
</tr>
<tr>
<td>________________________________</td>
</tr>
<tr>
<td>Notary Public’s Signature</td>
</tr>
<tr>
<td>________________________________</td>
</tr>
<tr>
<td>My Commission Expires</td>
</tr>
</tbody>
</table>

**FOR OFFICE USE ONLY**

The presence of the notary seal must be verified prior to scanning the Identification Verification Form.

I verify and confirm that the appropriate notary seal was present on the Identification Verification Form submitted by ________________________________ (applicant name).

<table>
<thead>
<tr>
<th>Name of Person Verifying</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>_________________________</td>
<td>_________________________</td>
</tr>
</tbody>
</table>
SHEBOYGAN POLICIES GOVERNING MEDICAL PRACTICES

CONFLICT MANAGEMENT

POLICY STATEMENT
Conflict is a normal response to differing opinions about needs, values and interests. While not all conflict is harmful, ineffectively managed conflict may adversely affect patient safety and quality of care, particularly when leadership groups disagree about accountabilities, policies, practices, and procedures. The Medical Staff, in collaboration with the Medical Executive Committee, Administration and the Governing Body, developed the conflict management process set forth in this policy in order to: (1) promote productive, collaborative, and effective teamwork among and between all individuals and groups at the Medical Center, including leadership groups and committees; and (2) maximize patient safety and quality of care. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. DEFINITIONS

“Conflict” means differences in beliefs, needs, interests, or values among leadership groups and/or other groups or individuals within the Medical Center.

“Dysfunctional Conflict” means an escalating Conflict that undermines productivity or organizational well-being, demoralizes teams and/or individuals, and/or jeopardizes patient safety and quality of care at the Medical Center.

“Conflict Management” means the process of identifying and handling Conflict in a manner that promotes patient safety, quality of care, and organizational well-being. Conflict management involves open, productive, and respectful communication that acknowledges the rights and responsibilities of stakeholder parties.

“Facilitator” means an individual skilled in Conflict management who can serve as a neutral facilitator.

2. INFORMAL CONFLICT MANAGEMENT.

2.1 Generally.
Most Conflicts can be informally resolved in a manner consistent with the Medical Center’s values and Code of Conduct Policy.

2.2 Informal Process.
Individuals and/or groups involved in a Conflict and other stakeholders will participate in the informal Conflict management process by:

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1 JCS LD.02.04.01, EP 1 and LD.01.03.01, EP 7 (Jul. 2015).
2 JCS LD.02.04.01, EP 3 (Jul. 2015).
(a) acknowledging the Conflict and respectfully listening to and considering the positions of others;
(b) providing an opportunity for key stakeholders to openly discuss the situation at hand, ask questions of one another, and evaluate pertinent information;
(c) demonstrating acceptance and tolerance of different perspectives and a commitment to fundamental fairness;
(d) refraining from behaviors and/or language that would be inconsistent with the Medical Center’s Code of Conduct Policy and/or could potentially escalate the Conflict; and
(e) requesting the assistance of a competent Facilitator whenever necessary.

If the Conflict cannot be satisfactorily resolved through these informal means and/or the Conflict has escalated to the point of becoming a Dysfunctional Conflict, the participants shall communicate the general nature of the Conflict to the Medical Center’s senior leadership (see Section 3.2(a)).

3. **FORMAL CONFLICT MANAGEMENT**

3.1 **Generally.**
Conflicts that cannot be resolved with informal Conflict management may need formal Conflict Management; however, involved parties must ensure a good faith effort has been expended to resolve the Conflict through informal means.

3.2 **Formal Process.**
Formal Conflict Management is necessary when a Conflict becomes a Dysfunctional Conflict. If such a Dysfunctional Conflict occurs, the following process will be implemented:

(a) **Notify Senior Leadership.** If not already aware, senior leadership of the Medical Center (the Administrator, the Medical Executive Committee, or the Governing Body) shall be notified about the Conflict and the need for implementation of the formal Conflict Management process. Throughout and after the Conflict Management process, the senior leader(s) will implement all necessary actions to protect patient safety and quality of care.

(b) **Determine the Nature of the Conflict.** The senior leader(s) will meet with the involved parties as soon as possible and identify the nature and extent of the Conflict. The senior leader(s) will also gather additional information as necessary.

(c) **Identify Necessary Supportive Resources.** The senior leader(s) will identify an appropriate internal or external Facilitator to assist with the Conflict Management. External facilitators (including mental health, legal, or human resource professionals)

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\(^3\) JCS LD.02.04.01, EP 5 (Jul. 2015).
\(^4\) JCS LD.02.04.01, EP 4 (Jul. 2015).
may be considered when the Conflict involves key organizational leaders, a particularly sensitive issue, and/or there are no unbiased internal resources.

(d) **Conflict Management.** The designated Facilitator will:

i. Expeditiously meet with the involved parties to define the issues associated with the Conflict and identify potential areas of common ground;\(^5\)

ii. Gather pertinent information about the Conflict;

iii. Work with parties to manage, and when possible, resolve the Conflict; and

iv. Assure appropriate flow of information to Medical Center leadership regarding the Conflict Management process and, in particular, issues that could adversely affect patient safety or quality of care.

**REFERENCES:**

*Joint Commission Standards*
- JCS LD.02.04.01 (Jul. 2015)
- JCS LD.01.03.01 (Jul. 2015)

**FORM(S):** None

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 9/26/17

**BOARD OF DIRECTORS APPROVAL:** 12/18/17

**POLICY STEERING COMMITTEE APPROVAL:** 10/25/17

\(^5\) JCS LD.02.04.01, EP 4 (Jul. 2015).
CONSULTATIONS

POLICY STATEMENT

It is the policy of the Medical Staff to assure that a consultation with a qualified Medical Staff member is ordered when the attending practitioner’s expertise does not meet the clinical needs of the patient, or when the best interests of the patient will be thereby served. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. INDICATIONS FOR REQUIRED CONSULTATION; QUALIFIED CONSULTANT

Whenever a Staff Member is confronted with any of the circumstances described below, the Staff Member must consult with Staff Members who possess the appropriate qualifications. An appropriately qualified consultant should: (1) be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board or by a comparable degree of competence based on equivalent training and experience; and (2) have the licensure, skills, judgment and Clinical Privileges requisite for evaluation and treatment of the condition or problem presented. Except in an emergency, the Medical Staff requires consultation with the following Staff Members in the following circumstances:¹

| Circumstance                                                                 | Consultant                              |
|                                                                            | An appropriately qualified consultant   |
| An issue or question arises that is outside the scope of the Staff Member’s licensure, education, training, experience, skills, or Clinical Privileges |                                           |
| The complexity of the patient’s condition requires careful coordination    | An appropriately qualified consultant   |
| Patient is known or suspected to be suicidal and/or homicidal              | Psychiatrist or Clinical Psychologist    |
| Admission to a particular unit or department of the Medical Center requires consultation (e.g., the Neonatal Intensive Care Unit) | Refer to the Department policy         |
| A surgery or procedure may interrupt a known or suspected pregnancy        | Obstetrician                             |
| Consultation is required by law                                            | An appropriately qualified consultant   |
| Consultation is requested by the patient or patient representative(s)      | An appropriately qualified consultant   |
| A surgery, procedure or treatment is considered high risk or controversial | An appropriately qualified consultant   |

¹ Wis. Admin. Code DHS § 124.12(5)(b)10 (2016); JCS MS.03.01.03, EP 4 and 5 (Jul. 2015).
Circumstance | Consultant
--- | ---
Problems of critical illness in which a significant question exists with respect to the appropriate procedure or therapy | An appropriately qualified consultant
Cases of difficult or equivocal diagnosis or therapy | An appropriately qualified consultant
Admission to Behavioral Health Services | Psychiatrist

2. **REQUEST, RESPONSE AND DOCUMENTATION**

2.1 **Request.**
The Staff Member requesting the consultation must:

(a) Contact the consulting Staff Member directly by telephone or in person (Staff Member to Staff Member contact required) to request the consult;

(b) enter an order requesting the consult; and

(c) Provide the consulting Staff Member with adequate information to enable the consulting Staff Member to provide the consultation, including the reason for the request and the extent of involvement in the care of the patient expected from the consultant (e.g., “for consultation and opinion only,” “for consultation, orders, and follow-up about a particular problem”).

2.2 **Consultation and Documentation.**
The consulting Staff Member shall be responsible for: (a) responding to a request for consultation within twenty-four (24) hours of his or her receipt of the request, unless otherwise directed by the requesting Staff Member; and (b) preparing and signing a consultation report which describes the consultant’s findings, opinions and recommendations, and reflects an actual examination of the patient and the medical record. Pre-procedure consultation reports should be entered into the medical record or dictated prior to the procedure.

**REFERENCES:**

**Federal Regulations**
- None.

**Wisconsin Statutes**
- None

**Wisconsin Administrative Code**

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2 JCS MS.03.01.03, EP 5 (Jul. 2015).
Joint Commission Standards
• JCS MS.03.01.03 (Jul. 2015)
• JCS RC.02.01.01 (Jul. 2015)

FORM(S): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013, 9/26/17

BOARD OF DIRECTORS APPROVAL: 4/18/2013, 12/18/17

POLICY STEERING COMMITTEE APPROVAL: 10/25/17
DESIGNATION OF QUALIFIED MEDICAL PERSONNEL

POLICY STATEMENT
As required under EMTALA, the Medical Center determines which non-Physician Staff Members or other Medical Center personnel are qualified to perform medical screening examinations. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. DEFINITIONS

“Medical Screening Examination” means an examination performed by a licensed Physician or Qualified Medical Person to determine with reasonable clinical confidence whether an emergency medical condition exists. Triage, which entails an assessment of an individual’s presenting signs and symptoms in order to prioritize when an individual will be seen by a Physician or QMP, is not a medical screening examination.

“Qualified Medical Personnel” or “QMP” means an individual, other than a licensed Physician, who is designated as qualified to administer one or more types of Medical Screening Examinations and/or complete and sign a transfer certification in consultation with a Physician.

2. QUALIFIED MEDICAL PERSONNEL

The Emergency Department Manager will ensure that the providers identified below meet the qualifications set forth below. If the provider is a Medical Center employee, the manager of the applicable Department will ensure that the provider identified below meets the qualifications.

<table>
<thead>
<tr>
<th>Medical Screening Examination</th>
<th>Qualified Medical Personnel</th>
<th>Additional Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Labor/False Labor</td>
<td>• Nurse Practitioners</td>
<td>• Registered Nurses must complete a competency checklist annually</td>
</tr>
<tr>
<td>• Rule Out Rupture of Membranes</td>
<td>• Registered Nurses</td>
<td></td>
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<tr>
<td>• Decreased Fetal Movement</td>
<td>• Physician Assistants</td>
<td></td>
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<tr>
<td>• Second or Third Trimester Vaginal Bleeding</td>
<td></td>
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</tr>
<tr>
<td>• Sexual Assault</td>
<td>• Nurse Practitioners</td>
<td>• Must be a recognized Sexual Assault Nurse Examiner (SANE) (complete a SANE training program approved by the Medical Executive Committee).</td>
</tr>
<tr>
<td></td>
<td>• Registered Nurses</td>
<td></td>
</tr>
</tbody>
</table>

1 42 CFR 489.24(a)(1)(i) (Interpretive Guidelines, effective October 17, 2008).
3. ADDITIONAL DESIGNATIONS

3.1 Development of Medical Screenings Examination Protocols.
The Chairperson of the appropriate Clinical Department (or his/her designee) is responsible for developing a Medical Screening Examination protocol which includes a description of: (a) the scope of a particular type of Medical Screening Examination; (b) the types of providers who may perform such examinations; and (c) the necessary qualifications and competencies which must be met in order for such providers to be designated as QMPs for such examinations.

3.2 Approval of Protocols by the Medical Executive Committee and Governing Board.
Each Medical Screening Examination protocol must be approved by the Medical Executive Committee and the Governing Board.

REFERENCES:
Federal Regulations
- 42 CFR § 482.24 (Interpretive Guidelines, effective October 17, 2008).

FORM(S): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013, 9/26/17

BOARD OF DIRECTORS APPROVAL: 4/18/2013, 12/18/17

POLICY STEERING COMMITTEE APPROVAL: 10/25/17
Expansion ("Train Up") of Privileges for Advanced Practice Professionals (APP) Addendum
Preceptorship Plan Details

Please complete this form in its entirety. The preceptorship may only occur at Aurora Sheboygan Memorial Medical Center (ASMMC), and the collaborating or sponsoring physician and APP must hold privileges at ASMMC.

Preceptorship Plan for: ________________________________________________________________

1. **List the cluster and the specific privilege(s) being requested.**

   ________________________________________________________________

   ________________________________________________________________

2. **List the name(s) of preceptor(s) providing direct supervision.** Direct supervision means that the collaborating or supervising physician is acting as the preceptor and is required to be physically present for the duration of the procedure or patient encounter. The preceptor must have the privilege(s) being requested by the APP and must be authorized to exercise such privileges at the site where precepting will take place.

   ________________________________________________________________

   ________________________________________________________________

3. **Anticipated length of training.** The recommended duration of a preceptorship plan is generally expected to be six months or less; however, may be extended for a limited time beyond 6 months per the discretion of the Medical Staff Leader, Credentials Committee, Medical Executive Committee and Governing Body.

   ________________________________________________________________

   ________________________________________________________________

4. **Specific number of procedures/patient encounters proposed to attain competency.** Please be specific as to how many procedures/patient encounters will be observed and how many procedures/patient encounters will be performed under direct supervision.

   ________________________________________________________________

   ________________________________________________________________
5. **Competency measures.** Identify tools you will use to measure competency. Is there an education component, such as NIH Stroke Scale found on the Aurora’s Learning Connection or will the APP be required to review Clinical Practice Guidelines. Be specific as to what competency measures will be utilized in addition to the required completion of proctoring forms.

6. **Patient population** (if applicable)

---

**Applicant Name**  
Signature  
Date

**Preceptor(s):**

---

**Print Name**  
Signature  
Date

**Print Name**  
Signature  
Date

**Print Name**  
Signature  
Date

**PLEASE NOTE:** Incomplete preceptorship plans will not be processed.

---

**FOR OFFICE USE ONLY**

<table>
<thead>
<tr>
<th>Approval</th>
<th>Date</th>
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<tbody>
<tr>
<td>Preceptorship Plan Received</td>
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<tr>
<td><strong>APPROVALS</strong></td>
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<td>Department Chairperson Approval</td>
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<td>Credentials Committee</td>
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<td>Medical Executive Committee</td>
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<td>Governing Body</td>
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Policy and Procedure for Expansion ("Train Up") of Privileges for Advanced Practice Professionals (APP)

1. Purpose

Advance Practice Professionals (APPs) are credentialed for core and special privileges within the subspecialty cluster in which they practice. However, APPs have variable levels of previous experience within the specialties and the Medical Staff recognizes that some privileges within a cluster may necessarily require more training and knowledge than the APP possesses in order to safely perform them. In these instances, the Medical Staff desires to establish the conditions under which an APP will be privileged to make certain that patient safety and quality are adequately protected. This policy hereby establishes a safe and effective training process to increase the capabilities and competencies (cognitive and procedural) of each APP who requests additional clinical privileges for which he or she has limited or no training and experience. The mechanism by which this training process is accomplished will be through this “Train Up” policy and associated processes.

Any APP seeking clinical privileges (including privileges under direct supervision) to provide care, treatment, or services must first be granted permission to do so by the governing body based upon a recommendation by the Credentials Committee and Medical Executive Committee. Requests for clinical privileges are processed only when the potential APP applicant meets the governing body’s current minimum threshold criteria. If potential APP applicants do not meet these criteria, their applications will not be processed. In the event there is a request for a privilege for which there is no established criteria for APPs and/or the privileges were previously granted only to physicians, the governing body must determine whether it will allow APPs the privilege in question. If the governing body allows the privilege for APPs, criteria will be developed in accordance with medical staff policy and granting of such new privileges will be subject to this policy.

APPs who do not meet all established eligibility criteria and cannot demonstrate the requisite competence for the requested expansion of privileges may be allowed to “train up” via this policy under the direct supervision of their collaborating or supervising physician, provided specific educational requirements for special request privileges have been met. Applicants who have not completed the Aurora Health Care education and/or certification requirements to function in a defined role, such as a first surgical assistant, are not eligible under this policy to “train up” for the specific privilege that has a certification and/or defined role requirements.
For the purposes of this policy, direct supervision means that the collaborating or supervising physician is acting as a preceptor\(^1\) and is therefore required to be physically present for the duration of the procedure or patient encounter that is the subject of a privilege given through this policy so that the physician is able to provide expert review, commentary and, ultimately, attestation of the APP’s ability to perform the privilege in a safe and competent manner.

2. **Scope**

This Policy applies to all APPs who are currently credentialed Advanced Practice Professionals in Good Standing. This policy does not apply to Medical Staff Members.

3. **Definitions**

For the purposes of this Policy, the term *Advanced Practice Professional Staff* includes:

- Advance Practice Nurses
  - Certified Registered Nurse Anesthetists (CRNAs)
  - Certified Nurse Midwives (CNMs)
  - Nurse Practitioners (NPs)
  - Clinical Nurse Specialists (CNSs)
- Physician Assistants (PAs)
- Psychologists (Ph.D or Psy.D)
- Chiropractors (DCs)
- Optometrists (ODs)

4. **Procedure**

APPs and their collaborating or supervising physicians will submit a written request ("preceptorship plan") to "train up" to the Medical Staff Services Department. A prerequisite is that the physician preceptor(s) must have the privilege(s) being requested by the APP and must be authorized to exercise such privileges at Aurora Sheboygan Memorial Medical Center.

The "preceptorship plan" will include:

- A. The specific privilege(s) requested
- B. The name(s) of preceptor(s) providing direct supervision
- C. The anticipated length of training and specific number of procedures/patient encounters proposed to attain competency
- D. Competency measures
- E. Patient population (if applicable)

While under a preceptorship plan, patient consent must be obtained by the APP performing the procedures. **Note**: Both the informed consent and performance of the procedure must be under direct supervision.

The preceptorship plan will be considered in accordance with the Medical Staff Bylaws and Medical Staff Policies Governing Medical Practices related to clinical privileging, e.g., Department Chairperson review and recommendation, Credentials Committee review and

---

\(^1\) Precepting and proctoring are not interchangeable terms. Precepting is a process through which a practitioner gains experience and/or training on new skills and knowledge. Proctoring is a different activity that confirms previously acquired competency.
recommendation, Medical Executive Committee review and recommendation, and Governing Body action.

If the APP holding privileges under direct supervision successfully completes the preceptorship plan and wishes to request the independent practice of the privilege and the collaborating or supervising physician confirms that the APP is competent to perform the privileges independently, then the Medical Staff policy for modification of clinical privileges should be followed.
FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

POLICY STATEMENT

To establish a systematic process to assure there is sufficient information available to confirm the current competency of practitioners initially granted privileges either as a member of the ASMMC Medical Staff or Advanced Practice Professional Staff. This process, termed focused professional practice evaluation (FPPE) is mandated by the Joint Commission, and provides the basis for obtaining organization-specific information that substantiates current clinical competence for those practitioners. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. SCOPE

FPPE routinely occurs at the time new privileges are granted, either as part of the initial application to the Medical Staff or Advanced Practice Professional Staff, or as currently appointed practitioners request new clinical privileges. FPPE is also utilized when a potentially negative trend or pattern of performance is identified in the practice of a currently appointed practitioner. Practitioners requesting Medical Staff membership but not requesting specific clinical privileges are not subject to the provisions of this policy.

2. DEFINITIONS

2.1 FPPE.

Focused Professional Practice Evaluation. The framework upon which to confirm a practitioner’s competence at the time new privileges are granted, either as part of the initial application to the Medical Staff or Advanced Practice Professional Staff, or as currently appointed practitioners request new clinical privileges. FPPE is also utilized when a potentially negative trend or pattern of performance is identified in the practice of a currently appointed practitioner. In addition to specialty-specific competencies, evaluation will also address the six ACGME general competencies of the practitioner’s performance:

- Patient Care
- Medical Knowledge
- Practice Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems Based Practice

2.2 Practitioner.

For purposes of this policy, the term “practitioner” means any Medical Staff Member or Advanced Practice Professional Staff Member granted privileges at ASMMC.
2.3 **Proctor.**
Practitioner performing the evaluation. The proctor must be a member in good standing of the ASMMC Medical Staff, with privileges in the specialty area related to the privileges being evaluated.

2.4 **Methods of Evaluation.**

- **Prospective Evaluation:** Presentation of cases with planned treatment outlined for treatment concurrence, review of case documentation for treatment concurrence or completion of a written or oral examination or case simulation.
- **Concurrent Evaluation:** Direct observation of the procedure being performed or assessment of medical management through observation of practitioner interactions with patients and staff.
- **Retrospective Evaluation:** Review of the documentation of a case after the care has been completed. This may also involve interviews of personnel directly involved in the case.

3. **POLICY**

3.1 **Medical Staff Position on Evaluation:**
The proctor’s role is typically that of an evaluator, not a consultant or mentor. A practitioner serving as a proctor for the purpose of assessing and reporting on the competence of another practitioner is an agent of Aurora Health Care. The proctor shall receive no compensation directly or indirectly from any patient for this service, and shall have no duty to the patient to intervene if the care provided by the proctored practitioner appears to be deficient. However, the proctor is expected to report immediately to the appropriate Department Chairperson or Medical Staff Officer any concerns regarding the care being rendered by the proctored practitioner, and may render emergency medical care to a patient for medical complications arising from the care provided by a proctored practitioner. Aurora Health Care will defend and indemnify any practitioner who is subject to a claim or suit arising out of his or her acts in the role of a proctor, provided that such proctor has acted in accordance with this policy and the Medical Staff Bylaws of ASMMC.

3.2 **Selection of Methods of Evaluation for FPPE:**
The evaluation methods to determine current competency for a practitioner will be part of the recommendation for granting of privileges by a Department Chairperson, and will be reviewed and approved by the ASMMC Credentials Committee and the ASMMC Medical Executive Committee.

Each specialty will define the appropriate FPPE evaluation methods which will be reviewed and approved by the ASMMC Credentials Committee and the ASMMC Medical Executive Committee at least once every three years. FPPE criteria will include the types of evaluation and the number of cases to be routinely proctored.

Evaluation may utilize a combination of methods of evaluation to obtain the best understanding of the care provided by each practitioner.
3.3 **Duration of FPPE:**
The duration of FPPE for newly appointed practitioners and newly-granted privileges shall continue until the time that the FPPE criteria have been satisfactorily completed.

3.4 **Medical Staff Oversight:**
The ASMMC Credentials Committee is charged with the responsibility of monitoring compliance with this policy. Department Chairpersons shall be responsible for overseeing the evaluation process for all applicants assigned to his/her Department.

4. **PROCEDURES/RESPONSIBILITIES**

4.1 **Each Medical Staff Department Chairperson:**
(a) Act as the proctor for each Medical Staff member or Advanced Practice Professional Staff Member.
(b) The Department Chairperson may request another physician within the department within the same area of practice as the practitioner being evaluated to assist with proctoring.
(c) Use appropriate methods and tools approved by the ASMMC Credentials Committee and the ASMMC Medical Executive Committee.
(d) Assure the confidentiality of the evaluation results and forms.

4.2 **ASMMC Credentials Committee shall:**
(a) Monitor compliance with this policy.
(b) Make recommendations to the ASMMC Medical Executive Committee regarding clinical privileges based on information obtained from the FPPE process.

4.3 **The Medical Staff Services Department shall:**
(a) Assist proctors in identifying cases for review when retrospective evaluation is selected as a method of proctoring.
(b) Receive completed evaluation forms from proctors.
(c) Make regular reports on the status of completion of FPPE to the ASMMC Credentials Committee.
REFERENCES:

Code of Federal Regulations
  • None.

Joint Commission Standards
  • JCS MS.08.01.01 (Nov. 2011).

FORM(S):

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/22/16

BOARD OF DIRECTORS APPROVAL: 5/16/16

POLICY STEERING COMMITTEE: 4/27/16
IMPAIRED STAFF MEMBER

POLICY STATEMENT
The organized Medical Staff and organization leaders have an obligation to protect patients, its Staff Members, and other persons present in the Medical Center from harm. Therefore, the organized Medical Staff designs a process that provides education about Staff Member health; addresses prevention of physical, psychiatric, and emotional illness; and facilitates confidential diagnosis, treatment, and rehabilitation of Staff Members who suffer from a potentially impairing condition. The purpose of the process is to facilitate rehabilitation, rather than discipline, by assisting a Staff Member to retain and to regain optimal professional functioning that is consistent with protection of patients, Staff Members and others present in the Medical Center. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. GENERALLY

1.1 Definition.
A Staff Member may be considered impaired if the Staff Member’ professional performance or conduct is adversely affected by age, loss of motor or cognitive skills, or physical or mental health disorders or illness, such as chemical dependency.

1.2 Guidelines.
The steps outlined in this policy are guidelines and are not directives that create any rights for the Staff Member. Notwithstanding anything to the contrary herein, if an impairment poses an imminent danger to the health, safety or welfare of any individual, the Staff Member shall be summarily suspended, pending further review, in accordance with the procedures specified in the Medical Staff Bylaws.

2. REFERRAL TO THE PRACTITIONER WELLNESS COMMITTEE

2.1 Communication of Practice and Conduct Concerns.
The Medical Staff actively encourages any individual (including a Staff Member, Medical Center employee, patient, visitor, vendor or other person) who has or becomes aware of a question or concern related to the possible impairment of any Staff Member, to promptly communicate such question or concern in accordance with the Communication of Practice and Conduct Concerns policy. The concern will be documented in accordance with such policy and referred to the Practitioner Wellness Committee as necessary.

2.2 Self-Referral.
All Staff Members are strongly encouraged to voluntarily seek the assistance of the Practitioner Wellness Committee and may do so by contacting any member of the Practitioner Wellness Committee. The Practitioner Wellness Committee member who is contacted will proceed in accordance with the Communication of Practice and Conduct Concerns policy.
3. **REVIEW BY THE PRACTITIONER WELLNESS COMMITTEE**

3.1 **Initial Evaluation by the Practitioner Wellness Committee Chairperson.**

The Practitioner Wellness Committee Chairperson shall perform an initial review of all concerns referred to the Practitioner Wellness Committee to determine whether the information provided indicates an imminent danger to the health, safety or welfare of any individual. If so, the Practitioner Wellness Committee Chairperson will refer the concern to any individual with the authority to impose a summary suspension as set forth in the Medical Staff Bylaws. The Practitioner Wellness Committee Chairperson will ensure that the concern is properly documented in the appropriate section of the Review and Evaluation Record form, obtain additional information as necessary, and consult with the applicable Clinical Chairperson. If the Practitioner Wellness Committee Chairperson; along with the Administrator, determines that the concern does not require review by the Practitioner Wellness Committee, the Practitioner Wellness Committee Chairperson will complete the appropriate section of the Review and Evaluation Record form and return it to the Director of Quality. The Director of Quality shall maintain a confidential record of all concerns that will not proceed through review by the Practitioner Wellness Committee. All such concerns shall be reviewed quarterly by the applicable Clinical Chairperson to determine whether there is a pattern of practice or conduct concerns that needs to be addressed.

3.2 **Appointment of Primary Contact Person; Delivery of Notice of Evaluation Letter.**

If the concern will proceed to review by the Practitioner Wellness Committee, the Practitioner Wellness Committee Chairperson will complete the appropriate section of the Review and Evaluation Record form and assign a member of the Practitioner Wellness Committee to serve as the Staff Member’s primary contact person. The responsibilities of the primary contact person include: (a) facilitating communication between the Practitioner Wellness Committee and the Staff Member; (b) providing on-going availability and support to the Staff Member; and (c) working with the Staff Member to develop and coordinate a comprehensive recovery program, if necessary. The Practitioner Wellness Committee Chairperson, or his/her designee, shall deliver a “Notice of Evaluation” letter to the Staff Member, identifying the primary contact person and inviting the Staff Member to meet with the primary contact person and provide any relevant information that may assist in the evaluation process.

3.3 **Evaluation and Report by Primary Contact Person.**

The primary contact person will make a reasonable effort to obtain the relevant facts by: (1) discussing the concern with the Staff Member, the initial reporter, and other individuals; (2) reviewing the Review and Evaluation Record form, relevant medical records, reports, and any other information deemed necessary or relevant by the primary contact person; and (3) consulting with internal or external specialists or resources as necessary. The Staff Member shall be invited to explain the activities and/or conduct involved and encouraged to submit a written explanation or response. Discussions with the Staff Member shall not constitute a formal hearing under the Medical Staff Bylaws, and need not be conducted as such. The primary contact person will generally conclude his or her evaluation within fourteen (14) days of receiving the concern, complete the appropriate section of the Review and Evaluation Record form, and forward the form to the Practitioner Wellness Committee.
Chairperson. The primary contact person will seek approval from the Practitioner Wellness Committee Chairperson in the event a longer time period is required.

3.4 Review by the Practitioner Wellness Committee.
The Practitioner Wellness Committee Chairperson will distribute the Review and Evaluation Record form and other relevant information to Practitioner Wellness Committee members, arrange for Practitioner Wellness Committee review, and invite the Staff Member to meet with the Practitioner Wellness Committee and submit written materials. The Practitioner Wellness Committee shall meet and review the Review and Evaluation Record form and all supporting documents, including any materials submitted by the Staff Member. In addition, the Practitioner Wellness Committee will discuss the concern with the Staff Member (if he/she accepts the opportunity), the initial reporter, and other individuals. Discussions with the Staff Member shall not constitute a formal hearing under the Medical Staff Bylaws, and need not be conducted as such.

3.5 Recommendations; Treatment Agreement.
Following its review, the Practitioner Wellness Committee shall describe its findings and recommendations in the appropriate section of the Review and Evaluation Record form.

(a) No Further Action. If a majority of Practitioner Wellness Committee members conclude that no impairment exists, the Practitioner Wellness Committee Chairperson shall complete the appropriate section of the Review and Evaluation Form and forward the form to the Director of Quality, who will ensure that all such documentation is appropriately maintained. The Practitioner Wellness Committee Chairperson shall inform the Staff Member of the Practitioner Wellness Committee’s findings and recommendations.

(b) Further Action Required. If a majority of Practitioner Wellness Committee members conclude that an impairment exists, the Committee shall, depending on the nature and severity of the impairment:

i. Continued Monitoring. Continue informal evaluations and schedule additional meetings with the Staff Member and others, as appropriate, for purposes of further analysis and monitoring of the impairment and for providing advice to the Staff Member regarding treatment options, which may include referral of the Staff Member to appropriate professional internal and external resources for evaluation, diagnosis, and treatment of the impairment; and/or

ii. Treatment and Recovery Agreement. Reach a formal written agreement with the Staff Member regarding a program of treatment and recovery, a sample of which is attached as Exhibit A (“Treatment Agreement”). The Staff Member shall be informed that failure to enter into a written Treatment Agreement on a voluntary basis may necessitate referral of the Staff Member for appropriate corrective action under the Medical Staff Bylaws.

(c) Corrective Action. If the Practitioner Wellness Committee determines corrective action is indicated, the Practitioner Wellness Committee will proceed in accordance with the corrective action process set forth in the Medical Staff Bylaws.
3.6 **Documentation.**
All information acquired in connection with the review and evaluation of health care services provided by an individual Staff Member and any records of investigations, inquiries, proceedings and conclusions of such review or evaluation, including any materials submitted by the Staff Member, shall be included in the Staff Member’s confidential file. As appropriate, such information may be factored into the decision to permit the Staff Member to maintain existing privilege(s), to modify the Staff Member’s existing privilege(s), or to revoke the Staff Member’s existing privilege(s) prior to or at the time of reappointment and renewal or modification of clinical privileges.

3.7 **Tentative Time Period for Review.**
Unless the matter is submitted for corrective action, the review process will generally be completed within sixty (60) days of the date the matter was referred to the Practitioner Wellness Committee. This timeframe may be used as a general guide, but may also be extended on a case-by-case basis.

3.8 **Need for Corrective Action; Breach of Treatment Agreement.**
If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a Staff Member is unable to safely perform the privileges he or she has been granted, the Practitioner Wellness Committee Chairperson shall forward the matter for appropriate corrective action in accordance with the Medical Staff Bylaws.

3.9 **Confidentiality.**
The Committee shall comply with all applicable laws regarding the confidentiality of information related to the review of health care services.

3.10 **Reporting.**
The Practitioner Wellness Committee shall meet as necessary and shall make reports to the Administrator and Chief of Staff.

**REFERENCES:**
- JCS MS.11.01.01 (Jan. 2011)

**FORM(S):**
- Review and Evaluation Record

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 3/19/2013; 3/22/16

**BOARD OF DIRECTORS APPROVAL:** 5/16/16

**POLICY STEERING COMMITTEE:** 4/27/16
Review and Evaluation Record
Impaired Staff Member

I. Intake (to be completed by the Director of Quality)

Date: ________________________ Completed by: _______________________________

Concern initially communicated to: _____________________________________________ on: __________________

Concern communicated by: _______________________________________________________

MR# of patient (if any): ______________________ Discharge Date:____________________

Persons/parties involved and contact information: __________________________________________

__________________________

Received by Director of Quality on: ______________________ Clinical Chairperson on: 

____________________________

Initial Summary of Facts/Circumstances: ____________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Additional documentation available:   __ Medical Records       __ Incident Report       __ Written Complaint

__ Other: _____________________________________________________________________
NPI Number: _______________   ID Number*: _______________ - _______________

II. Initial Evaluation by Clinical Chairperson (in consultation with the Director of Quality)

Date: _________________________

Completed by: _______________________________ in consultation with: __________________________

Answer each question below.

Does the concern indicate an imminent danger to the health, safety or welfare of any individual? ___ yes ___ no
   (If yes, immediately refer the concern to any individual with the authority to impose summary suspension under the Medical Staff Bylaws.)
   Concern referred to: ________________________ on: _______________
   Comments: ________________________________________________________________________________

Is the concern related to a Staff Member who may be impaired? ___ yes ___ no
   (If yes, refer to the Impaired Staff Member Policy.)
   Comments: ________________________________________________________________________________

Does the concern involve allegations of disruptive conduct? ___ yes ___ no
   (If yes, the concern must be referred to the PRC Chairperson.)
   Concern referred to: ________________________ on: _______________
   Comments: ________________________________________________________________________________

Has the concern been referred for corrective action? ___ yes ___ no
   (If yes, notify the PRC Chairperson that the concern was referred for corrective action.)
   Concern referred to: ________________________ by: ________________________ on: _______________
   Comments: ________________________________________________________________________________

Does the concern warrant further attention by the PRC? ___ yes ___ no
   (If no, obtain concurrence of Administrator or Chief of Staff, provide an explanation below and forward to the Director of Quality for appropriate filing and review.)
   Concern referred to: ________________________ on: _______________
   Comments: ________________________________________________________________________________
NPI Number: _______________  ID Number*: ________________ - ________________

III. Initial Evaluation by Practitioner Wellness Committee Chairperson

Date: _______________  Signature: __________________________________________

Does the concern warrant further attention by the Practitioner Wellness Committee?  ___ yes  ___ no
(If no, provide an explanation below.)

Comments: ________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Appointed Primary Contact: __________________________________________

Initial Questions (if any): ________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Review and Evaluation Record sent to Primary Contact on: _________________

Letter informing Review Subject of pending review sent by PWC Chairperson on: _________________

Other communication with Review Subject: ________________________________________________
_____________________________________________________________________________________
NPI Number: ________________  ID Number*: ________________ - ________________

IV. Evaluation by Primary Contact Person

Documents Reviewed: __________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Interview(s) with Review Subject:

Date: ________________  Participants: _______________________________________________________________________________________

Comments: _______________________________________________________________________________________

Date: ________________  Participants: _______________________________________________________________________________________

Comments: _______________________________________________________________________________________

__ No interview. Explain: _____________________________________________________________________________________

Other Interviews:

Date: ________________  Participants: _____________________________________________________________________________________

Comments: _______________________________________________________________________________________

Date: ________________  Participants: _____________________________________________________________________________________

Comments: _______________________________________________________________________________________

Patient Outcome (indicate one)  Comments:

__ Concern does not involve patient
__ Unknown to reviewer
__ No adverse outcome
__ Minor adverse outcome
   (complete recovery expected)
__ Major adverse outcome
   (complete recovery NOT expected)
__ Catastrophic adverse outcome
   (e.g., permanent severe disability, death)

Affect on Care (check all that apply)  Comments:

__ Care not affected
__ Increased monitoring/observation
__ Additional treatment/intervention
__ Life-sustaining treatment/intervention
__ Unknown to reviewer
IV. Evaluation by Primary Contact Person (cont)

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<td>__ Controversial</td>
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<tr>
<td>__ Inappropriate</td>
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<td>__ Reviewer Uncertain</td>
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<td>__ Diagnosis</td>
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<td>__ Documentation does not substantiate clinical course/treatment</td>
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<td>__ Documentation is not timely</td>
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<td>__ Documentation not legible</td>
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<td>__ Other: __________________________</td>
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<tr>
<td>__ Potential system or process issue</td>
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<tr>
<td>__ Potential ancillary/nursing staff issue</td>
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<th>Impairment (indicate one)</th>
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<td>__ Impairment (describe)</td>
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NPI Number: ________________  ID Number*: ________________ - ________________

IV. Evaluation by Primary Contact Person (cont)

Other Comments (attach additional pages as necessary):
____________________________________________________________________________________________
____________________________________________________________________________________________
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____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Primary Contact:

Name ______________________ Signature ______________________ Date ________________

Name ______________________ Signature ______________________ Date ________________
V. Review by Practitioner Wellness Committee Chairperson

Date: ______________________

Practitioner Wellness Committee meeting scheduled?   ___ yes   ___ no  (If no, provide an explanation below.)

Comments: ______________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Letter informing Review Subject of pending PWC meeting sent by PWC Chairperson on: __________________
VI. Evaluation by Practitioner Wellness Committee

Meeting Date: ______________________

Documents Reviewed: _____________________________________________________________

Members in Attendance: ___________________________________________________________

Other(s) in Attendance: ___________________________________________________________

Presence of Review Subject: ___ yes ___ no  If no, explain: ______________________________

Findings of Peer Review Committee:

Patient Outcome (indicate one)  Comments:
___ Concern does not involve patient
___ Unknown to reviewer
___ No adverse outcome
___ Minor adverse outcome
   (complete recovery expected)
___ Major adverse outcome
   (complete recovery NOT expected)
___ Catastrophic adverse outcome (e.g., death)

Affect on Care (check all that apply)  Comments:
___ Care not affected
___ Increased monitoring/observation
___ Additional treatment/intervention
___ Life-sustaining treatment/intervention
___ Unknown to reviewer

Overall Care (indicate one)  Comments:
___ Appropriate
___ Controversial
___ Inappropriate
___ Reviewer Uncertain
VI. Evaluation by Practitioner Wellness Committee (cont)

<table>
<thead>
<tr>
<th>Issue Identification (check all that apply)</th>
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<td>_ Diagnosis</td>
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<tr>
<td>_ Clinical Judgment/Decision-Making</td>
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<tr>
<td>_ Technique/Skills</td>
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<td>_ Knowledge</td>
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<td>_ Responsiveness</td>
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<td>_ Conduct / Communication with patient/family</td>
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<td>_ Conduct / Communication with staff</td>
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<td>_ Planning</td>
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<td>_ Follow-up / Follow through</td>
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<td>_ Compliance with policies</td>
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<td>_ Supervision of others</td>
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<td>_ Other:</td>
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<table>
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<td>_ Documentation does not substantiate</td>
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<td>_ Documentation not legible</td>
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<tr>
<td>_ Potential system or process issue</td>
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<td>_ Potential ancillary/nursing staff issue</td>
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<th>Impairment (indicate one)</th>
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<tr>
<td>_ Impairment (describe)</td>
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VI. Evaluation by Practitioner Wellness Committee (cont)

<table>
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<th>Preliminary recommendation(s)</th>
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<td>__ Documented discussion with Clinical Chair</td>
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<td>__ Treatment Agreement (attach a copy)</td>
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<td>__ Written warning*</td>
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<tr>
<td>__ Issuance of a letter of reprimand*</td>
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<tr>
<td>__ Requirement to complete specific education*</td>
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<tr>
<td>__ Proctoring/Monitoring*</td>
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<tr>
<td>__ Suspension or revocation of Clinical Privileges*</td>
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<td>__ Summary suspension*</td>
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<td>__ Revocation of Staff Membership*</td>
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<td>__ Other: ________________________________</td>
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<td>__ Other: ________________________________</td>
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* Requires referral for corrective action

Other Comments: ____________________________________________

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MEDICAL RECORDS

POLICY STATEMENT

It is the policy of the Medical Staff to maintain complete and accurate medical records. For the purposes of this Policy, the term “medical records” includes all written documents, computerized electronic information, images (digital and film), laboratory reports and pathology slides, videos, audio recordings, and other forms of information regarding the condition of a patient.\(^1\) The confidentiality, use and disclosure of protected health information contained in medical records is addressed in the Medical Center’s Use and Disclosure Policy.

1. GENERAL REQUIREMENTS

1.1 Form. Every page included in a medical record must be clearly labeled with the patient's complete name and medical record number. Only those individuals authorized by the Medical Center may make entries into a patient’s medical record and must do so only through the Medical Center’s password-protected electronic system, or on Medical Center-approved medical record forms.\(^2\) All handwritten entries must be made with a pen (pencils and felt tip pens are not permitted).

1.2 Legibility. All handwritten entries in the medical record must be legible in order to reduce potential misunderstandings that could lead to medical errors or other adverse patient events.\(^3\)

1.3 Date, Time, Authentication and Co-Signature.\(^4\)

(a) Date, Time, Authentication. All medical record entries must be dated, timed (using military time), and authenticated (by written signature, identifiable initials, computer key, or other code) by the individual who made the entry. All entries must be made as soon as possible after an event or observation is made. An entry may not be made in advance, and it is not acceptable to pre-date or back-date a medical record entry (see Sections 1.4 and 1.7 below regarding late entries and corrections). If it is necessary to summarize events that occurred over a period of time (such as an entire shift), the entry should indicate the actual time the entry was made with the narrative documentation identifying the time certain events occurred.

(b) Electronic Signature. The use of an electronic signature or code is only acceptable if the individual has an attestation statement on file in the Health

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\(^1\) 42 CFR § 482.24 (Interpretive Guidelines, effective October 17, 2008).
\(^2\) JCS RC.01.02.01, EP 1 (Jan. 2010).
\(^3\) 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(5)(a)1 (2009).
\(^4\) 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008); JCS RC.01.01.01, EP 11 (Jan. 2010); JCS RC.01.02.01, EPs 2-4 (Jan. 2010); JCS RC.01.03.01, EPs 1 & 3 (Jan. 2010).
Information Services Department acknowledging that he or she is the only individual authorized to use the electronic signature or code. Delegation of an electronic signature or authentication code to another individual is prohibited. A medical record entry may not be authenticated by use of a rubber stamped signature.

(c) Co-Signature. In certain circumstances, medical record entries must be co-signed by a Physician Medical Staff Member (e.g., certain entries by an Advanced Practice Professional must be co-signed by the Advanced Practice Professional’s supervising or collaborating physician). Such co-signature requirements may be set forth in this Policy, the Aurora System Hospital Co-Signature Requirements document, other Medical Staff and Medical Center policies, and/or in the designation of Clinical Privileges or Clinical Functions. The co-signing Physician accepts responsibility for the content of the medical record entry.

1.4 Late Entries.
When a medical record entry was missed or not entered into the medical record in a timely manner, a late entry should be used to record the information in the medical record. Such late entry shall:

(a) Identify the new entry as a “late entry.”

(b) Enter the current date and time – do not try to give the appearance that the entry was made on a previous date or an earlier time.

(c) Identify or refer to the date and time (if known) of the incident for which the late entry is written.

(d) If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get information to write late entry). For example, use of supporting documentation on other Medical Center worksheets or forms.

(e) When using late entries, document as soon as possible. There is not a time limit to writing a late entry, however, the more time that passes the less reliable the entry becomes.

1.5 Completeness.
All entries in the medical record must be complete. A medical record is considered complete if it contains sufficient information to: (a) identify the patient; (b) support the diagnosis/condition; (c) justify the care, treatment, and services provided; (d) document the course and results of care, treatment, and services; and (e) promote continuity of care.

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5 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008).
7 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008); JCS RC.01.02.01, EP 2 (Jan. 2010).
among providers. All medical records must be completed within thirty (30) days after the patient’s discharge.

1.6 Symbols and Abbreviations.
A list of unacceptable abbreviations, acronyms, symbols and dose designations shall be identified and approved by the Medical Executive Committee. An official record of such list is available at each nursing station, the Health Information Services Department and the Pharmacy Department. Only those symbols, abbreviations, acronyms and dose designations not on such list may be used.

1.7 Correction of Errors.

(a) Correcting Electronic Errors. When an error needs to be corrected in or a change needs to be made to an electronic medical record entry, the correction should be made through Computerized Physician Order Entry System (“CPOE”), if available. Whenever possible, the individual who authored the original entry must make the correction. If an individual other than the original author will make the correction, the author of the correction should communicate the correction to the original author as appropriate.

(b) Correcting Handwritten Errors. When an error needs to be corrected in or a change needs to be made to a handwritten medical record entry, the following procedures must be followed:

i. Whenever possible, the individual who authored the original entry must make the correction. If an individual other than the original author will make the correction, the author of the correction should communicate the correction to the original author as appropriate.

ii. **DO NOT OBLITERATE OR OTHERWISE ALTER THE ORIGINAL ENTRY** by blacking out with marker, using white out, writing over an entry, or otherwise obscuring the original text of the entry;

iii. Draw line through entry (thin pen line). Make sure that the inaccurate information is still legible;

iv. Initial and date the entry;

v. State the reason for the error (i.e., in the margin or above the note if room); and

vi. Document the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available

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8 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008); JCS RC.01.01.01, EPs 4-8 (Jan. 2010).
9 42 CFR §§ 482.24(b) and 482.24(c)(2)(viii) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(3)(c)3 (2009); JCS RC.01.03.01, EP 2 (Jan. 2010).
10 Wis. Admin. Code DHS § 124.14(5)(b) (2009); JCS IM.02.02.01, EP 2 and 3 (March 2011).
line/space documenting the current date and time and referring back to the incorrect entry.

(c) Alterations/Corrections Requested by the Patient. Refer to the Medical Center’s HIPAA Policy for guidance regarding the corrections or addendums to a medical record requested by a patient or a patient’s representative.

2. CONTENT

The Attending Practitioner and other Staff Members, as applicable, shall be responsible for the preparation of a complete and legible medical record for each patient. Each medical record shall include the information set forth below (as applicable)\(^{11}\) and any additional required documentation as may be described in Departmental policies.

- General Requirements (2.1)
- Demographic / Identification Information (2.2)
- Time and Means of Arrival (2.3)
- Advance Directives (2.4)
- Allergies (2.5)
- Medications (2.6)
- Emergency Department Note (2.7)
- Admission Order and Note (2.8)
- Progress Notes (2.9)
- Practitioner Orders (2.10)
- Diagnostic Testing and Results (2.11)
- Consultation Reports (2.12)
- Informed Consent or Refusal (2.13)
- History and Physical Examinations (2.14)
- Pre- and Post-Procedure Documentation (2.15)
- Anesthesia Evaluations and Reports (2.16)
- Anatomical Gifts (2.17)
- Maternity and Newborn Records (2.18)
- Pathology Reports (2.19)
- Communications (2.20)
- Patient-Generated Information (2.20)
- Autopsy Findings (2.21)
- Electrocardiographic Strips and Reports (2.22)
- Restraints and Seclusion (2.23)
- Adverse Events (2.24)
- Transfer Summary (2.25)
- Final Diagnosis and Discharge Summary (2.26)
- Ongoing Ambulatory Care Services (2.27)

2.1 General Requirements.\(^{12}\)

The medical record must contain information such as notes, documentation, records, reports, recordings, images, scans, films, test results, and assessments to: (a) justify admission; (b) justify continued hospitalization; (c) support the diagnosis; (d) describe the patient’s progress; and (e) describe the patient’s response to medications and services. In addition, the medical record must contain complete information/documentation regarding evaluations, interventions, care provided, services, care plans, discharge plans, and the patient’s response to those activities.

2.2 Demographic / Identification Information.\(^{13}\)

The medical record must contain the patient’s: (a) name, address, date of birth; (b) gender, (c) language and communication needs, and (d) legal status (if the patient is incapacitated or receiving behavioral health care services). In addition, the medical record must contain the name and contact information of any legally authorized representative of the patient.

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\(^{11}\) JCS RC.01.01.01, EP 1 (Jan. 2010).
\(^{12}\) 42 CFR § 482.24(c) (Interpretive Guidelines, effective October 17, 2008).
\(^{13}\) Wis. Admin. Code DHS § 124.14(3)(a)1 (2009); JCS RC.02.01.01 EP 1 (Jan. 2010).
2.3 **Time and Means of Arrival.**\(^{14}\)
For patients who receive urgent or immediate services, the medical record must contain:
(a) the time and means of arrival at the Medical Center; (b) any emergency care, treatment and services provided to the patient before his/her arrival at the Medical Center (if available); and (c) the time of physician involvement or notification, administration of treatment (including medications), and discharge or transfer from the emergency or urgent care department.

2.4 **Advance Directives.**
The medical record must contain copies of any advance directives as specified in the Medical Center’s Advance Directives Policy.\(^{15}\)

2.5 **Allergies.**
The medical record must identify the existence of any allergies to food, medications, latex, or other substances.\(^{16}\)

2.6 **Medications.**\(^{17}\)
The medical record must include information regarding the strength, dose, rate of administration, route, access site, administration device (if any), and unfavorable reactions, for all medications: (i) used by the patient prior to arrival; (ii) ordered, prescribed or administered after the patient’s arrival; and (iii) dispensed or prescribed on discharge. Refer to the Medical Center’s Provider Orders Policy for information regarding medication orders. Refer to Appendix A of this Policy for applicable co-signature requirements.

2.7 **Emergency Department Record.**
The Emergency Department Record must be completed within twenty-four (24) hours of the patient’s discharge from the Emergency Department.

2.8 **Admission Order and Note.**
For each hospital inpatient, the medical record must contain an admission order and note. Refer to the Medical Center’s Admission, Transfer and Discharge Policy for specific documentation requirements.

2.9 **Progress Notes.**\(^{18}\)

(a) **Care, Treatment and Services.** The medical record must contain progress notes which provide a chronological description of the course and results of care, treatment, and services provided, the patient’s progress, and any revisions to the plan of care. Such progress notes shall be entered at the time of observation and

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\(^{14}\) JCS RC.02.01.01, EPs 2 & 21 (Jan. 2010); see also Wis. Admin. Code DHS § 124.24(2)(d)(i) (2009).
\(^{15}\) JCS RC.02.01.01, EP 4 (Jan. 2010); JCS R1.01.05.01, EPs 9 & 11 (Jan. 2010).
\(^{16}\) JCS RC.02.01.01, EP 2 (Jan. 2010).
\(^{17}\) 42 CFR § 482.24(c)(2)(vi) (Interpretive Guidelines, effective October 17, 2008); JCS RC.02.01.01, EP 2 (Jan. 2010).
\(^{18}\) 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(3)(a)12 (2009); JCS RC.01.01.01, EP 7 & 8 (Jan. 2010); JCS RC.02.01.01, EP 2 (Jan. 2010).
shall be sufficient to permit continuity of care and transfer of the patient. Whenever possible, each of the patient’s clinical problems shall be clearly identified in the progress notes and correlated with specific orders as well as results of tests, procedures and treatments. Final responsibility for an accurate description of the patient’s condition and progress rests with the attending Practitioner. The attending Practitioner (or his/her designee) shall enter a progress note at least daily for acutely and critically ill patients and patients for whom there is difficulty in diagnosis or management of the clinical problem. If a progress note is entered by an Advanced Practice Professional, refer to the Aurora System Hospital Co-Signature Requirements document for applicable co-signature requirements.

(b) Need for Continued Hospitalization. The medical records must contain documentation describing the need for continued hospitalization after specific periods of stay (as identified by the utilization review plan and/or criteria developed for concurrent review). This documentation shall contain an adequate written record of the reason for continued hospitalization (a simple reconfirmation of the patient’s diagnosis is not sufficient). This documentation may also contain: The estimated period of time the patient shall need to remain in the Medical Center; and Plans for post-hospital care.

2.10 Practitioner Orders.
The medical record must contain written and verbal orders as specified in the Medical Center’s Provider Orders Policy.19

2.11 Diagnostic Testing and Results.
The medical record must contain all orders for and results and reports from diagnostic and therapeutic tests and procedures, including without limitation, all clinical laboratory, imaging, and other diagnostics.20 Interpretations of imaging reports shall be documented and shall be signed by a qualified physician or another individual authorized by the Medical Staff to interpret the image.21 Refer to the Medical Center’s Provider Orders Policy for information regarding orders of diagnostic services. Refer to Appendix A of this Policy for applicable co-signature requirements.

2.12 Consultation Reports.22
The medical record must contain consultation reports from each consulting practitioner, including a documented opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient’s medical record, and the consulting practitioner’s recommendations. Refer to the Aurora System Hospital Co-Signature Requirements document for applicable co-signature requirements.

19 JCS RC.02.01.01, EP 2 (Jan. 2010).
20 42 CFR § 482.24(c)(2)(vi) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS §§ 124.14(3)(a)6-7 and 124.18 (1)(e)1 (2009); JCS RC.02.01.01, EP 2 (Jan. 2010).
22 42 CFR § 482.24(c)(2)(iii) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(3)(a)8 (2009); JCS RC.02.01.01, EP 2 (Jan. 2010).
2.13 **Informed Consent or Refusal.**

The medical record must contain documentation of informed consent or refusal (including documentation of circumstances when a patient leaves the facility against medical advice) in accordance with the Medical Center’s informed consent and informed refusal policy. 23

2.14 **History and Physical Examinations.**

(a) **Purpose.** The purpose of a medical history and physical examination (H&P) is to determine whether there is anything in the patient’s overall condition that would affect the planned course of the patient’s treatment, such as a medication allergy, or a new or existing co-morbid condition that requires additional interventions to reduce risk to the patient. 24

(b) **Content.** At a minimum, the history and physical examination report must include the patient’s: (i) chief complaint; (ii) details of the present illness; (iii) relevant past medical, social and family histories (including past response to treatment, known allergies, current medications and dosages); (iv) emotional, behavioral and social status when appropriate; and (v) all pertinent findings, conclusions and impressions resulting from a comprehensive, current assessment of all body systems. 25

(c) **Inpatients.** The Staff Member who is responsible for the care and treatment of the patient during the patient’s inpatient stay is responsible for ensuring that an H&P is performed, documented, and authenticated for each hospital inpatient: (a) prior to any non-emergent surgery, or any inpatient procedure requiring anesthesia services, or (b) within twenty-four (24) hours of the patient’s admission, whichever occurs first. 26

(d) **Outpatients.** If a hospital outpatient will undergo a surgical or other procedure requiring anesthesia services (other than local anesthesia), the Staff Member who is responsible for the care and treatment of the patient during the patient’s outpatient stay is responsible for ensuring that an H&P is performed, documented, and authenticated prior to any non-emergent surgery, or any outpatient procedure requiring anesthesia services (other than local anesthesia). 27

(e) **Emergency Services.** If, due to an emergency, it is not possible to complete a pre-procedure H&P, the performing Practitioner shall, at a minimum, enter a notation describing the emergency and any available information relevant to the care of the patient, including but not limited to the patient’s vital signs, available history and

23 42 CFR § 482.24(c)(2)(v) (Interpretive Guidelines, effective October 17, 2008); JCS RC.02.01.01, EPs 4 & 21 (Jan. 2010).
24 42 CFR § 482.22(c)(5)(i) (Interpretive Guidelines, effective October 17, 2008).
26 42 CFR § 482.22(c)(5)(i) (Interpretive Guidelines, effective October 17, 2008); 42 CFR § 482.24(c)(2) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(3)(a)9 (2009); JCS RC.02.01.03, EP 3 (Jan. 2010).
27 42 CFR § 482.22(c)(5)(i); 42 CFR § 482.24(c)(2)(i)(B) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS §124.14(3)(a)9 (2009).
(f) **Pre-Admission H&Ps and Updates.** An H&P performed by a qualified physician or Advanced Practice Professional no more than thirty (30) days prior to the patient’s admission or registration may be used (even if such pre-admission H&P is performed by a provider who is not a current Medical Staff or Advanced Practice Professional Staff member); however, when a pre-admission/registration H&P is used, a qualified Staff Member must complete and document an updated examination of the patient, including any changes in the patient’s condition that may be significant for the planned course of treatment. The qualified Staff Member shall use his/her clinical judgment, based upon his/her assessment of the patient’s condition and co-morbidities (if any), in relation to the patient’s planned course of treatment, to decide the extent of the update assessment needed as well as the information to be included in the update note in the patient’s medical record. If, upon examination, the Staff Member finds no change in the patient's condition since the pre-admission H&P was completed, he/she may indicate in the patient’s medical record that the pre-admission H&P was reviewed, the patient was examined, and that “no change” has occurred in the patient's condition since the pre-admission H&P was completed. The updated H&P examination must be completed and documented in the patient’s medical record: (a) prior to any non-emergent surgery, or any inpatient or outpatient procedure requiring anesthesia services, or (b) within twenty-four (24) hours after the patient’s inpatient admission or outpatient registration, whichever occurs first. Any portion of the updated H&P performed by an Advanced Practice Professional shall be reviewed and co-signed by the admitting Physician or the Advanced Practice Professional’s supervising Physician and such co-signing Physician accepts responsibility for the content of the pre-admission H&P and the updated H&P.

(g) **Multiple Participants.** More than one qualified practitioner may participate in performing, documenting, and authenticating an H&P for a single patient. When performance, documentation, and authentication are shared among qualified practitioners, the practitioner who authenticates the H&P will be held responsible for its contents.

(h) **Readmission.** If a patient is readmitted to the Medical Center within thirty (30) days for the same or a related problem, an interval H&P examination reflecting subsequent history and changes in physical findings may be used, provided the original information is readily available.

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28 42 CFR § 482.22(c)(5)(i) (Interpretive Guidelines, effective October 17, 2008); 42 CFR § 482.24(c)(2)(i)(B) (Interpretive Guidelines, effective October 17, 2008) (citing the Federal Register, 71 Fed. Reg. page 68676); JCS MS.03.01.01, EPs 10 & 11 (Jan. 2010).

Consultation and Co-Signature Requirements.30

i. Dentists, Podiatrists, & Oral Surgeons. A Dentist, Podiatrist or Oral Surgeon who possesses H&P privileges may independently complete and sign an H&P prior to a procedure. If the Dentist, Podiatrist or Oral Surgeon has admission privileges, but is not privileged to perform H&Ps, the Dentist, Podiatrist or Oral Surgeon shall consult with a Medical Staff Physician regarding the completion of the pre-procedure H&P. The Dentist, Podiatrist or Oral Surgeon shall be responsible for those aspects of the H&P that relate to their specialty, and the Medical Staff Physician shall be responsible for those aspects of the H&P that relate to the patient’s other medical conditions (if any). Both the Dentist, Podiatrist or Oral Surgeon and the consulting Medical Staff Physician must sign the H&P, as applicable.

ii. Advanced Practice Professionals. If any portion of the H&P is performed or documented by an Advanced Practice Professional, refer to the Aurora System Hospital Co-Signature Requirements document for applicable co-signature requirements.

2.15 Pre- and Post-Procedure Documentation.31

(a) Pre-Procedure Documentation. Prior to surgery or any other high-risk procedure and/or the administration of moderate or deep sedation or anesthesia (e.g. any procedure requiring written informed consent), each patient’s medical record must contain:

i. an H&P;

ii. the patient’s written informed consent (if required by the Medical Center’s informed consent policy);

iii. consultation reports, if required; and

iv. results of all currently required laboratory, EKG, and x-ray studies. Generally, laboratory, EKG and x-ray results are acceptable if they have been obtained within the thirty (30) days prior to the procedure, however, it may be necessary to obtain certain imaging or laboratory results within shorter time periods (e.g., pregnancy tests must be performed the day of surgery and coagulation tests should be performed as close to the procedure time as possible).

30 JCS MS.03.01.01, EP 10 (Jan. 2010). The organized medical staff defines when a medical history and physical examination must be validated and countersigned by another Staff Member.

31 JCS RC.02.01.03, EP 1 (Jan. 2010).
(b) **Procedure (Operative) Report.**

i. The performing Practitioner must either:

- document a full procedure report, immediately after the procedure and before the patient is transferred to the next level of care (e.g. the patient leaves the recovery room);\(^32\) or

- document a brief operative note immediately after the procedure to include name(s) of the primary surgeon and assistants, procedure(s) performed, description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis, and document a full procedure report within twenty four (24) hours of the procedure;\(^33\) or

- accompany the patient from the procedure room to the next unit or area of care, and document a full procedure report in the new unit or area of care.\(^34\)

ii. The full procedure report must be signed by the performing Practitioner and must include the following information:\(^35\)

- Date and time of the procedure;
- Pre-procedure diagnosis;
- Type of anesthesia administered;
- Name and description of the specific procedure performed;
- Name(s) of performing provider and any individual(s) (e.g. surgical assistants) who performed a significant surgical or procedural task during the procedure (even when performing those tasks under supervision);
- A description of techniques, findings, and tissues removed or altered;
- Estimated blood loss, specimens removed, complications, prosthetic devices, grafts, tissues, transplants, or implants (tissue or devices); and
- Post-procedure diagnosis.

(c) **Post-Procedure Documentation.** The medical record must contain the following post-procedure information:

i. The patient’s vital signs and level of consciousness;

ii. Any medications, including intravenous fluids and any administered blood, blood products, and blood components;

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\(^{33}\) 33 JCS RC.02.01.03, EP 5, Note 1 (March 2011).

\(^{34}\) JCS RC.02.01.03, EP 5, Note 2 (Jan. 2010).

\(^{35}\) 42 CFR § 482.51(b)(6) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(3)(a)(10) (2009); JCS RC.02.01.03, EP 6 (Jan. 2010).
iii. Any unanticipated events or complications (including blood transfusion reactions) and the management of those events.  

(d) **Discharge From Post Procedural Observation.** If the patient is admitted and subsequently discharged from a post-sedation or post-anesthesia care area, the medical record must contain the name of the practitioner responsible for the discharge, and documentation that the patient was discharged from the post-sedation or post-anesthesia care area either by the responsible practitioner or by another individual in accordance with written discharge criteria.  

2.16 **Anesthesia Evaluations and Reports.**
An anesthesia provider must ensure that the following evaluations/reports are properly documented in the medical record. If such evaluations or reports are completed by a Certified Registered Nurse Anesthetist, refer to the Aurora System Hospital Co-Signature Requirements document for applicable co-signature requirements. 

(a) **Pre-Procedure Evaluation.** The medical record must contain a pre-anesthesia evaluation, including at a minimum: (1) information regarding the choice of anesthesia and the procedure anticipated, (2) the patient’s previous medication and anesthetic history, (3) potential anesthetic problems, ASA patient status classification, and orders for preoperative medications, for all inpatient and outpatient procedures. The pre-procedure assessment shall be recorded within forty-eight (48) hours prior to procedure and before any pre-procedure medication has been administered.  

(b) **Pre-Induction Re-evaluation.** The anesthesia provider shall conduct and document a re-evaluation immediately prior to induction.  

(c) **Intraoperative Report.** The anesthesia provider shall complete an intraoperative report, which shall include, at a minimum: (1) the name and profession of the practitioner who administered anesthesia, the supervising anesthesiologist (if any) and the performing practitioner; (2) name, dosage, route and time of administration of all drugs and anesthesia agents; (3) type, route and amount of IV fluids administered; (4) blood or blood products, if applicable; (5) mechanism of oxygenation, flow rate, and pulse oximetry readings; (6) continuous recordings of patient status, including blood pressure, heart and respiration rate; and (7) any complications or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient’s response to treatment.  

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36 JCS RC.02.01.03, EP 8 (Jan. 2010).
37 JCS RC.02.01.03, EPs 9 & 11 (Jan. 2010).
38 42 CFR § 482.52(b)(1) (Interpretive Guidelines, effective October 17, 2008).
39 42 CFR § 482.52(b)(2) (Interpretive Guidelines, effective October 17, 2008).
(d) **Post-Procedure Evaluation.** A post-anesthetic follow-up examination must be completed and documented by a provider who is authorized to administer anesthesia within forty-eight (48) hours after the procedure.\(^{40}\)

### 2.17 Anatomical Gifts.

The medical record must contain documentation of any anatomical gifts, including (a) the name and title of the person who requests the anatomical gift; (b) the name of the individual who provided consent for the anatomical gift; (c) the consenting individual’s relationship to the patient; (d) the response to the request for an anatomical gift; and (e) if a determination is made that a request should not be made, the basis for that determination.\(^{41}\) Refer to the Medical Center’s Policy(ies) regarding anatomical gifts.

### 2.18 Maternity and Newborn Records.

(a) **Prenatal Findings.** Except in an emergency, before a maternity patient may be admitted to the hospital, the patient's attending physician must submit a legible copy of the prenatal history to the Medical Center’s obstetrical staff. The prenatal history shall note complications, Rh determination, and any other matters essential to adequate care of the patient and the newborn.\(^{42}\)

(b) **Maternal Medical Record.** Each obstetric patient shall have a complete hospital record which shall include:

i. Prenatal history and findings;

ii. Labor and delivery record, including anesthesia;

iii. Physician’s progress record;

iv. Physician’s order sheet;

v. A medicine and treatment sheet, including nurses’ notes;

vi. Any laboratory and x-ray reports;

vii. Any medical consultant’s notes; and

viii. Estimated blood loss.

(c) **Newborn Medical Record.** Each newborn infant shall have a complete hospital record which shall include: (1) a record of pertinent maternal data, type of labor and delivery, and the condition of the infant at birth; (2) a record of physical examinations; (3) a progress sheet recording medicines and treatments, weights, feedings and temperatures; and (4) the notes of any medical consultant.

(d) **Fetal Death.** In the case of a fetal death, the weight and length of the fetus shall be recorded on the delivery record.

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\(^{40}\) 42 CFR § 482.52(b)(3) (Interpretive Guidelines, effective October 17, 2008).


2.19 **Pathology Reports.**
The medical record must contain all pathology reports, including reports of microscopic findings (if any). If only macroscopic examination is warranted, the medical record must contain a statement that the tissue has been received and a macroscopic description of the findings provided by the laboratory.43

2.20 **Communications and Patient-Generated Information**
As needed to provide care, treatment and services, the medical record must contain entries describing communications with the patient and/or the patient’s representatives (e.g., in-person discussion, telephone calls, emails, etc.) and any information generated by the patient.44

2.21 **Autopsy Findings.**
The medical record must contain all relevant autopsy findings and any other required documentation as specified in the Medical Center’s Autopsy Policy.45

2.22 **Electrocardiographic (ECG) Strips and Reports.**
Electrocardiograph strips and reports shall be filed as a permanent record in the patient’s medical record. The attending physician may retain a duplicate of the ECG strips and reports if so requested, but the original recordings shall remain in the patient’s medical record.

2.23 **Restraints and Seclusion.**
The medical record must contain required documentation regarding the use of restraints or seclusion as specified in the Medical Center’s Restraints and Seclusion Policy.46

2.24 **Adverse Events.**
The medical record must contain a complete and accurate description of any adverse event (e.g., accidents, complications, hospital-acquired infections, unfavorable reactions to drugs or anesthesia, falls, etc.).47

2.25 **Transfer Summary.**
The medical record must contain a transfer summary when a patient is moving between certain settings within the Medical Center. Refer to the Medical Center’s Admission, Transfer and Discharge Policy for specific documentation requirements.

2.26 **Final Diagnosis, Discharge Order and Discharge Summary.**
The medical record of Medical Center inpatients and certain outpatients must contain a final diagnosis (as applicable), a discharge order, and a discharge summary. Refer to the Medical Center’s Admission, Transfer and Discharge Policy for specific documentation requirements.

44 JCS RC.02.01.01, EP 4 (Jan. 2010).
46 JCS RC.02.01.05 (Jan. 2010).
47 42 CFR § 482.24(c)(2)(iv) (Interpretive Guidelines, effective October 17, 2008).
2.27 **Ongoing Ambulatory Care Services.**⁴⁸
For each patient who receives ongoing ambulatory care services, the medical record must contain a summary list that includes the following: (a) any significant medical diagnoses and conditions; (b) any significant operative and invasive procedures; (c) any adverse or allergic drug reactions; and (d) any current medications, over-the-counter medications, and herbal preparations. The summary list is updated whenever there is a change in diagnoses, medications, or allergies to medications, and whenever a procedure is performed.

3. **REQUEST FOR CLARIFICATION FORMS**

Request for Clarification Forms must be completed within seven (7) days of the request.

4. **MEDICAL RECORD AUDITS**

The hospital conducts an ongoing review of medical records, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information, and measures the delinquency rate at least quarterly.⁴⁹

5. **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

All Staff Members agree to comply with Medical Center policies and procedures governing the use and disclosure of health information (commonly referred to as “Protected Health Information” or “PHI”), as may be amended from time to time. Such Staff Members participate in an organized health care arrangement with Aurora Health Care, Inc. (“Aurora”). Participation means the Staff Members agree, when present at an Aurora facility, to abide by the privacy policies and practices as outlined in Aurora’s Notice of Privacy Practices (“Notice”). Participation also means such Notice, when provided to patient with the patient’s acknowledgment (unless an exception applies), meets the federal Notice requirements for both the Staff Member and Aurora for care provided at an Aurora facility. Inappropriate use and disclosure of PHI shall subject the Staff Member to the corrective action process specified in the Medical Staff Bylaws.

**REFERENCES:**

**Federal Regulations**
- 42 CFR § 482.22 (Interpretive Guidelines, effective October 17, 2008).
- 42 CFR § 482.24 (Interpretive Guidelines, effective October 17, 2008).
- 42 CFR § 482.51 (Interpretive Guidelines, effective October 17, 2008).
- 42 CFR § 482.52 (Interpretive Guidelines, effective October 17, 2008).

⁴⁸ JCS RC.02.01.07 (Jan. 2010).
⁴⁹ JCS RC.01.04.01, EPs 1 & 2 (Jan. 2010); JCS MS.05.01.03, EP 3 (Jan. 2010).
Wisconsin Statutes
• None.

Wisconsin Administrative Code

Joint Commission Standards
• JCS MS.03.01.01 (Jan. 2010).
• JCS MS.05.01.03 (Jan. 2010).
• JCS RC.01.01.01 (Jan. 2010).
• JCS RC.01.02.01 (Jan. 2010).
• JCS RC.01.03.01 (Jan. 2010).
• JCS RC.01.04.01 (Jan. 2010).
• JCS RC.02.01.01 (Jan. 2010).
• JCS RC.02.01.03 (Jan. 2010).
• JCS RC.02.01.05 (Jan. 2010).
• JCS RC.02.01.07 (Jan. 2010).
• JCS RI.01.05.01 (Jan. 2010).

FORM(S): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013; 3/22/16

BOARD OF DIRECTORS APPROVAL: 5/16/16

POLICY STEERING COMMITTEE: 4/27/16
MEDICAL STAFF COMMITTEES

POLICY STATEMENT

It is the policy of the Medical Staff to have standing and special committees approved by the Medical Executive Committee to perform functions within the Medical Center. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. **BYLAWS COMMITTEE**

1.1 **Composition**

The Bylaws Committee shall consist of the Medical Staff Chief of Staff Elect, Medical Staff Secretary-Treasurer, and one Medical Staff member appointed by the Medical Staff Chief of Staff, who shall be appointed to serve as the chairperson. The Administrator (or his/her designee) and Manager of Medical Staff Services shall be invited to attend all meetings of the Bylaws Committee in a non-voting capacity. Non-members from both within and outside the Medical Center may be consulted by the Bylaws Committee to provide expertise as required or desired for the Bylaws Committee to perform its duties.

1.2 **Duties**

1.2.1 All members of the Bylaws Committee should be familiar with the governing documents of the Medical Staff, which consist of the Medical Staff Bylaws and Policies Governing Medical Practices. In addition, the Bylaws Committee members should be familiar with other applicable Medical Center policies, The Joint Commission standards, and other applicable legal, regulatory, and accreditation requirements.

1.2.2 Proposed amendments to the Medical Staff Bylaws and Policies Governing Medical Practices shall be processed in the following manner:

(a) To ensure that the Medical Staff Bylaws accurately reflect the current structure, policies and practices of the Medical Staff and comply with all legal, regulatory, and accreditation requirements, the Bylaws Committee shall, periodically and at any other time it deems necessary, review, recommend and prepare proposed amendments to the Medical Staff Bylaws for approval in accordance with the Medical Staff Bylaws.

(b) To ensure that the Policies Governing Medical Practices accurately reflect the current structure, policies and practices of the Medical Staff and comply with all legal, regulatory and accreditation requirements, the Bylaws Committee shall periodically and at any other time it deems necessary, review, recommend and prepare proposed amendments to the Policies Governing Medical Practices for approval in accordance with the Medical Staff Bylaws.

1.2.3 The Bylaws Committee shall also have the authority, subject to the approval of the Medical Executive Committee and the Governing Body, to make modifications to the Medical Staff Bylaws and Policies Governing Medical Practices, provided such
corrections do not materially change any provision of the Medical Staff Bylaws or Policies Governing Medical Practices, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, or correction of statutory, regulatory, or accreditation standard citations.

1.2.4 The chairperson may be asked by the Medical Executive Committee to serve in the capacity of an advisor to the Medical Executive Committee for purposes of reviewing proposed changes to the Medical Staff Bylaws and Policies Governing Medical Practices and attend those Medical Executive Committee meeting(s) wherein proposed changes to the Medical Staff Bylaws and Policies Governing Medical Practices are discussed.

1.2.5 To perform such other duties as requested from time to time by the Medical Executive Committee.

1.3 Meetings
The Bylaws Committee shall meet as often as necessary and on call of the chairperson.

1.4 Quorum
A quorum shall consist of at least fifty percent (50%) of the voting members of the Bylaws Committee.

2. PRACTITIONER WELLNESS COMMITTEE

2.1 Composition
The Members of the Practitioner Wellness Committee shall be the Chief of Staff, the Chief of Staff Elect, the Secretary-Treasurer, the immediate past Chief of Staff and a psychiatrist, if available. The Chief of Staff (or his/her designee) shall serve as the chairperson. The Administrator (or his/her designee), the Manager of Medical Staff Services, and the Medical Staff Services Coordinator shall be invited to attend the Committee meetings, but shall not be eligible to vote at such meetings. In addition, the chairperson may invite one or more recovering impaired Staff Members to attend Committee meetings who shall not be eligible to vote at such meetings.

2.2 Duties and Responsibilities
The duties and responsibilities of the Practitioner Wellness Committee shall be to:

2.2.1 Develop educational initiatives which promote physician health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of physicians and other providers who suffer from potentially impairing conditions.¹

¹ JCS MS.11.01.01, EP 1 (Jul. 2015).
2.2.2 Develop and implement a process for identifying and assessing Staff Members who may suffer from an impairing condition, and address such conditions as necessary. Such process shall include referral to Medical Staff leadership for appropriate corrective action (including any state or federally mandated reporting requirements), if, at any time during the diagnosis, treatment, or rehabilitation phase of the process, it is determined that a Staff Member is unable to safely perform his or her Clinical Privileges;²

2.2.3 Consult with, and refer to, internal and external specialists and resources as necessary; and

2.2.4 Make regular reports to the Administrator and Chief of Staff, including documentation of recommendations, specific actions taken, and evaluations of the effectiveness of such actions.

2.3 Meetings
The Practitioner Wellness Committee shall meet as needed at the call of its chairperson, to fulfill its duties and responsibilities. Non-voting consultants may be required to attend meetings of the Practitioner Wellness Committee by its chairperson.

2.4 Quorum.
A quorum shall consist of at least fifty percent (50%) of the voting members of the Practitioner Wellness Committee.

3. CREDENTIALS COMMITTEE

3.1 Composition
The Credentials Committee shall consist of Chief of Staff Elect, and one active Medical Staff Member (other than the Clinical Chairperson) from each clinical department appointed by the Chief of Staff. The Chief of Staff Elect shall serve as the chairperson. The Administrator (or his/her designee), the Manager of Medical Staff Services, and the Coordinator of Medical Staff Services shall be invited to attend all meetings of the Credentials Committee, but are not eligible to vote at such meetings. From time to time the chairperson may also invite other individuals in a non-voting capacity.

3.2 Duties and Responsibilities
The purpose and responsibilities of the Credentials Committee shall include, but are not limited to:

3.2.1 Reviewing the credentials of all Applicants and making recommendations to the Medical Executive Committee for Medical Staff and Advanced Practice Professional Staff appointment, assignments to departments, and delineation of Clinical Privileges;

² JCS MS.11.01.01, EP 8 (Jul. 2015).
3.2.2 Periodically reviewing all information available regarding the performance and clinical competence of Staff Members and other Practitioners and Advanced Practice Professional with Clinical Privileges at the Medical Center and, as a result of such reviews, making recommendations to the Medical Executive Committee for reappointments and renewal or changes in Clinical Privileges;

3.2.3 Consulting with, and obtaining any information from, any sources which the Credentials Committee deems necessary, desirable or relevant to the matter in question;

3.2.4 Reporting at each general Medical Executive Committee meeting and at other meetings as requested by the Medical Executive Committee; and

3.2.5 Performing such other duties as requested from time to time by the Medical Executive Committee.

3.3 Meetings
The Credentials Committee shall meet as often as necessary, but in no event less than bimonthly and maintain a permanent record of its proceedings and actions. The chairperson may call special meetings of the Credentials Committee at any time.

3.4 Quorum
A quorum shall consist of at least fifty percent (50%) of the voting members of the Credentials Committee.

4. INFECTION PREVENTION COMMITTEE

4.1 Composition
The Infection Prevention Committee shall consist of at least three (3) Medical Staff Members appointed by the Chief of Staff one of whom shall be appointed to serve as the chairperson. Other Medical Staff Members and representatives, including without limitation, those from administration, nursing service, laboratory service, infection control, pharmacy, and quality management may be consulted by the Infection Prevention Committee to provide expertise as required for the Infection Prevention Committee to perform its duties.

4.2 Duties
The Infection Prevention Committee shall carry out surveillance and investigation of infections in the Medical Center and implement measures deemed to reduce these infections to the extent prescribed, including, but not limited to:

4.2.1 Establishing techniques and systems for discovering and isolating infections occurring in the Medical Center;

4.2.2 Establishing written infection control policies and procedures which govern the use of aseptic technique and procedures in all areas of the Medical Center;

4.2.3 Establishing a method of control used in relation to the sterilization and disinfection of instruments, medications, and other items requiring sterility and disinfection. There
shall be a written policy requiring identification of sterile items and specified time periods in which sterile items shall be reprocessed;

4.2.4 Establishing policies specifying when individuals with specified infections or contagious conditions, including carriers of infectious organisms, shall be relieved from or reassigned duties. These individuals shall remain relieved or reassigned until there is evidence that the disease or condition no longer poses a significant risk to others;

4.2.5 Annually reviewing infection control policies, procedures, systems and techniques, including infection control policies as related to Medical Staff activities, with input from non-committee members, including but not limited to members of the Medical Staff, nursing service, and the laboratory;

4.2.6 Developing, reviewing and maintaining an approved program of Infection Control within the Medical Center, including a review of the Medical Center’s infection control data;

4.2.7 Reviewing and submitting recommendations to the Medical Executive Committee through required reporting by the Practice Evaluation Committee; and

4.2.8 Such other duties as requested from time to time by the Medical Executive Committee.

4.3 Meetings
The Infection Prevention Committee shall meet at least twice each year and on call of the chairperson.

4.4 Quorum
A quorum shall consist of at least fifty percent (50%) of the voting members of the Infection Prevention Committee.

5. Medical Executive Committee

Refer to the Medical Staff Bylaws.

6. Practice Evaluation Committee

6.1 Composition
The Practice Evaluation Committee shall be composed of (1) the Medical Staff Secretary-Treasurer who shall serve as chairperson; (2) the Chief of Staff Elect; (3) and five (5) other Medical Staff Members representing different specialties, and representatives, including without limitation, those from administration, nursing service, risk management, and quality management, may be consulted by the Practice Evaluation Committee to provide expertise as required or desired for the Practice Evaluation Committee to perform its duties.
6.2 **Duties**
The duties of the Practice Evaluation Committee shall include, but are not limited to:

6.2.1 Assuring that quality indicators for peer review are reviewed and updated on an annual basis, as indicated;

6.2.2 Undertaking quality assessment as a part of the Medical Staff peer review, and coordinating the quality assessment and peer review activities of all Medical Staff departments;

6.2.3 Monitor and evaluate the ongoing professional practice of Practitioners and Advanced Practice Professionals;

6.2.4 Perform Focused Professional Practice Evaluation when potential Practitioner and/or Advanced Practice Professional opportunities are identified;

6.2.5 Assure that the process for peer review is clearly defined, fair, defensible, timely, consistent, and useful;

6.2.6 Providing a forum to discuss quality of care issues;

6.2.7 Make recommendations to the Medical Executive Committee regarding professional practice improvement opportunities, as indicated; and,

6.2.8 Such other duties as requested from time to time by the Medical Executive Committee.

6.3 **Meetings**
The Practice Evaluation Committee shall meet as required to accomplish its duties, but not less than quarterly and on call of the chairperson.

6.4 **Quorum**
A quorum shall consist of at least fifty percent (50%) of the voting members of the Practice Evaluation Committee.

**REFERENCES:**
- Medicare Conditions of Participation, 42 C.F.R. § 482.30
- Wis. Admin. Code Chapter HFS §§ 124.08, 124.11, 124.17
- Joint Commission Standards, July 2015

**FORM(S):**

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:**
- August 1, 2006; November 21, 2006; February 5, 2008 / April 1, 2008; June 1, 2010 / August 10, 2010; March 19, 2013; March 24, 2015; September 22, 2015, September 26, 2017
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ON-CALL COVERAGE AND RESPONSE

POLICY STATEMENT

To describe the responsibilities of Staff Members who provide on-call services to Medical Center patients, including Staff Members who participate in Emergency Department call rotations and Staff Members who are responsible for ensuring continuous availability of professional services during a patient’s inpatient or outpatient stay.

1. EMERGENCY DEPARTMENT CALL COVERAGE

1.1 Participating Staff Members.
As provided in the Medical Staff Bylaws: (a) all Active and Associate Medical Staff Members must participate in Emergency Department back-up and other specialty coverage in accordance with Medical Center policies and/or as requested by the Medical Executive Committee; and (b) the Medical Executive Committee may require the participation of Courtesy Medical Staff Members and Advanced Practice Professional Staff Members in Emergency Department call coverage under certain circumstances, including but not limited to gaps in coverage related to a particular specialty. A Staff Member may be released from the obligation to participate in Emergency Department call coverage as set forth in the Medical Staff Bylaws or as otherwise provided by the Medical Executive Committee in its discretion.

1.2 Simultaneous Obligations.
In the event the on-call Staff Member is unavailable to answer call in the allotted timeframe due to an elective procedure, or he/she is involved in an emergency, the on-call Staff Member will designate an alternate to be contacted.

1.3 Response Times.
Staff Members who participate in Emergency Department call coverage must comply with the following response times:

(a) Telephone Response. Must respond to pages from Medical Center personnel via telephone as soon as reasonably possible, but in no event later than fifteen (15) minutes of being paged.\(^1\)

(b) In Person Response. Must respond in-person within thirty (30) minutes of answering the page, if requested to do so by the Staff Member responsible for the medical screening examination.\(^2\) The Medical Executive Committee may create exceptions to the thirty (30) minute response time requirement for certain specialties or subspecialties. Any such exceptions must be documented in writing and communicated to the effected Staff Members. An on-call Staff Member may arrange for an alternate Staff Member to present to the Emergency Department and provide further in-person assessment or stabilizing treatment only if all of the following requirements are met:

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i. the alternate Staff Member is acceptable to the individual responsible for the medical screening examination in the Emergency Department;

ii. the alternate Staff Member possesses the same or similar Clinical Privileges at the Medical Center as the on-call Staff Member; and

iii. the alternate Staff Member is qualified to provide any required emergency medical treatment or services and any interventional treatment or services. If the alternate Staff Member will participate in any part of the medical screening examination, he or she must be a Qualified Medical Person (refer to the Medical Center’s Designation of Qualified Personnel and EMTALA policies).

The designated on-call Staff Member is ultimately responsible for providing the necessary services to the individual in the Emergency Department regardless of who makes the in-person appearance.

1.4 **Failure to Respond.**

If a Staff Member fails to respond to a page from Medical Center personnel, or fails to appear in-person to the Emergency Department as requested, Medical Center personnel will contact one or more of the following individuals (listed in order of priority): (a) the Staff Member’s designated alternate; (b) an associate of the Staff Member who practices in the same specialty; (c) the patient’s attending physician; and (d) the appropriate Clinical Chairperson. Failure to respond as provided in this Policy may result in corrective action under the Medical Staff Bylaws. In addition, the failure of an on-call Staff Member to respond to a call or to come to the Emergency Department in person may expose the Staff Member to liability under EMTALA.\(^3\)

1.5 **On-Call Schedules.**

On-call schedules shall be coordinated by the Medical Staff Services Office in accordance with any directives established by the Medical Executive Committee. Staff Members who are unable to provide coverage for the on-call rotation schedule are responsible for making prior arrangements with a qualified Staff Member who has the requisite clinical privileges at the Medical Center and who agrees to provide the coverage. The name(s) and phone number(s) of the alternate Staff Member(s) covering shall be given to the Medical Staff Services Office.

2. **General Inpatient and Outpatient Call Coverage**

2.1 **Participating Staff Members.** Staff Members responsible for ensuring continuous availability of professional services during a patient’s inpatient or outpatient stay (including designated alternates) must: (a) ensure that adequate professional services are continuously available during the patient’s stay at the Medical Center; and (b) respond to requests for assistance or guidance from Medical Center staff in a timely manner. The Staff Member must either: (a) be personally available to respond to pages from Medical Center staff; or (b) designate a qualified

\(^3\) 42 U.S.C § 1395dd(d)(1)(c).
alternate Staff Member to respond to requests for assistance or guidance when such Staff Member is unavailable.

2.2 **Simultaneous Obligations.**

In the event the on-call Staff Member is unavailable to answer call in the allotted timeframe due to an elective procedure, or he/she is involved in an emergency, the on-call Staff Member will designate an alternate to be contacted.

2.3 **Response Times.**

Staff Members responsible for ensuring continuous availability of professional services during a patient’s inpatient or outpatient stay (including designated alternates) must comply with the following response times:

(a) **Telephone Response.** Must respond to pages from Medical Center staff via telephone as soon as reasonably possible, but in no event later than thirty (30) minutes of being paged.

(b) **In Person Response.** Required to exercise professional medical judgment in determining whether a Medical Center staff request for guidance requires the Staff Member to respond in person.

2.4 **Failure to Respond.**

If a Staff Member fails to respond as provided in this Policy, Medical Center personnel will contact one or more of the following individuals (listed in order of priority): (a) the Staff Member’s designated alternate; (b) an associate of the Staff Member who practices in the same specialty; (c) the patient’s attending physician; (d) the Physician on call for the Staff Member’s specialty; and (e) the appropriate Clinical Chairperson. Failure to respond as provided in this Policy may result in corrective action under the Medical Staff Bylaws.

2.5 **Contact Information; On-Call Schedules.**

Staff Members must ensure that the Medical Center has the following information: (1) the Staff Member’s current contact information; (2) a schedule of any periods of unavailability and the dates and times an alternate Staff Member will assume responsibility for the Staff Member’s patients; (3) the names and contact information for such alternate Staff Members; and (4) any necessary updates to such information.
REFERENCES:

Federal Statutes
• 42 U.S.C § 1395dd(d)(1)(c).

Wisconsin Administrative Code

FORM(S):
None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013; 11/25/14

BOARD OF DIRECTORS APPROVAL: 4/18/2013; 12/15/14

POLICY STEERING COMMITTEE: 1/23/15
ONGOING AVAILABILITY AND DESIGNATION OF ALTERNATE PROVIDERS

POLICY STATEMENT

Staff Members must ensure timely, adequate professional care for their patients in the Medical Center by being continuously available, or designating a qualified alternate Staff Member with whom prior arrangements have been made. This policy describes the requirements for designating alternate Staff Members.

1. ONGOING AVAILABILITY

Each Staff Member shall assure timely, adequate professional care for his or her patients in the Medical Center by being continuously available, or designating a qualified alternate Staff Member with whom prior arrangements have been made to attend to Staff Member’s patients when the Staff Member is unavailable.

2. DESIGNATION OF ALTERNATE STAFF MEMBERS

If an alternate Staff Member will participate in the care of a Staff Member’s patient the Staff Member must:

2.1 Discuss the participation of the alternate Staff Member with his/her patient and/or patient representative (as appropriate).

2.2 Ensure the alternate Staff Member:

(a) possesses the same or similar Clinical Privileges at the Medical Center as the Staff Member. In the event there is not a Staff Member with the same or similar Clinical Privileges, the Staff Member shall designate a member of the Staff who has the capabilities to determine the appropriate care for the patient and/or facilitate transfer;

(b) is qualified to provide any required emergency medical treatment or services and any interventional treatment or services to the Staff Member’s patients;

(c) has been informed of the dates and times during which the Staff Member expects to be unavailable and the alternate Staff Member will assume responsibility for the care and treatment of the Staff Member’s patients; and

(d) has been provided with any patient-specific information necessary for such alternate Staff Member to assume responsibility for the care and treatment of such patients.

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1 JCS PC.04.01.01, EP 2 (Jan. 2010).
2.3 Inform the Medical Center of any periods of unavailability and provide the Medical Center with: (1) a schedule of the dates and times the alternate Staff Member will assume responsibility for Staff Member’s patients; (2) the names and contact information for such alternate Staff Member; and (3) updates to such alternate Staff Member information and schedules so such information remains current.

2.4 If the Staff Member will be unavailable for an extended period of time (e.g., leave of absence, traveling outside the community) or the care of a patient will be transferred from an attending Staff Member to an alternate Staff Member, the Staff Member must document in the Staff Member’s orders and progress notes of each inpatient, the time period during which care will be transferred and the name and contact information for such alternate Staff Member.

3. FAILURE TO COMPLY

Failure to comply with the requirements set forth in this policy shall be considered a serious breach of these Policies Governing Medical Practices and may result in disciplinary action. In the absence of an appropriately qualified alternate Staff Member, the Administrator, the Chief of Staff or the applicable Clinical Chairperson has the authority to call any Medical Staff Member with the Clinical Privileges necessary to assume the care of the Staff Member’s patient(s).

REFERENCES:
None

FORM(S):
None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013

BOARD OF DIRECTORS APPROVAL: 4/18/2013
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

POLICY STATEMENT
To establish a systematic process to evaluate professional practice trends that impact quality of care and patient safety. This process, termed ongoing professional practice evaluation (OPPE) is mandated by the Joint Commission, and is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. SCOPE
OPPE applies to all practitioners with clinical privileges at ASMMCC.

2. DEFINITIONS

2.1 OPPE.
Ongoing Professional Practice Evaluation. The framework upon which OPPE is structured is based on the six ACGME general competencies:

- Patient Care
- Medical Knowledge
- Practice Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems Based Practice

2.2 Practitioner.
For purposes of this policy, the term “practitioner” means any Medical Staff Member or Advanced Practice Professional Staff Member granted privileges at ASMMCC.

3. POLICY

3.1 Selection of Indicators for OPPE Profile Reports:
(a) Indicators and targets are approved by the Medical Staff Department, the ASMMCC Credentials Committee, and the ASMMCC Medical Executive Committee.
(b) Any changes, including deletions, must be approved as stated above.

3.2 Responsibility for Review of OPPE Profiles:
(a) Department chairpersons are responsible for review of all the practitioners in their respective department.
(b) The Chief of Staff is responsible for review of all Department Chairperson profiles.

3.3 Frequency of Review:

(a) OPPE profiles will be reviewed every six months. This provides four OPPE cycles in a two-year reappointment period.

(b) Practitioner profile reports show data for the individual practitioner for the current report period. Peer comparison report is also available for the same report period.

3.4 Use of Information Resulting from OPPE:

(a) Information resulting from OPPE is used to determine whether to continue, limit, or revoke any existing privilege(s).

4. PROCEDURES/RESPONSIBILITIES

4.1 Maintenance of OPPE Data and Evaluation Process:

(a) The OPPE process at ASMMC is comprised of data pulled from the following databases:
   i. BI Launchpad (Epic volume data).
   ii. PeriData (Obstetrical data).
   iv. Premier (Physician Focus reports).
   v. Press Ganey (patient experience data).
   vi. Safety Surveillor.

(b) OPPE forms are developed specific to each practitioner, customizing forms specific to each practitioner based on approved Special Privileges.

4.2 Practitioner Notification:

(a) OPPE forms are emailed to each practitioner and copied to the respective Department Chairperson.

4.3 Profile Reviews:

(a) Action is taken as necessary when an issue is identified. This may be a formal action, such as Focused Professional Practice Evaluation (FPPE), or it may be informal communication between the Department Chairperson and the practitioner.

4.4 Practice Evaluation Committee (PEC):

(a) Department Chairperson may recommend to PEC implementation of Focused Professional Practice Evaluation (FPPE) for an individual practitioner based on trends identified during routine OPPE.
4.5 Medical Staff Services Office:

(a) The Medical Staff Services Office, in conjunction with the applicable Department Chairperson, reviews outcomes of OPPE for all providers at the time of reappointment.

(b) If at the time of reappointment, the outcome of the OPPE indicates no data or limited data to evaluate, peer or department recommendations are requested. The Medical Staff Services Office may request performance quality data from the practitioner. The practitioner will be obligated to obtain performance quality data form his/her primary site and ensure it is made available to the Medical Staff Services Office at ASMMC.

4.6 ASMMC Credentials Committee:

(a) The Credentials Committee considers OPPE information when making a decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege.

(b) If the outcome of OPPE indicates no data or limited data to evaluate, the Credentials Committee may review and consider performance data from another facility.

REFERENCES:

Code of Federal Regulations
- None.

Joint Commission Standards
- JCS MS.08.01.03 (Sep. 2012)
- JCS MS.09.01.01 (Sep. 2012)

FORM(S):

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/22/16

BOARD OF DIRECTORS APPROVAL: 5/16/16

POLICY STEERING COMMITTEE: 4/27/16
**PEER REVIEW**

**POLICY STATEMENT**

To ensure that the Aurora Sheboygan Memorial Medical Center ("Hospital"), through the activities of their medical staff organizations, assess the Ongoing Professional Practice Evaluation (OPPE) of individuals granted clinical privileges and use the results of such assessments to improve care and, when necessary, perform Focused Professional Practice Evaluation (FPPE). Goals are to:

- Monitor and evaluate the ongoing professional practice of individual practitioners with clinical privileges;
- Create a culture with a positive approach to peer review by recognizing practitioner excellence as well as identifying improvement opportunities;
- Perform focused professional practice evaluation when potential practitioner improvement opportunities are identified;
- Promote efficient use of practitioner and quality staff resources;
- Provide accurate and timely performance data for practitioner feedback, Ongoing and Focused Professional Practice Evaluation and reappointment;
- Assure that the process for peer review is clearly defined, fair, defensible, timely, consistent and useful.

All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. **DEFINITIONS**

1.1 **Peer Review.**

*Peer review* is the evaluation of an individual practitioner’s professional performance and includes the identification of opportunities to improve care. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner’s performance, rather than appraising the quality of care rendered by a group of professionals or a system.

Peer review is conducted using multiple sources of information including: 1) the review of individual cases, 2) the review of aggregate data for compliance with general rules of the medical staff and, 3) clinical standards and use of rates in comparison with established benchmarks or norms.

The individual’s evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice as defined by the six General Competencies described below:

- **Patient Care**
- **Medical Knowledge**
- **Practice Based Learning and Improvement**
• Interpersonal and Communication Skills
• Professionalism
• Systems Based Practice

1.2 Peer.
A “peer” is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner’s performance will determine what “practicing in the same profession” means on a case-by-case basis. For example, for quality issues related to general medical care, a practitioner (MD or DO) may review the care of another practitioner. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty.

1.3 Peer Review Body.
The peer review body designated to perform the initial review by the Medical Executive Committee or its designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the Hospital. The initial peer review body will be the Practice Evaluation Committee (PEC) or unless otherwise designated for specific circumstances by the Medical Executive Committee.

1.4 Ongoing Professional Practice Evaluation (OPPE).
The routine monitoring and evaluation of current competency for current medical staff. These activities comprise the majority of the functions of the ongoing peer review process and the use of data for reappointment.

1.5 Focused Professional Practice Evaluation (FPPE):
The establishment of current competency for new medical staff members, new privileges and/or concerns from OPPE. These activities comprise what is typically called proctoring or focused review depending on the nature of the circumstances.

1.6 Conflict of Interest.
A member of the medical staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion. An automatic conflict of interest would result if the practitioner is the provider under review or a first degree relative or spouse. A potential conflict of interest is either due to a provider’s involvement in the patient’s care not related to the issues under review or because of a relationship with the practitioner involved as a direct competitor, partner or key referral source.

It is the obligation of the individual reviewer to disclose to the peer review committee the potential conflict. It is the responsibility of the peer review body to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the PEC chair will be informed in advance and make the determination if a substantial conflict exists and inform the committee. When either an automatic or substantial conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions other than to provide specific information requested.
In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the PEC or the Medical Executive Committee will replace, appoint or determine who will participate in the process so that bias does not interfere in the decision-making process.

2. **Policy**

2.1 **Peer Review.**

(a) All peer review information is privileged and confidential in accordance with medical staff and Hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

(b) The involved practitioner will receive provider-specific feedback on a routine basis. Outcomes of all cases reviewed through PEC are incorporated into OPPE profiles.

(c) The medical staff will use the practitioner-specific peer review results in making its recommendations to the Hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

(d) The Hospital will keep practitioner-specific peer review and other quality information concerning a practitioner in a secure, locked file and, when appropriate, secure electronic databases. Practitioner-specific peer review information consists of information related to:

   i. performance data for all dimensions of performance measured for that individual practitioner;

   ii. the individual practitioner's role in sentinel events, significant incidents or near misses; and

   iii. correspondence to the practitioner regarding commendations, comments regarding practice performance, or corrective action.

(e) Only the final determinations of the PEC, any subsequent actions or recommendations and correspondences between the committee and the practitioner and External Peer Review reports are considered part of an individual provider’s quality file. Any other written or electronic documents related to the review process other than the final committee decisions (e.g. potential issues identified by Hospital staff, physician reviewer preliminary case rating, questions and notes) shall be considered working notes of the committee and shall be saved on the Peer Review Secured Drive.

(f) Peer review information in the individual provider quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or Hospital employee. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. The PEC Chairperson will assure that only authorized individuals have access to individual provider quality files and that the files are reviewed under the supervision of the Director of Medical Staff Services or designee.
Only the following individuals shall have access to provider-specific peer review information and only for purposes of quality improvement:

i. The specific provider;

ii. The Chief of Staff, Chief of Staff Elect, PEC Chairperson and Chief Medical Officer for purposes of considering corrective action;

iii. Medical staff Department Chairpersons (for members of their departments only) to conduct OPPE;

iv. Members of the Medical Executive Committee, Credentials Committee and medical staff services professionals for purposes of considering reappointment or correction action.

v. The Quality Director and quality staff supporting the peer review process;

vi. Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g., Joint Commission or state/federal regulatory bodies; and

vii. Individuals with a legitimate purpose for access as determined by the Board of Directors.

viii. The Hospital President when information is needed for involvement in the process of immediate formal corrective action for purposes of summary suspension as defined by the medical staff bylaws;

(g) No copies of peer review documents will be created and distributed unless authorized by medical staff policy or bylaws, the Medical Executive Committee, the Board or by mutual agreement between the Chief of Staff and the PEC Chairperson, for purposes of deliberations regarding corrective action on specific cases. OPPE reports may be shared within Aurora Health Care and Aurora Health Care Medical Group as deemed appropriate.

3. **PROCEDURE**

3.1 **Circumstances Requiring Internal Peer Review (IPR):**

(a) IPR is conducted by the medical staff using its own members as the source of evaluation of practitioner performance. It is performed as an ongoing professional practice evaluation and outcome will be included on OPPE Profile and reported to the appropriate committee for review and action.

(b) In the event a decision is made by the Board of Directors to investigate a practitioner's performance or circumstances warrant the evaluation of one or more providers with privileges, the Medical Executive Committee or its designee shall appoint a panel of appropriate medical professionals to perform the necessary IPR activities as described in the Medical Staff Bylaws.
3.2 Circumstances Requiring External Peer Review (EPR):

(a) Either the PEC, Medical Executive Committee or the Board of Directors will make determinations on the need for EPR. No practitioner can require the Hospital to obtain EPR if it is not deemed appropriate by the PEC, Medical Executive Committee or Board of Directors.

(b) Circumstances that may benefit from EPR include:
   
i. Litigation - when dealing with the potential for a lawsuit.
   
   ii. Ambiguity - when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges.
   
   iii. Lack of internal expertise - When no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the Medical Executive Committee or governing board.
   
   iv. Miscellaneous issues - when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the Medical Executive Committee or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

(c) Prior to submitting material to the EPR reviewer, the authorizing body will define whether or not the results will be considered definitive regarding the quality and appropriateness of care rendered for the individual cases reviewed. This will be based on the nature of the review, the expertise of the reviewer, and the issues under review. If the review rating is to be considered definitive, there will be no appeal of the report ratings unless it results in formal corrective action relative to the provider's membership or privileges.

(d) Once the results of EPR are obtained, the report will be reviewed by the body that authorized the EPR and any designees as it sees fit within 30 days of receipt to determine if any improvement opportunities are present. If improvement opportunities exist, they will be handled through the same mechanism as IPR unless the issue is already being addressed in the corrective action process.

(e) The authorizing body will also prospectively determine the nature of the involvement for the practitioner under review. The practitioner will always be made aware that EPR is being obtained and will receive a copy of the report. The practitioner will be given an opportunity to provide input regarding its findings in the same timeframes as for IPR prior to the committee's final decision regarding whether improvement opportunities exist and, if necessary, what improvement approach or corrective action is needed.
3.3 **Participants in the Review Process:**
Participants in the review process will be selected according to the medical staff policies and procedures. The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities. The peer review body will consider the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual.

3.4 **Individual Case Review:**
Peer review will be conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the Quality Management staff and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability.

3.5 **Rate and Rule Indicator Data Evaluation:**
The evaluation of aggregate practitioner performance measures via either rate or rule indicators will be conducted on an ongoing basis by the PEC or its designee.

3.6 **Selection of Practitioner Performance Measures:**
Measures of practitioner performance will be selected to reflect the six General Competencies and will utilize multiple sources of data.

3.7 **Thresholds for Focused Professional Practice Evaluation:**
If the results of Ongoing Professional Practice Evaluation indicate a potential issue with practitioner performance, the PEC may initiate a focused evaluation to determine if there is a problem with current competency of the practitioner for either specific privileges or for more global dimensions of performance. These potential issues may be the result of individual case review or rule or rate indicators. A single egregious case may initiate a focused review by the PEC.

3.8 **Oversight and Reporting:**
Direct oversight of the peer review process is delegated by the Medical Executive Committee to the PEC. The PEC will report to the Board of Directors through the Medical Executive Committee at least quarterly.
3.9 **Statutory Authority:**
This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and Wisconsin Statute § 146.37 and 146.38. All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled consistent with the following language:

“Statement of confidentiality”

Data, records, documents, and knowledge, including but not limited to minutes and case review materials, collected for or by individuals or committees assigned peer review functions are confidential, not public records, shall be used by the committee and committee members only in the exercise of proper functions of the committee, and are not available for court subpoena.”

**REFERENCES:**

Joint Commission Standards
- JCS MS.08.01.01 (Sep. 2012).
- JCS MS.08.01.03 (Sep. 2012).
- JCS MS.09.01.01 (Sep. 2012).

**FORM(S):** None

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 11/25/14; 9/22/15; 3/22/16

**BOARD OF DIRECTORS APPROVAL:** 12/15/14; 11/16/15; 5/16/16

**POLICY STEERING COMMITTEE:** 1/23/15; 10/28/15, 4/27/16
Behavioral Complaint/Grievance Algorithm

1. **Behavioral Complaint/Grievance is received involving Medical Staff or Advanced Practice Professional**

2. **Complaint/Grievance is sent to provider for response**

3. **Department Chairperson reviews complaint/grievance including provider’s response and makes determination**

   - **Unsubstantiated complaint/grievance**
     - No further action/consider trending for future occurrences

   - **Indeterminate (Trend)**
     - Trend for future occurrences
     - If 3 or more occurrences within 12 rolling months may forward to Chief of Staff for review/potential PI Plan
     - Chief of Staff may consult with Chief Medical Officer

   - **Substantiated complaint/grievance**
     - Department Chair may recommend an Action Plan including:
       - No action warranted
       - Focus study
       - Educational offerings
       - Forward to Chief of Staff / Chief Medical Officer for additional review/potential PI plan

     *Chief of Staff may refer to Physician Wellness Committee*

4. **Involved provider receives notification letter regarding the final determination of the case.**

5. **Follow-up with patient is required for any complaint/grievance referred by patient/family**

**Referral Sources:**
- Patient/Family;
- Friend;
- Caregiver;
- Physician

**Approved:** ASMMC Executive Committee, 9/27/16
Clinical Case involving Medical Staff or Advanced Practice Professional meets screening criteria for review

Case Summary prepared by Quality RN

Primary Review by Department Chairperson

Case sent to involved provider for response

Department Chairperson reviews involved provider’s reply and makes recommendation

Practice Evaluation Committee reviews case and makes final determination

Standard of Care Met

Standard of Care Not Met (minimal, moderate, significant deviation)

Involved provider receives notification letter regarding the final determination of the case.

Final determination may include follow-up action such as:
- Focus study
- Discuss at department meeting for educational purposes
- Performance Improvement plan related to: education, documentation, patient care

Follow-up with patient is required for any complaint/grievance referred by patient/family

Referral Sources: Patient/Family; Friend; Caregiver; Physician; Risk; Quality Indicators; System Quality Teams

Approved: ASMMC Executive Committee, 9/27/16
PROVIDER ORDERS

POLICY STATEMENT

It is the policy of the Medical Staff to assure provider orders are properly entered, initiated, received and completed by appropriate staff in accordance with the following guidelines. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

1. GENERALLY

1.1 Ordering Providers.

Only a Practitioner or other individual acting within the scope of his/her license and the scope of his or her Clinical Privileges (as authorized by the Medical Center) is qualified to enter orders (the “Ordering Provider”). The Ordering Provider must ensure that the medical record contains documentation describing the diagnosis, condition or indication for each medication, diagnostic service, and therapeutic service ordered.¹

1.2 Form, Legibility and Timeliness.

All orders must include the patient’s complete name and medical record number and be entered into the medical record in full compliance with the form, legibility and timeliness requirements set forth in Aurora’s Medical Records Policy.

1.3 Symbols and Abbreviations.

A list of unacceptable abbreviations, acronyms, symbols and dose designations shall be identified and approved by the Medical Executive Committee. An official record of such list is available at each nursing station, the Health Information Services Department and the Pharmacy Department. Only those symbols, abbreviations, acronyms and dose designations not on such list may be used.²

1.4 Incomplete, Unclear, Illegible or Unacceptable Orders.³

An order that is incomplete, unclear, illegible, contains unacceptable symbols or abbreviations, or is otherwise unacceptable will not be implemented until the order is clarified and, if appropriate, a new order issued. The Staff Member or Clinical Assistant responsible for implementation of the order shall contact the Ordering Provider for clarification and, if appropriate, issuance of a new order. Whenever possible, the Ordering Provider will re-issue the order with the clarifying details. If the Ordering Provider is not available, the Staff Member or Clinical Assistant responsible for implementation of the order shall contact one or more of the following individuals (listed in order of priority) for clarification: (a) the Ordering Provider’s designated alternate; (b) the patient’s attending physician; (c) an associate of the Ordering Provider who practices in the same specialty; (d) the Physician on call for the Ordering Provider’s service in the Emergency Department; and (e) the appropriate Clinical Chairperson.

¹ JCS MM.04.01.01, EP 9 (Jan. 2010).
² JCS NPSG.02.02.01, EP 3 (Jan. 2010).
³ JCS MM.04.01.01, EP 5 (Jan. 2010).
1.5 **Correction of Incomplete or Inaccurate Orders.**
An existing order may not be corrected, altered, added to, or modified in any way. If a change is necessary, the order must be discontinued and a new order must be entered by the Ordering Provider.

1.6 **Non-Specific Orders Prohibited.**
The use of blanket or other non-specific orders is prohibited. All orders that are a resumption or continuation of a previous order must be re-entered in their entirety in the Computerized Physician Order Entry System (“CPOE”) by the Ordering Provider. Examples of **unacceptable** non-specific orders include, but are not limited to:

(a) “Continue previous medications”
(b) “Resume preoperative orders”
(c) “Resume orders from the floor”
(d) “Discharge on current medications”
(e) “Resume home medications”
(f) “Resume all previous orders for medications”

1.7 **Authentication and Co-Signature.**

(a) **Authentication.** All orders must be dated, timed (using military time), and authenticated (by written signature, identifiable initials, or computer key) by the Ordering Provider. The use of an electronic signature is only acceptable if the individual has an attestation statement on file in the Health Information Services Department acknowledging that he or she is the only individual authorized to use the electronic signature. An order may not be authenticated by use of a rubber stamped signature. See also Section 2.4(d) regarding authentication of verbal orders.

(b) **Co-Signature.** In certain circumstances, orders must be co-signed by a Physician Medical Staff Member (e.g., certain entries by an Advanced Practice Professional must be co-signed by the Advanced Practice Professional’s supervising or collaborating Physician, and certain entries made by a Dentist or Podiatrist must be co-signed by a Physician). Refer to Aurora’s Hospital Co-Signature Requirements Chart. The co-signing Physician accepts full professional and legal responsibility for the content of the order.

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4 JCS MM.04.01.01, EP 8 (Jan. 2010).
5 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008); JCS RC.01.02.01, EP 2 (2009)
6 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008); JCS RC.01.01.01, EP 11; RC.01.02.01, EP 3-4 (Jan. 2010).
8 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008). Aurora’s Hospital Co-Signature Requirements Chart.
2. **ENTRY OF ORDERS**

### 2.1 Computerized Physician Order Entry

Except as otherwise provided in this Policy, all orders for medication, diagnostic services and therapeutic services must be entered into CPOE by the Ordering Provider.

### 2.2 Written Orders

(a) **Restrictions on Use of Written Orders.** Written orders may NOT be used, unless:

i. a patient emergency precludes the Ordering Provider from directly entering and initiating the order in CPOE;

ii. the CPOE is not functioning;

iii. the Ordering Provider is unable to access CPOE because he/she is physically remote from the Medical Center and does not have access to CPOE; or

iv. the Ordering Provider is in the process of performing a procedure precluding direct order entry (e.g., OR/cath lab).

(b) **Issuing a Written Order.** A written order must be entered into the medical record on the physician order sheet.

### 2.3 Pre-Printed Order Sets

Pre-printed order sets may be used if they have been reviewed and approved by the Medical Center. If an Ordering Provider uses a preprinted paper order set, the Ordering Provider must: (a) sign, date, and time the last page of the order set (the last page must identify the total number of pages in the order set); and (b) initial each place in the preprinted order set where changes, such as additions, deletions, or strike-outs of components that do not apply, have been made. It is not necessary to initial every preprinted box that is checked to indicate selection of an order option, as long as there are no changes made to the option(s) selected.

### 2.4 Verbal Orders

(a) **Restrictions on Use of Verbal Orders.**

i. Verbal orders are **strongly discouraged** and should NOT be used, unless it would be permissible for the Ordering Provider to issue a written order (see Section 2.2(a) above), but it is impossible or impractical for the Ordering Provider to write the order.

ii. Verbal Orders are not to be used merely for the convenience of the Ordering Provider.

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9 42 CFR § 482.23(c)(2); CMS Transmittal 47, June 5, 2009.

10 JCS MM.04.01.01, EP 7 (Jan. 2010).

11 42 CFR § 482.23(c)(2)(i) (Interpretive Guidelines, effective October 17, 2008); JCS MM.04.01.01, EP 6 (Jan. 2010).

iii. Verbal Orders may only be issued to an individual who is authorized to receive verbal orders. The following persons are authorized by the Medical Staff to receive verbal orders: physician assistants, registered nurses, chiropractors, respiratory therapists, pharmacists, physical therapists, occupational therapists, speech therapists, radiologic technicians, respiratory technicians, psychologists, dietitians and social workers. Such authorized individuals may receive a verbal order and enter it into the patient’s medical record, if the verbal order relates to the clinical area in which such authorized individual is trained.

iv. Only physician assistants and registered nurses are authorized to receive verbal Do Not Resuscitate orders. (Refer to the Medical Center’s DNR Policy.)

v. Only physician assistants, registered nurses, respiratory therapists, radiological technicians, and pharmacists are authorized to receive verbal orders for drugs and/or biologicals.

vi. Verbal orders are never acceptable for chemotherapy agents.

(b) Issuing a Verbal Order.

i. An Ordering Provider must communicate a verbal order, in person or over the telephone, only to a duly authorized individual and such verbal order must relate to the clinical area in which such authorized individual is trained.\(^\textit{13}\)

ii. The Ordering Provider must clearly enunciate the verbal order to the individual accepting the order. The following elements shall be included in all verbal orders:

- Name of Ordering Provider;
- Name of patient;
- Age and weight of patient, when appropriate;
- Date and time of order;
- Purpose or indication for the order; and
- All other elements required for the particular order (e.g., see Section 4.2 for minimum requirements of medication orders).

(c) Mandatory Read Back.\(^\textit{14}\) The accepting individual shall write the complete order on an order sheet and shall read the entire order back to the Ordering Provider. The accepting individual must then receive confirmation from the Ordering Provider.

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\(^\textit{13}\) 42 CFR § 482.23(c)(2)(ii) (Interpretive Guidelines, effective October 17, 2008). An authorized person may receive a verbal order from an APNP. See Wisconsin Department of Health and Family Services, DQA Memo 07-019, October 30, 2007.

\(^\textit{14}\) 42 CFR § 482.23(c)(2)(i) (Interpretive Guidelines, effective October 17, 2008); JCS NPSG.02.01.01, EP 2 (Jan. 2010); 71 FR 68680.
Provider that he/she has received the correct order.\textsuperscript{15} Once confirmation is received, the accepting individual shall enter the verbal order into CPOE.\textsuperscript{16}

(d) **Authentication of Verbal Orders.**

i. Verbal orders must be promptly authenticated in CPOE by the Ordering Provider (or a practitioner assuming care of the patient) as soon as possible, and in all events within forty-eight (48) hours\textsuperscript{17} (except for Verbal Do Not Resuscitate Orders which must be authenticated within twenty-four (24) hours) of the Ordering Provider’s communication of the verbal order.

ii. When an individual practitioner other than the Ordering Provider authenticates a verbal order, such individual accepts professional and legal responsibility for the order and validates that the order is complete, accurate, and final based on the patient’s condition. The authenticating provider should be responsible for the care of the patient and have knowledge of the patient’s hospital course, medical plan of care, condition and current status. An individual who does not possess this knowledge about the patient should not authenticate a verbal order.\textsuperscript{18}

iii. A Physician Assistant (PA) or Advanced Practice Nurse Prescriber (APNP) may only authenticate a verbal order issued by another practitioner if all of the following requirements are met:

- the PA or APNP has the authority to issue the order itself (if the PA or APNP is not authorized to issue the order in need of authentication, he or she cannot authenticate it);
- the PA or APNP has physician-delegated functions with regard to the care of the patient; and
- the PA or APNP has knowledge of the patient’s hospital course, medical plan of care, condition and current status.\textsuperscript{19}

(e) **Monitoring and Evaluation.** The Medical Staff shall participate in performance monitoring and evaluation to identify, improve and reduce the likelihood of medical errors related to verbal orders.

\textsuperscript{15} JCS NPSG.02.01.01, EP 3 (Jan. 2010).
\textsuperscript{16} JCS NPSG.02.01.01, EP 1 (Jan. 2010).
\textsuperscript{17} Wis. Admin. Code DHS § 124.12(5)(b)11.; Although the code section provides that a verbal order must be authenticated within 24 hours, the Wisconsin Department of Health Services (DHS) has granted a variance providing that the authentication must occur within 48 hours. See Wisconsin Department of Health and Family Services, DQA Memo 07-019, October 30, 2007.
\textsuperscript{18} Wisconsin Department of Health and Family Services, DQA Memo 07-019, October 30, 2007.
\textsuperscript{19} Wisconsin Department of Health and Family Services, DQA Memo 07-019, October 30, 2007.
3. **REQUIREMENTS FOR CERTAIN TYPES OF ORDERS**

3.1 **Admission Orders.**
The admitting Practitioner (or his or her designated alternate) must enter and initiate in CPOE admitting orders to the nursing unit within one (1) hour of a patient’s admission to the admitting unit. At least two different Medical Center staff members will try to reach the admitting practitioner or his or her designated alternate to obtain admission orders. These attempts will be documented in the patient’s medical record. If the admitting Practitioner cannot be reached to obtain admission orders within one (1) hour of a patient’s admission to the admitting unit, the Medical Center staff will contact one or more of the following individuals (listed in priority) to obtain admission orders: (a) the admitting provider’s designated alternate; (b) an associate of the admitting Practitioner; (c) the Physician on call for this service in the ED; and (d) the applicable Clinical Chairperson.

3.2 **Orders for Therapeutic Services (Treatment).**
In addition to basic requirements for orders, all orders for therapeutic services shall include: (a) the purpose or indication, if appropriate; (b) the type of therapeutic service; (c) any specific requirements or instructions; and (d) the frequency and duration of therapeutic services.

3.3 **Orders for Diagnostic Testing.**
In addition to basic requirements for orders, all orders for diagnostic testing shall include: (a) the reason, purpose or indication (orders for outpatient diagnostic tests must include the symptoms, diagnosis or ICD-9-CM code); (b) the type of testing; (c) any specific requirements or instructions; (d) the frequency, schedule and duration of testing; and (e) if the test requires the administration of medications or other substances (e.g., contrast dye), the order must include the necessary elements for medication orders. An order for imaging studies (X-ray, CT Scan, MRI, etc.) must include a concise statement describing the reason for the imaging study.  

3.4 **Medication Orders.**

(a) **Requirements.** In addition to basic requirements for orders (form, timeliness, authentication), all orders for medications must include:
   
   i. Drug name;
   
   ii. Purpose, diagnosis, condition or indication (as applicable) if not elsewhere in the patient’s medical record (e.g., physician note), or if needed for purposes of clarification;
   
   iii. Dosage form (e.g., tablets, capsules, inhalants);
   
   iv. Exact strength or concentration;

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20 Wis. Admin. Code DHS § 124.18(e)(2).
21 JCS MM.04.01.01, EPs 2, 3, and 9 (Jan. 2010).
v. Dose, frequency and route of administration (e.g., p.o., IV, IM, rectal, etc.);
vi. Quantity and/or duration; and
vii. Specific instructions for use.

(b) **Acceptable Types of Medication Orders.** The following types of medications orders are acceptable:

i. PRN (as needed) Orders: Orders acted upon based on the occurrence of a specific indication or symptom. Such orders should include the indications for use and specific time intervals.

ii. Standing Orders: A prewritten medication order and specific instructions to administer a medication to a patient in clearly defined circumstances.

iii. Automatic Stop Orders: Orders that include a date or time to discontinue a medication.

iv. Titrating Orders: Orders in which the dose is either progressively increased or decreased in response to the patient’s status. Whenever possible, such orders should include objective parameters for titration.

v. Taper Orders: Orders in which the dose is decreased by a particular amount with each dosing interval.

vi. Range Orders: Orders in which the dose or dosing interval varies over a prescribed range, depending upon certain objective criteria related to the patient’s status or situation (e.g., insulin dosages for specific blood glucose ranges).

vii. Other Orders: Orders for compounded drugs or drug mixtures not currently available, medication-related devices (nebulizers, catheters), investigational medications, herbal products, discharge or transfer medications.

(c) **High Alert and Hazardous Medications.** The Medical Center maintains a list of high-alert and hazardous medications and utilizes specific strategies for avoiding errors related to such medications. Orders must be written in accordance with the requirements set forth in such policies.

(d) **Look-Alike or Sound-Alike Medications.** Medications with look-alike or sound-alike names (“LASA medications”) may result in medication errors. The Medical Center utilizes specific safety strategies to avoid errors related to LASA medications. A list of LASA medications shall be maintained by the Medical

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22 JCS MM.04.01.01, EP 1 (Jan. 2010).
23 JCS MM.01.01.03 (Jan. 2010).
24 JCS MM.04.01.01, EP 4 (Jan. 2010).
Center’s pharmacy. Staff Members shall comply with Aurora’s Look-Alike Sound-Alike Medications Policy.

(e) Medications that Require Weight-Based Dosing. Certain medications (including medications administered to pediatric patients) require weight-based dosing. The Medical Center maintains guidelines for weight-based dosing and all medication orders must be entered in compliance with such guidelines.

(f) Labor-Inducing Medications. Only a Physician with OB privileges or a Certified Nurse Midwife may order the administration of a labor-inducing medication, and such orders must include parameters providing for the discontinuation of the labor-inducing medication by a registered nurse.

(g) Formulary Drugs. Ordering Providers are encouraged to use Medical Center formulary drugs. In extenuating circumstances, non-formulary drugs shall be provided when ordered by the attending practitioner and when approved alternatives are unacceptable. All non-formulary medications shall be reviewed by the Aurora Pharmacy and Therapeutics Committee.

(h) Review. All medication orders shall be reviewed by the attending Practitioner at least every thirty (30) days.

(i) Automatic Cancellation. All existing medication orders shall be automatically cancelled when a patient undergoes a procedure requiring general anesthesia or moderate sedation. Following the procedure, an Ordering Provider must re-enter orders for each individual medication (as noted in Section 1.7, an order stating “resume previous medications” or other non-specific orders are unacceptable).

(j) Stop Orders. The Medical Center’s stop order policy does not prevent the Ordering Provider from ordering medication for any reasonable length of time that the Ordering Provider may choose, and is intended to cover only those situations in which drug administration orders do not state a specific length of time or duration. If the following medications are ordered without specific limitations as to dosage and time, such medications shall be automatically discontinued as follows, unless specifically reordered by the attending Practitioner:

25 NPSG.03.03.01 (Jan. 2010).
26 JCS MM.04.01.01, EP 10 (Jan. 2010).
<table>
<thead>
<tr>
<th>Antibiotics</th>
<th>10 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled Substances</td>
<td>5 days</td>
</tr>
<tr>
<td>All pre-op and/or prenatal medication</td>
<td>must be renewed post-op/postpartum</td>
</tr>
<tr>
<td>Transfer medication orders</td>
<td>must be renewed when transferring to a higher or lower level of care (e.g., transferring into or out of ICU)</td>
</tr>
<tr>
<td>IV Fluids</td>
<td>3 days</td>
</tr>
</tbody>
</table>

The Pharmacy Department shall notify the nursing station of any impending stop orders forty-eight (48) hours in advance of the effective time of the stop order. This will be done by generating a computerized stop order report. The stop order report shall be placed in the physician order section of the patient’s chart by the responsible clerk. It is the responsibility of the attending Practitioner to review the chart for stop order reports and to reorder the medication as necessary.

3.5 Standing Orders.

(a) All standing orders shall be listed on a “Physician Order Sheet” sheet that must be included in the patient’s medical record and signed and dated by the Ordering Provider or the attending Practitioner.

(b) Standing orders shall be followed in the absence of other specific orders by the Ordering Provider or the attending practitioner, insofar as the proper treatment of the patient will allow. Each Practitioner shall review his or her standing order regimens at least annually and revise as necessary. Notwithstanding the foregoing, new orders shall be entered and initiated in CPOE for each patient upon transfer into and out of the ICU/CCU, post-operatively and at each Medical Center admission, regardless of frequency of admission.

3.6 Transfer Orders.

All orders for patients who presented to the Medical Center’s Emergency Department and will be transferred to another facility must be issued in accordance with Aurora’s EMTALA policy.

3.7 Discharge Orders.

A discharge order must be entered into the medical record for all Medical Center inpatients and outpatients. If an Advanced Practice Professional issues the discharge order, such order must be co-signed by the patient’s admitting or attending Physician as provided in Aurora’s Hospital Co-Signature Requirements Chart. All orders for medications, therapeutic services, and diagnostic services intended for post discharge must be re-entered as discharge orders in their entirety by the Ordering Provider.
3.8 **Blood Transfusion Orders.**
All orders for blood transfusions must be entered in accordance with the Medical Center’s policies on blood and blood components.

3.9 **Restraint and Seclusion Orders.**
All orders for restraints and seclusion must be entered in accordance with the Medical Center’s policy regarding restraints and seclusion.

3.10 **Do-Not-Resuscitate Orders.**
Do-Not-Resuscitate (DNR) orders must be entered in accordance with the Medical Center’s policy on withholding and withdrawal of treatment.

3.11 **Therapeutic Diet Orders.**

(a) A registered dietitian may issue the following for a patient’s nutritional regimen:

i. Changes in therapeutic diets (i.e., sodium levels, protein levels, potassium levels);

ii. Modification in diet textures;

iii. Oral supplements;

iv. Tube feedings when directed per a physician order, or changes in tube feeding products, rates, schedules, and flush;

v. Parenteral nutrition macro-nutrients, when directed by the attending physician;

vi. Weight, including daily weight;

vii. Speech therapists, Nutrition education;

viii. Vitamin and mineral supplements; and

ix. Calorie counts.

(b) A licensed speech therapist may recommend modifications in diet textures (e.g., order puree, the addition or deletion of thickener).
REFERENCES:

Federal Regulations and Other Guidance
- 42 CFR § 482.23 (Interpretive Guidelines, effective October 17, 2008).
- 42 CFR § 482.24 (Interpretive Guidelines, effective October 17, 2008).
- CMS MLN Matters Memo No. SE0829, CR 5971 Clarification related to Signature Requirements.

Wisconsin Statutes
- None.

Wisconsin Administrative Code and Other Guidance

Joint Commission Standards
- JCS MM.01.01.03 (Jul. 2015).
- JCS MM.04.01.01 (Jul. 2015).
- JCS NPSG.02.01.01, EP 1 (Jul. 2015).
- JCS NPSG.03.03.01 (Jul. 2015).
- JCS RC.01.01.01 (Jul. 2015).
- JCS RC.01.02.01 (Jul. 2015).

FORM(s): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013, 9/26/17

BOARD OF DIRECTORS APPROVAL: 4/18/2013, 12/18/17

POLICY STEERING COMMITTEE APPROVAL: 10/25/17
**UNENFORCEABLE ORAL AGREEMENTS AND ARRANGEMENTS**

**POLICY STATEMENT**

The Medical Center is committed to establishing policies and developing effective internal controls that will promote adherence to applicable legal requirements and ensure compliance with the principles and guidelines established under the Medical Center’s Compliance Program. These ongoing efforts require Medical Center compliance with all laws, not only with respect to the delivery of health care, but also with respect to its business affairs and dealings with physicians. Accordingly, in the event a written agreement is necessary to qualify for an exception and/or avoid liability under applicable law, including without limitation, the physician self referral prohibition statute, commonly referred to as the “Stark Law,” no oral agreement or arrangement between the Medical Center and any physician (or a member of a physician’s immediate family), pursuant to which any remuneration is to be provided to such physician (or a member of such physician’s immediate family), shall be enforceable, and all such oral agreements and arrangements shall be considered null and void with no force and effect. Accordingly, except in rare circumstances defined as exceptions under the Stark Law as agreed to by the Medical Center and the applicable physician, all agreements and arrangements between the Medical Center and any physician (or a member of a physician’s immediate family), pursuant to which any remuneration is to be provided to such physician (or a member of such physician’s immediate family), must be in writing, signed by both parties, and meet the requirements of all applicable laws. For purposes of this Policy, the terms “physician” and “member of a physician’s immediate family” shall have the meanings prescribed to such terms in 42 C.F.R. § 411.351. All capitalized terms not defined in this Policy shall have the meaning set forth in the Medical Staff Bylaws.

**REFERENCES:**

42 U.S.C. § 1395nn  
42 C.F.R. § 411.351

**FORM(S):**

None

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 9/26/17

**BOARD OF DIRECTORS APPROVAL:** 12/18/17

**POLICY STEERING COMMITTEE APPROVAL:** 10/25/17