ADVANCED PRACTICE PROFESSIONAL STAFF

I. PURPOSE

This policy of the Medical Staff defines the categories, scope of privileges, and removal procedures for Advanced Practice Professional Staff.

II. SCOPE

This policy applies to all Advanced Practice Professional Staff members of Aurora Medical Center - Manitowoc County.

III. DEFINITIONS

AMCMC is defined as Aurora Medical Center - Manitowoc County.

Medical Center is defined as Aurora Medical Center - Manitowoc County.

IV. POLICY

A. Categories of Advanced Practice Professional Staff

Advanced Practice Professional Staff shall consist of:

- Advanced 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
- Anesthesiologist Assistants

B. Supervision of CRNA Services

a. Certified Registered Nurse Anesthetists with prescriptive authority (APNP) that are licensed in the State of Wisconsin are allowed to provide services independently in the absence of a supervising anesthesiologist or performing physician.

b. Certified Registered Nurse Anesthetists without an APNP license or who have an APNP license from another state cannot practice independently, and must be directly supervised by an anesthesiologist or CRNA with an APNP license. This requires the anesthesiologist or APNP CRNA to be physically present in
the immediate operating room area at all times during which the non-APNP CRNA is providing patient care. In addition, only the anesthesiologist or licensed APNP CRNA is allowed to write the anesthesia plan (pre-, post- and intraoperative) and issue/sign orders for medications. An attestation statement will be added by the supervising anesthesiologist or APNP CRNA at the end of the case in the computerized record to cover the ordering and formulation of the plan for anesthesia in these situations.

c. If CRNA who is not licensed as an APNP is practicing in an off-site surgery center, a APNP CRNA or anesthesiologist is required to be on-site.

C. Supervising Physicians of Advanced Practice Professionals

The supervising physicians of an Advanced Practice Professional shall assume full responsibility, and be fully accountable for the conduct of the Advanced Practice Professional within the Medical Center. The supervising physician of an Advanced Practice Professional must be a member of the Medical Staff.

D. Removal Procedures and Status

1. Advanced Practice Professionals are not members of the Medical Staff and, accordingly, have none of the duties or prerogatives of Medical Staff members except as otherwise expressly set forth in this policy and/or the Medical Staff Bylaws.

2. If an Advanced Practice Professional is the subject of a recommendation or action adversely affecting the Advanced Practice Professional’s clinical privileges, the Advanced Practice Professional is entitled to the rights applicable to Advanced Practice Professionals provided in the Medical Staff Bylaws. For purposes of this paragraph “adversely affecting: shall mean reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges.

3. The Medical Center retains the right, through the Medical Executive Committee, to suspend or terminate any or all of the privileges of any Advanced Practice Professional for any reason, without recourse on the part of such person or others to the review and appeal procedures of the Medical Staff Bylaws, including, without limitation: (i) when the supervising physician’s Medical Staff membership is terminated for any reason; (ii) when the supervising physician’s clinical privileges are curtailed to the extent that the professional services of the Advanced Practice Professional within the Medical Center are no longer necessary or permissible; (iii) when the Advanced Practice Professional’s employment by the supervising physician or the clinic where the supervising physician practices is terminated; or (iv) when the Advanced Practice Professional is no longer covered by adequate professional liability insurance as required by the Governing Board.

Cross References: AMCMC Surgical Services Policy SUR-062
AMCMC Medical Staff Bylaws

Owner: AMCMC Medical Staff Services
References:  
Wis. Adm. Code N § 8.10  
Wis. Adm. Code Med § 8.07  
Wis. Adm. Code Med § 8.08  
Joint Commission Standard HR. 01.02.05 (Jan. 2010)

Review Dates:  
7/24/2015
I. PURPOSE

It is the policy of the Medical Staff to complete background checks on all members of the Medical and Allied Practice Professional Staff in accordance with State law.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center - Manitowoc County.

III. DEFINITIONS

AMCMC is defined as Aurora Medical Center - Manitowoc County.

Medical Center is defined as Aurora Medical Center - Manitowoc County.

IV. POLICY

A. Background Information Disclosure

1. As part of the application process, the practitioner is required to complete a background information disclosure form which is provided by the Medical Center.

2. Provided the completed background information disclosure form does not reveal any information that would make the individual ineligible for Medical or Allied Practice Professional Staff membership under State law, the practitioner may provide services at the Medical Center for not more than sixty (60) days pending the receipt of the results of the required electronic background search submitted by the Medical Center to the State. Services provided during this sixty (60) day period shall be provided under the supervision of the appropriate Clinical Chairperson.

B. Initial and Continued Membership

1. Initial and continued membership on the Medical or Allied Practice Professional Staff is contingent upon background results that meet the eligibility requirements under State law. Members of the Medical or Allied Practice Professional Staff must complete a background information disclosure form and be subject to the electronic background search at least every four (4) years.
C. Use of Credential Verification Organization

1. If the Medical Center engages a credentials verification organization, the Medical Center may require such organization to perform background checks.

Cross References: AMCMC Medical Staff Bylaws

Owner: AMCMC Medical Staff Services


Review Dates:
I. PURPOSE

It is the policy of the Medical Center to maintain the confidentiality of all Medical and Allied Practice Professional staff files and records, including but not limited to documents regarding discussions and deliberations relating to credentialing, peer review, and quality improvement activities (collectively, the “Records”). The Records shall be maintained and kept confidential in accordance with the Federal Health Care Quality Improvement Active, Section 146.38 of the Wisconsin Statutes and other applicable State and Federal law. The Records shall be disclosed only as described in this policy and in accordance with applicable law.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center - Manitowoc County.

III. DEFINITIONS

AMCMC is identified as Aurora Medical Center - Manitowoc County.

Medical Center is defined as Aurora Medical Center - Manitowoc County.

IV. POLICY

A. Location and Security

1. All Records shall be maintained under the care and custody of Medical Staff Office authorized personnel. The Medical Staff Office will be kept locked, except during those times that authorized personnel are present and able to monitor access in accordance with this policy.

2. Information stored electronically in MSO For Windows shall have protected access by login and password and shall be restricted by a facility code.

B. Means of Access

1. Requests for Access

   a. All requests for access to the Records shall be presented to the Medical Staff President or designee. A record of all requests made, including whether each request was granted or denied, shall be kept in the Medical Staff Office. Requests for access
shall specify (i) the specific information being requested, and (ii) the purpose of the request.

b. Unless otherwise stated, an individual permitted access under this Policy shall be afforded a reasonable opportunity to inspect the Records and to make notes regarding the requested times during the inspection of the Records. No individual shall remove or make copies of any Records without specific prior written consent of the Medical Staff President or designee. No individual shall alter any of the Records.

c. An applicant for, or member of, the Medical Staff or Allied Practice Professional Staff (“applicant/member”), or a person or organization authorized by the applicant/member, may review the applicant’s/members Records under the following circumstances:

i. The request is approved by the Medical Staff President or designee.

ii. The applicant/member must agree that he or she will not remove any items from his or her Records. The applicant/member may, in writing to the Medical Staff President, request that the applicant/member be permitted to add a written explanation to his or her Records.

iii. Medical Staff Office personnel shall make any copies approved by the Medical Staff President or designee. The cost to the requestor, if any, for such copies shall be determined by Medical Staff Office personnel.

iv. In the event the requestor is a person or organization authorized by the applicant/member (including, but not limited to the applicant’s/member’s legal counsel), the Medical Center shall not grant the request until the requestor provides the Medical Center with a copy of the written authorization from the applicant/member and the Medical Center’s legal counsel has been consulted, as necessary, regarding the access request.

2. Individuals Who May Access the Records

a. The following individuals may access the Records to the extent necessary to perform their official functions:

i. Authorized representatives may have access to the Records to fulfill their responsibilities. Authorized Representatives include the Administrator of the Medical Center, the Medical Staff President, the Medical Staff Vice President, Department Chairpersons, the Medical Center’s legal counsel, members of the Medical Executive Committee, and Medical Staff Office personnel.
b. Applicants/Members may access the Records to the extent described herein:

i. Applicants/Members may have copies of any documents in his or her Records which:

(a) He or she submitted. That is, his or her initial appointment application, application for reappointment, request for privileges, copies of licensure and certifications, or correspondence to or from himself or herself.

(b) Was addressed to him or her.

(c) Copies were previously provided to him or her.

ii. Applicants/Members may not view confidential letters of reference obtained during the initial appointment or subsequent reappointments.

iii. Applicants/Members may be allowed access to further information in his or her Records only if, following a written request by the practitioner, the Medical Executive Committee and the Governing Board grant written permission for good cause.

(a) Factors to be considered in determining good cause includes:

(i) Reason(s) for which access is requested;

(ii) Whether the applicant/member might further release the information;

(iii) Whether the information could be obtained in a less obtrusive manner;

(iv) Whether the information was obtained in specific reliance upon continued confidentiality;

(v) Whether the applicant/member will suffer serious adverse consequences unless the information is released; and

(vi) whether a harmful precedent might be established by the release.

c. Consultants or attorneys engaged by the Medical Center may be granted access to the Records to enable them to perform their functions.

d. Information contained in the Records may be released in response to a written request from another healthcare facility. No information shall be released until a copy of a signed
authorization and release from liability is obtained. The request must:

i. Be on the requesting healthcare facility’s stationary;

ii. Include the reason(s) for the request;

iii. Include a signed authorization and release from liability statement by the practitioner consenting to the release of information.

Disclosure shall be limited to the specific information requested.

All responses regarding an applicant/member who has been the subject of corrective action at the Medical Center shall be reviewed and approved by the Medical Staff President, Administrator of the Medical Center, and/or the appropriate Department Chairperson.

e. Representatives of regulatory or accreditation agencies may be granted access to Records on Medical Center premises and in the presence of an Authorized Representative identified in Section B.2 provided that:

i. No original or copies in the Records be removed from the premises;

ii. Access is provided only with the concurrence of the Medical Staff President and the Administrator of the Medical Center, or their designees; and

iii. The regulatory or accreditation agency representative demonstrates the following:

(a) Specific statutory, regulatory, or other authority to review the requested Records;

(b) That the Records requested are directly related to the matter being investigated;

(c) That the Records requested are the most direct and the least intrusive means to carry out the survey or a pending investigation, bearing in mind that the Records regarding individual applicants/members are strictly confidential;

(d) Sufficient specificity to allow for the production of individual applicant/member Records without undue burden to the Medical Staff or Medical Center; and

(e) In the case of requests for documents with applicant/member identifiers not eliminated, the need for such identifiers is clear.
3. Other Access Request
   a. All subpoenas pertaining to the Records shall immediately be referred to the Medical Center’s Quality Director. Before responding to such a subpoena, the Quality Director shall consult, as necessary, with the Medical Center’s legal counsel regarding the appropriate response to the subpoena.
   b. All other requests by persons or organizations outside of the Medical Center for information contained in the Records shall be forwarded to the Medical Staff President and the Administrator of the Medical Center. The release of any such information shall require the concurrence of the Medical Executive Committee and the Governing Board.

C. The Medical Staff Record
   1. The Medical Staff Record consists of two separate parts:
      a. The Credentials part includes the following documents:
         i. Profile, appointment approval, appointment confirmation letter, reappointment approval, reappointment confirmation letter, clinical privileges, audit, continuing education (if applicable), certifications/awards (if applicable), National Practitioner Data Bank (NPDB), activity reports, and miscellaneous correspondence.
      b. The Quality Assessment part includes the following documents:
         i. Adverse peer reviews in which the Medical Staff member or Allied Health Professional provided a written response, adverse peer reviews that were reviewed at a department/committee meeting, professional/peer references, reappointment performance profile, and complaints as identified by an Authorized Representative.

Cross References: None

Owner: AMCMC Medical Staff Services

References:

Review Dates:
MEDICAL STAFF AND ALLIED PRACTICE PROFESSIONAL RECORDS CONFIDENTIALITY
AND NOTIFICATION STATEMENT FOR AURORA MEDICAL CENTER –
MANITOWOC COUNTY

I have requested access to inspect the Quality Assessment record for the Medical Staff/Allied Practice Professional practitioner(s) listed below. In recognition of Medical Staff and Allied Practice Professional records confidentiality and the importance of such confidentiality to the performance of effective credentialing, peer review, and performance improvement, and in the recognition that the information in these records was both generated and disclosed to me in reliance upon that confidentiality, I understand that I am expected to:

1. Preserve the confidentiality of those records to the extent allowed by law, disclosing that information only as necessary for completion of the peer review process.
2. Notify Aurora Medical Center - Manitowoc County (AMCMC) prior to any further disclosure of that information outside the purpose stated below, whether pursuant to subpoena or otherwise, and to cooperate with any efforts of AMCMC to contest that disclosure.
3. Review the record(s) in the presence of authorized AMCMC staff.
4. Not remove or copy any items from the record unless express permission is granted.

Practitioner(s) records to be reviewed: (use additional paper as necessary)

1. 
2. 
3. 

Reason for review: (use additional paper as necessary)

Reviewer Signature: ________________________________
Reviewer Printed Name: ________________________________
Witness Signature: ________________________________
Witness Printed Name: ________________________________
Date: ________________________________
UNENFORCEABLE ORAL AGREEMENTS AND ARRANGEMENTS

I. PURPOSE

It is the policy of the Medical Staff to promote adherence to applicable legal requirements and ensure compliance with the principles and guidelines established under the Medical Center’s Compliance Program.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

IV. POLICY

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 healthcare, 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 CFR § 411.351.

Cross References: None

Owner: Medical Staff

References: None

Review Dates:
CONSULTATIONS

I. PURPOSE

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.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

Staff Member is defined according to current Bylaws definition.

IV. POLICY

A. 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:

1.1 An issue or question arises that is outside the scope of the Staff Member’s licensure, education, training, experience, skills, or Clinical Privileges

1.2 The complexity of the patient’s condition requires careful coordination

1.3 The patient is known or suspected to be suicidal and/or homicidal

1.4 Admission to a particular unit or department of the Medical Center requires consultation
1.5 A surgery or procedure may interrupt a known or suspected pregnancy

1.6 Consultation is required by law

1.7 Consultation is requested by the patient or patient representative(s)

1.8 A surgery, procedure or treatment is considered high risk or controversial

1.9 Problems of critical illness in which a significant question exists with respect to the appropriate procedure or therapy

1.10 Cases of difficult or equivocal diagnosis or therapy

B. Request, Response and Documentation

1. Request

   a. The staff member requesting the consultation must:

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

      ii. Enter an order requesting the consult; and

      iii. 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. 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 finding, 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.

3. Failure to Request

   If the attending Staff Member fails to request a consultation when indicated, the Chief of Staff, or advisory physician when applicable, should accept the responsibility of seeing that a consultation is obtained.

4. Nurse Questioning Care

   If a nurse has any reason to doubt or question the care provided to any patient, or believes that appropriate consultation is needed and has not been obtained, refer to the Medical Center’s Code of Professional Conduct Policy.
FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

I. PURPOSE

It is the policy of the Medical Staff to establish a systemic process, termed focus professional practice evaluation (FPPE), which ensures that sufficient information is available to confirm the current competency of practitioners.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

Practitioner is defined as members of the medical or allied practice professional staff of the Medical Center.

IV. POLICY

A. Practitioners requesting medical staff membership with no clinical privileges are not subject to the provisions of this policy as they do not require FPPE.

B. The Clinical Department Chair shall be responsible for overseeing the FPPE process for all practitioners assigned to his/her department.

C. The FPPE process will be initiated in each of the following circumstances:
   a. To confirm an individual practitioner’s current competence at the time of initial appointment of privileges;
   b. To confirm a currently privileged practitioner’s competence at the time of an additional privilege request;
   c. An ongoing professional practice evaluation (OPPE) reveals that a currently privileges practitioner has low or no clinical activity for a particular privilege and the Clinical Department Chair and/or Medical Executive Committee (MEC) requests and FPPE to be performed; or
   d. Concerns arise regarding a currently privileged practitioner and the Clinical Department Chair and/or MEC requests an FPPE to be performed.

D. FPPE data may be obtained from:
   a. Personal interaction with the practitioner;
   b. Medical record review;
   c. Interviews of Medical Center staff interacting with the practitioner;
d. Chart audits by non-medical staff personnel based on medical staff-defined criteria;

e. Data routinely obtained for OPPE as either individual case reviews or aggregate data; or

f. An external source where the practitioner is involved in an ongoing peer review program.

E. Responsibilities of Clinical Department Chairs

a. Review and evaluate FPPEs for practitioners assigned to his/her department; forwarding any concerns to the MEC and/or Peer Review Committee as deemed necessary; and

b. Recommend and assign proctors as needed.

F. Responsibilities of Medical Staff Office

a. Compile FPPE data and forward to Clinical Department Chairs for review and evaluation; and

b. Compile and forward summary data to the Peer Review Committee for review.

G. Responsibilities of Practitioner Undergoing FPPE

a. Make every reasonable effort to be available to the proctor (if assigned), including notifying the proctor of each patient in which care is to be evaluated in sufficient time to allow the proctor to concurrently observe or review the care provided;

b. Secure agreement from the proctor (if assigned) to attend the procedure for elective surgical or invasive procedures for which direct observation is required and the department requires the FPPE to be completed before the practitioner can perform the procedure without a proctor present. OPTION: The practitioner may proceed with concurrence of the proctor for an elective procedure in which the proctor is not available;

c. Notify the proctor (if assigned) as soon as reasonably possible when the practitioner admits and treats a patient in an emergency situation;

d. Provide the proctor (if assigned) patient information as requested;

e. Inform the proctor (if assigned) of any unusual incident(s) associated with his/her patients; and

f. Request a change of proctor (if assigned) if disagreements with the current proctor may adversely affect the practitioner’s ability to satisfactorily complete the proctorship. Requests should be made by contacting the appropriate Clinical Department Chair or Chief of Staff.

H. Responsibilities of the Proctor

a. Must be in good standing at the Medical Center and must have privileges in the specialty area relative to the privilege(s) to be evaluated;

b. Ensure the confidentiality of all documentation pertaining to the FPPE;

c. Submit any summary reports and/or additional information requested by the Clinical Department Chair;
d. Inform the appropriate Clinical Department Chair if the practitioner undergoing the FPPE is not sufficiently available or lacks sufficient cases to complete the process in the allotted timeframe;

e. Promptly notify the appropriate Clinical Department Chair if at any time there is concern regarding the practitioner’s competency to perform specific clinical privileges or care related to a specific patient(s) during the FPPE period; and

f. Complete the Proctoring Verification Form (Attachment I) and return the Medical Staff Office.

I. Medical Staff Ethical Position on the Proctor Role

The proctor’s role is typically that of an evaluator, not a consultant, preceptor, or mentor. The following ethical principles shall apply to performing this role:

a. The proctor shall charge no professional fee directly or indirectly from any patient for this service;

b. The proctor shall have no duty to personally intervene directly in patient care if the care provided by the proctored practitioner appears to be deficient. However, the proctor is expected to immediately report any concerns regarding the care being rendered by the proctored practitioner that has the potential for imminent patient harm to the appropriate Clinical Department Chair, the Chief of Staff, or the Medical Center President.

c. The proctor, or any other qualified practitioner, may render emergency medical care to a patient for complications arising from the care provided by a proctored practitioner.

Cross References: None
Owner: Medical Staff
References: None
Review Dates: 04/2013
PROCTORING VERIFICATION

I hereby verify that I proctored ____________________________ for

___________ (_____ minimum) _________________________________

procedures at Aurora Medical Center Manitowoc County.

☐ There were no quality issues noted. I attest to his/her competency in performing this procedure.

☐ The following issues were noted:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

___________________________________   _____________ __________
Printed Name of Proctor     Date

___________________________________
Signature of Proctor

Printed by MEIC: 05/09/13
Approved by Governing Board: 07/29/13
I. PURPOSE

It is the policy of the Medical Staff to establish a systemic process, termed ongoing professional practice evaluation (OPPE), which ensures that sufficient information is available to confirm the current competency of practitioners.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

Practitioner is defined as members of the medical or allied practice professional staff of the Medical Center.

IV. POLICY

A. Practitioners requesting medical staff membership with no clinical privileges are not subject to the provisions of this policy as they do not require OPPE.

B. The Clinical Department Chair shall be responsible for overseeing the OPPE process for all practitioners assigned to his/her department.

C. OPPE criteria for review may include, but is not limited to:

   a. Review of operative and other clinical procedures performed and their outcomes;
   b. Patterns of blood and pharmaceutical usage;
   c. Requests for tests and procedures;
   d. Length of stay patterns;
   e. Morbidity and mortality data;
   f. Practitioner’s use of consultants and specialists;
   g. Unexpected outcomes and critical events;
   h. Significant departure from established patterns of clinical practice;
   i. Patient safety data and outcome and utilization measures;
   j. Care management reports;
k. Valid complaints from patients, family members, other health care providers, administrative staff, health plans, or payors;

l. Cases referred for legal review; or

m. Other relevant criteria as determined by the medical staff.

D. OPPE data may be obtained from internal or external (primary care facility) sources

E. Responsibilities of Clinical Department Chairs

a. Review and evaluate OPPEs for practitioners assigned to his/her department; forwarding any concerns to the Medical Executive Committee and/or Peer Review Committee as deemed necessary.

F. Responsibilities of the Medical Staff Office

a. Compile OPPE data and forward to Clinical Department Chair for review and evaluation; and

b. Compile and forward summary data to the Peer Review Committee for review.

G. Responsibilities of the Practitioner Undergoing OPPE

a. Provide any information or explanation regarding data as requested.
INITIAL APPLICATION, REAPPOINTMENT, AND MODIFICATION OF MEDICAL STAFF CATEGORY AND/OR CLINICAL PRIVILEGES

I. PURPOSE

A Medical Staff or Allied Practice Professional Staff member’s request for initial appointment and/or clinical privileges, reappointment, or modification of medical staff category and/or clinical privileges shall be processed in accordance with the following guidelines.

II. SCOPE

This policy applies to all credentialed practitioners at Aurora Medical Center - Manitowoc County.

III. DEFINITIONS

APP is defined as Allied Practice Professional members
CVO is defined as the Medical Center’s Central Verification Office
Medical Center is defined as Aurora Medical Center - Manitowoc County
Member is defined as a member of the Medical Center’s Medical or Allied Practice Professional staff category

IV. POLICY

A. Request for Initial Appointment and Clinical Privileges

1. The applicant or his or her office initiates an initial application request. Information at time of request shall include, at a minimum: but is not limited to:

   a. Applicant name and title
   b. Applicant date of birth and/or social security number
   c. Applicant email address to be used for credentialing correspondence

B. Application for Initial Appointment
1. It is the applicant’s responsibility to provide the documentation to the Medical Center and CVO as required in Article 2 of the Medical Center’s Medical Staff Bylaws. Failure to do so shall result in the application process to be terminated and the application shall be marked “withdrawn by applicant”.

2. In the event there is undue delay in obtaining required information, the Medical Staff Services Office shall request assistance from the applicant. Under these circumstances, the time periods for processing the application described in this policy will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after thirty (30) days shall result in termination of the application process and the application shall be marked “withdrawn by applicant”.

C. Time Periods for Processing

1. All individuals and groups required acting on an application for appointment and/or clinical privileges must do so in a timely and good faith manner and, except for good cause, each application should be processed within the following time periods measured from the receipt of the completed application:

<table>
<thead>
<tr>
<th>Individual / Group</th>
<th>Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical Staff Services and CVO</td>
<td>1. Sixty (60) days</td>
</tr>
<tr>
<td>2. Clinical Chairperson</td>
<td>2. Next scheduled meeting</td>
</tr>
<tr>
<td>3. Medical Executive Committee</td>
<td>3. Next scheduled meeting</td>
</tr>
<tr>
<td>4. Governing Board</td>
<td>4. Next scheduled meeting</td>
</tr>
</tbody>
</table>

2. These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of the correction action or hearing and appeal process specified in the Medical Center’s Medical Staff Bylaws are activated, the time requirements provided therein govern the continued processing of the application.

3. The applicant shall be notified in writing of the Medical Center’s final decision regarding appointment as indicated in Article 2 of the Medical Center’s Medical Staff Bylaws.

D. Requests for Reappointment and Renewal or Modification of Medical Staff Category and/or Clinical Privileges

1. All applicants must submit a request for reappointment and renewal of clinical privileges prior to completion of each term of appointment, which may not exceed two (2) years. Applicants may, however, request a modification of Medical Staff category and/or clinical privileges at any time.

2. Only applicants who continuously meet the qualifications and requirement regarding appointment, Medical Staff categories, and clinical privileges (as applicable) set forth in the Medical Center’s Medical Staff Bylaws and Medical Staff Policies Governing Medical Practices shall be entitled to request reappointment and renewal or modification of the
Medical Staff category and/or clinical privileges. The Medical Center shall also review data collected through the ongoing professional practice evaluation of the applicant to determine whether the applicant shall be entitled to reappointment and renewals or modification of Medical Staff category and/or the clinical privileges.

3. Except as set forth in this section, all requests for reappointment and renewal or modification of Medical Staff category and/or clinical privileges shall be processed in the same manner as requests for initial appointment and clinical privileges.

4. Requests for reappointment and renewal or modification of Medical Staff category and/or clinical privileges shall be processed in accordance with the following procedures:

   a. Reappointment Generally
      i. The Medical Staff Services Department shall mail (electronically, interoffice, intra-office, or USPS mail services) a reappointment application to each member at least twelve (12) weeks prior to the expiration date of his/her current appointment period
      ii. In the event a member fails to timely file a complete reappointment application at least eight (8) weeks prior to the expiration date of his/her current appointment period: (1) the member's Medical Staff or Allied Practice Professional Staff membership and clinical privileges (if any) shall be automatically suspended at the end of the current appointment period, or at the end of the term for which clinical privileges were granted; and (2) such member shall be deemed to have voluntarily resigned from the Medical Staff or Allied Practice Professional Staff and relinquished all clinical privileges if any. If such member desires to continue to be on the Medical Staff or Allied Practice Professional Staff, he or she must re-apply and meet all of the requirements for initial appointment and clinical privileges (if requested).

   b. Modification Outside of General Reappointment
      A Medical Staff or Allied Health Professional Staff member requesting a modification of Medical Staff category and/or clinical privileges must submit a written request for the same to the Medical Staff Services Office of the Medical Center. Such a request may be made at any time, except within twelve (12) months of the time a similar request has been denied.

Cross References: Aurora Medical Center - Manitowoc County Medical Staff Bylaws

Owner: Medical Staff Services Office

References: Aurora Medical Center - Manitowoc County Medical Staff Bylaws

Review Dates: 02/28/2012
Medical Staff Policy Governing Medical Practices

POLICY NO: MS-010 (formerly 183-016)

Effective Date:
01/2002

Revision Dates:
02/2003; 12/2003; 03/2005; 01/2006; 02/2008; 08/2008; 02/2009; 02/2010; 03/2010; 05/2010; 12/2010; 08/2011; 08/2012; 01/2013 (update to case review form only) 11/2014

PEER REVIEW

I. PURPOSE

It is the policy of the Medical Staff and the Medical Center to conduct peer review and evaluation of the quality of patient care provided by, and the conduct of, Medical Staff members through quality assessment and improvement activities. The peer review activities identified in this Policy are a major component in the Medical Center’s program, which has been organized to help improve the quality of healthcare in the Medical Center. These activities will be conducted in a manner consistent with Wisconsin Statutes § 146.37 and § 146.38.

II. GOALS

1. Improve patient outcomes by pursuing and maintaining excellence in provider performance.

2. Create a culture with a positive approach to peer review by recognizing provider excellence as well as identifying improvement opportunities.

3. Promote efficient use of provider and quality staff resources.


5. Support medical staff and Advanced Practice Providers (APP) educational goals to improve patient care.

6. Provide a link with the hospital performance improvement structure to assure responsiveness to system improvement opportunities identified by the medical staff and APP.

III. SCOPE

This policy applies to all credentialed practitioners at Aurora Medical Center - Manitowoc County (AMCMC).

IV. DEFINITIONS

Any terms used in this Policy have the same meaning and definition as those terms that are defined in the Medical Staff Bylaws. In addition, for the purpose of this Policy, the following words or phrases are defined as follows:
1. “Concurrent Review” means active real-time observation of a Medical Staff member while he or she is performing professional services and/or implementing a plan of care by a Peer Reviewer who directly observes the Medical Staff member’s cognitive abilities, skills, compliance with the Medical Center’s policies and procedures, documentation, and other relevant aspects of the Medical Staff member’s practice.

2. “Internal Peer Review” means a review conducted by a Peer or Peers who are AMCMC Medical Staff members.

3. “External Peer Review” means a review conducted by a Peer or Peers who are not AMCMC Medical Staff members.

4. “Focused Professional Practice Evaluation” or “FPPE” means a time-limited study, review, investigation, evaluation or assessment of the training, experience, skill, professional conduct, qualifications, current competence, and/or clinical judgment or expertise of a particular Medical Staff member. Relevant information obtained from FPPE shall be integrated into performance improvement activities. The FPPE process is NOT part of the corrective action process. If corrective action is indicated, the procedure outlines in the Medical Staff Bylaws must be followed.

5. “Ongoing Professional Practice Evaluation” or “OPPE” means a continuous process in which certain data is evaluated to identify professional practice trends that impact quality of care and patient safety. Relevant information obtained from OPPE shall be integrated into performance improvement activities. The OPPE process is NOT part of the corrective action process. If corrective action is indicated, the procedures outlined in the Medical Staff Bylaws must be followed.

6. “Peer” means an individual who possesses the same or similar licensure, certifications and functions as the Review Subject, shares the same training, expertise and competency as the Review Subject, and either 1) practices in the same or similar specialty as the Review Subject, or 2) practices in a different specialty but possesses specialized training that includes the primary elements of the type of care or technique that is subject to review.

7. “Peer Reviewer” means an individual who is participating in an OPPE, FPPE, or Peer Review under the direction of the Peer Review Committee.

8. “Review Subject” means the Medical Staff member whose professional services or conduct is the subject of an OPPE, FPPE, Internal and/or External Peer Review.

9. “Standard of Care” means the degree of care that a reasonable, prudent and careful Medical Staff member would exercise under the same or similar circumstances as determined by the Peer Review Committee or the Medical Executive Committee. The Standard of Care may be established by common practice by statute, or by specialty boards or organizations, including but not limited to references to peer-reviewed literature and relevant clinical practice guidelines.

10. “Prospective Review” means the evaluation of a Medical Staff member’s anticipated professional services and plan of care performed prior to the initiation of such services or plan of care by a Peer Reviewer who evaluates the plan of care in advance and assists the Medical Staff member with proposed treatments as needed.

11. “Retrospective Review” means the evaluation of a Medical Staff member’s performance after services have been rendered or a plan of care has been initiated or completed by examining relevant records and information, and determining whether the Review Subject’s conduct and documentation were appropriate.

V. GENERALLY
A. Peer Review Committee (PRC)

1. The Peer Review Committee (PRC) shall be composed of at least five (5) Medical Staff members from different specialties or departments to serve as the PRC. The Chief of Staff shall designate one (1) of the PRC members to serve as the Chairperson. The goal is not to have representation from every specialty, but rather to create a cadre of dedicated, clinically credible, and respected peer reviewers who are well trained in the peer review process. In addition, the Medical Center’s President, Quality Director, and Chief Nursing Officer shall serve on the PRC in a non-voting capacity. If additional clinical expertise is needed, the PRC may request assistance from others as it deems appropriate.

2. The PRC shall meet every other month.

3. The practitioner being evaluated shall be invited to attend the PRC meeting to provide input.

4. A quorum shall consist of those present, but not less than two (2) voting members of the PRC.

5. Clinical Chairpersons are responsible for working with the Medical Staff members in their department who are under review to implement recommendations of the PRC.

6. In addition to individual cases, the PRC reviews selected complications and mortalities.

B. Internal Peer Review

1. Internal Peer Review may be performed based upon pre-determined indicators chosen by each clinical department. Cases that “fall out” according to these indicators will be assigned to a Peer Reviewer.

2. Internal Peer Review may also be performed based on concerns raised by other Medical Staff members, Medical Center staff, patients or families. All such concerns will be forwarded to the Quality Director or designee. Cases will be screened by the Quality Director and the Clinical Department Chairperson, or their designees, to determine which cases need Internal Peer Review.

3. The Internal Peer Review process shall be conducted in accordance with the Peer Review Process flowchart attached hereto.

4. If a quality of care issue is identified, the practitioner in question will be invited to provide input to the PRC. If a department peer review discussion is warranted, the practitioner in question will be given at least fourteen (14) days advance notice of the date and time of the meeting.

C. External Peer Review

1. External Peer Review may be performed whenever deemed appropriate. Examples include but are not limited:
   a. Lack of a qualified Internal Peer Reviewer;
   b. Practices that involve new technology or innovative use of existing technology;
   c. Substantial conflicts between a Review Subject and available Peer Reviewers;
   d. Substantial conflicts between a Peer Reviewer and PRC members;
   e. Concerns related to potential litigation; and
f. Responding to a request of the Medical Center’s Governing Board.

2. The timing and completion of an External Peer Review will vary on a case-by-case basis, depending on the availability of a qualified external reviewer, the scope of the review, and other relevant factors.

D. Allied Professional Practitioners (APPs)

1. FPPE, OPPE and Peer Review processes for APPs will be conducted in the same manner as the processes implemented for Medical Staff members under this Policy; provided, however:

   a. A Peer for an APP shall be defined as an individual who either 1) practices in the same or similar specialty as the Review Subject, or 2) practices in a different specialty but possesses specialized training that includes the primary elements of the type of care of technique that is subject to review; and

   b. Dependent APPs are not entitled to the hearing and appeal rights set forth in the Medical Staff Bylaws.

E. Documentation

1. All information acquired in connection with the review and evaluation of health care services provided by an individual Review Subject and any records of investigations, inquiries, proceedings and conclusions of such review or evaluation, including any materials submitted by the Review Subject, shall be included in the Review Subject’s confidential Quality File.

2. All Quality Files shall be maintained in accordance with state and federal laws and regulations pertaining to confidentiality and non-discoverability.

F. Confidentiality

1. All Peer Review activities shall be conducted in a manner consistent with applicable confidentiality laws. All Peer Review records and activities are confidential and shall not be disclosed except as required by law.

2. The Peer Review activities described in the Policy and conducted in good faith are intended to be protected by the civil immunity protections of Wisconsin Statute § 146.37 and § 146.38.

3. The confidentiality and immunity provisions apply to individuals involved in Peer Review activities as well as other individuals designated to assist in carrying out the External Peer Review duties and responsibilities.

Cross References: Code of Professional Conduct – Medical Staff

Owner: Medical Staff Services Office

References: Wisconsin Statutes § 146.37 and § 146.38
Medicare Conditions of Participation, 42 CFR § 482.22(b)
Wisconsin Administrative Code Chapter HFS 124.10

Peer Review Process

Pre-determined indicators

Specific concerns raised

Case identified for physician review

Yearly review of pre-determined indicators by each clinical department

If need for review confirmed by Quality Management Data Support Specialist, case is assigned to peer reviewer

Reviewer completes Peer Review Case Rating Form

Issue identified?

Yes

No

Case brought to PRC for possible action, with physician in question invited to attend meeting

Issue confirmed?

Yes

No

PRC develops recommendation for physician

Issue resolved?

Yes

No

PRC refers case to MEC for possible action

Review shows “Case Appropriate”. Case brought to PRC as informational

PRC deems “Care Appropriate”

Peer Review & Evaluation Form filed in Medical Staff Office

Results sent to physician, Dept. Chairperson and copy filed in physician Quality file

Yes

No
I. PURPOSE

It is the policy of the Medical Staff to effectively and discretely provide the reporting, investigation, and management of an impaired practitioner.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

Practitioner is defined as a member of the medical or allied practice professional staff at Aurora Medical Center – Manitowoc County.

IV. POLICY

The Medical Center adopts the American Medical Association (AMA) definition of an impaired physician as definition of an impaired practitioner for purposes of this policy. An impaired practitioner at the Medical Center is therefore defined as a practitioner who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol (https://texmed.org/Template.aspx?id=4520, Date viewed 2/2/2010).

Because impairment not only affects the Medical Center but also the medical staff, all decisions regarding an impaired or suspected impaired, practitioner shall be agreed upon by the Medical Center President and the Chief of Staff (or respective designees). All requests for information regarding the impaired practitioner shall be forwarded to the Medical Center President or his/her designee.

The Practitioner Health Committee may be utilized at any time during this process at the request of the Medical Staff President or the Chief of Staff.

A. Initial Application

If any physical, psychiatric, or substance abuse condition is identified in the initial application process, the condition will be reviewed by the Medical Center President, Chief of Staff, and the appropriate Clinical Department Chairperson(or respective designees) prior to granting privileges and prior to review by the Governing Board.

1. The Medical Center President, Chief of Staff, and Clinical Department Chairperson will determine if there is an existing condition that could impair the ability of the applicant to engage in clinical practice at the Medical Center.

2. For those applicants for whom it is determined that a condition exists that could impair his/her ability to practice, they shall be required to authorize his/her treating clinician to discuss his/her condition with one or all of the following: Medical Center President, Chief...
of Staff, Clinical Department Chairperson. The applicant shall be required to authorize his/her treating clinician to submit copies of semiannual reports of treatment compliance, along with any other records deemed necessary.

3. Failure to follow any requests may result in refusal of medical staff membership and/or clinical privileges at the Medical Center.

B. Reporting and Investigation

1. Reports of a suspected impaired practitioner shall be in writing and may be self-reported or reported by others. The report shall be brought to the Medical Center President who will immediately inform the Chief of Staff.

   a. The original report and a description of the actions taken shall be included in the practitioner’s quality file in the Medical Staff Office;
   
   b. If the investigation reveals there is no merit to the report, the report shall be destroyed;
   
   c. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be filed in the practitioner’s quality file in the Medical Staff Office and the practitioner’s activities and practice shall be monitored until it can be established if there is a legitimate impairment problem.

2. If an investigation produces sufficient evident that the practitioner is impaired, the Medical Center President shall meet personally with the practitioner, or designate another appropriate individual to do so.

   a. The practitioner shall be told that the results of an investigation indicate an impairment that affects his/her practice;
   
   b. The practitioner shall not be told who filed the report; and
   
   c. The practitioner does not need to be told specific details/incidents contained in the report.

C. Option of the Medical Center

1. Require the practitioner to undertake a rehabilitation program as a condition of continued appointment and clinical privileges;

2. Impose appropriate restrictions on the practitioner’s privileges;

3. Immediately suspend the practitioner’s privileges until rehabilitation has been accomplished. (This can be done if the practitioner does not agree to voluntarily discontinue his/her privileges).

D. Rehabilitation / Reinstatement

Exception to the rehabilitation / reinstatement portion of this policy includes impairment due to age, irreversible medical illness, or other factors not subject to rehabilitation.

1. Rehabilitation

   The Medical Center shall assist the practitioner in locating a suitable rehabilitation program. The Medical Center shall not reinstate the practitioner until it is established to the Medical Center’s and the Medical Executive Committee’s (MEC) satisfaction that the practitioner has successfully completed a rehabilitation program in which the Medical Center and the MEC have approved.

2. Reinstatement
Upon sufficient proof that an impaired practitioner has successfully completed an approved rehabilitation program, the Medical Center and the MEC may consider reinstating the practitioner to the medical or allied practice professional staff using the following steps:

a. The practitioner must authorize the Physician Director of the rehabilitation program to release the following information in a letter to the Medical Center:

   • Whether the impaired practitioner is participating in the program;
   • Whether the impaired practitioner is in compliance with all the terms of the program;
   • Whether the impaired practitioner attends required program meetings regularly;
   • Whether, in the opinion of the rehabilitation program physician(s), the impaired practitioner is rehabilitated;
   • Whether an after-care program has been recommended to the impaired practitioner, and if so, a description of the after-care program; and
   • Whether, in the Program Director’s opinion, the impaired practitioner is capable of resuming medical practice and providing continuous, competent care to patients.

b. The impaired practitioner must inform the Medical Center of the name and address of his/her primary care physician and must authorize that physician to provide the Medical Center with information regarding his/her condition and treatment.

   The Medical Center shall request the said primary care physician to provide information regarding the precise nature of the impaired practitioner’s condition, the course of treatment, and the answers to the questions posed above with regards to if the impaired practitioner is indeed rehabilitated and is capable of resuming his/her medical practice.

   The Medical Center has the right to require an opinion from other physician consultants of its choice.

3. Additional precautions include the assumption that all information received by the Medical Center indicates the impaired practitioner is rehabilitated and capable of resuming patient care. The Medical Center must take the following additional precautions when restoring clinical privileges:

a. The impaired practitioner must identify two (2) physicians who are willing to assume responsibility for the care of the impaired practitioner’s patients in the event s/he is unable or unavailable to care for them;

b. The Medical Center shall require the impaired practitioner to provide periodic reports from his/her primary care physician, for a period of time determined by the Medical Center President and the Chief of Staff, stating if the impaired practitioner is continuing treatment and/or therapy as appropriate, and that his/her ability to treat and care for patients at the Medical Center is not impaired;

c. The assigned Clinical Department Chairperson, or a physician appointed by the Clinical Department Chairperson, shall monitor the impaired practitioner’s exercise of clinical privileges at the Medical Center. The MEC shall determine the nature of that monitoring after reviewing all of the circumstances surrounding the incident(s).

d. The impaired practitioner must agree to submit to an alcohol and/or drug screening test(s) (if appropriate to the impairment) at the request of a member of the Medical Center leadership, a physician, a nurse, or any individual working at the Medical Center who suspects the impaired practitioner may be under the influence of alcohol and/or drugs.
Cross References:  Policy MS-014 Practitioner Health Committee
Owner:  Medical Staff
References:  None
Review Dates:  10/2010; 04/2013
I. PURPOSE

It is the policy of the Medical Staff to utilize the Practitioner Health Committee in accordance with the following guidelines.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

Practitioner is any member of the medical or allied practice professional staff at the Medical Center.

IV. POLICY

A. Composition

The Practitioner Health Committee shall be composed of three (3) to five (5) members of the medical staff appointed by the Medical Executive Committee, one of who shall be appointed as the chairperson. Individual members of the Practitioner Health Committee shall serve a two (2) year term unless the Medical Executive Committee specified otherwise at the onset of the individual's appointment to the Practitioner Health Committee.

B. Meetings

The Practitioner Health Committee shall meet as necessary and shall make reports to the Medical Center President and Chief of Staff. The Practitioner Health Committee shall not make reports to the Medical Executive Committee except as necessary to pursue a corrective action, including summary suspension, when (i) it is believed that the practitioner is unable to safely perform the clinical privileges s/he has been granted, (ii) the impairment requires that action be taken immediately in the best interest of patient care, or (iii) the practitioner fails to reach or comply with an agreement with the Practitioner Health Committee regarding a program of treatment and recovery.

C. Functions

The functions of the Practitioner Health Committee shall be:

1. Education of the medical and allied practice professional staff about illness and impairment recognition issues specific to practitioners;

2. Address prevention of physical, psychiatric, emotional illness, or chemical dependency among practitioners;
3. Facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition as more specifically set forth in this policy; and

4. Consult with internal and external specialists and resources, and make referrals to same, as it deems necessary to carry out its functions.

D. Definition of Impaired Practitioner

An impaired practitioner is one whose professional performance or conduct has been adversely affected due to physical, mental health, emotional issues or illness, or chemical dependency.

E. Report of Impairment

1. Any individual may make a written report to the Medical Center President documenting his/her belief that a practitioner suffers from impairment. The report shall include a description of the incident(s) and behavior(s) that led to the belief that the practitioner may be impaired.

2. The Medical Center President and the Chief of Staff shall discuss the allegations with the individual making the report. Based on that discussion, the Medical Center President and the Chief of Staff will determine whether the matter requires additional attention.

3. If the Medical Center President and the Chief of Staff believe the allegations are unfounded, the matter will be dropped and no record of the incident will appear in the practitioner’s file. If the Medical Center President and the Chief of Staff agree that the allegations are not unfounded, they may refer the matter to the Practitioner Health Committee. The practitioner will be notified of this action if it should be taken.

4. The affected practitioner may self-refer to the Practitioner Health Committee by making a written or oral report directly to a Practitioner Health Committee member describing the practitioner’s impairment.

F. Evaluation

1. The Practitioner Health Committee shall informally and confidentially evaluate the complaints and/or concerns regarding the practitioner to determine whether a problem of impairment exists. Such evaluation may include discussions with the individual making the initial report and with others who may have relevant information.

2. The Practitioner Health Committee shall meet with the practitioner in a carefully structured, planned setting and review with the practitioner the complaints and accumulated evidence.

3. If after the evaluation and investigation, the Practitioner Health Committee, by majority, determines that no impairment exists, the matter will be dropped and no record of the incident shall appear in the practitioner’s file. The Practitioner Health Committee Chairperson shall convey this disposition to the practitioner.

4. If after the evaluation and investigation, the Practitioner Health Committee, by majority, determines that an impairment exists, the Practitioner Health Committee has the following options depending on the nature and severity of the impairment:

   a. Continue informal evaluations and schedule additional meetings with the practitioner for purposes of further analysis of the problem and for providing advice to the practitioner regarding treatment options;

   b. Reach an agreement with the practitioner regarding a program of treatment and recovery (“Agreement”). Consistent with the requirements set forth below, the Practitioner Health Committee and practitioner shall agree on and set forth, its specific details in writing; or
c. Inform the practitioner that failure to reach a written Agreement on a voluntary basis may necessitate referral of the practitioner to the Medical Executive Committee for review of appropriate corrective action under the Medical Staff Bylaws.

G. Agreement

Any Agreement reached pursuant to the above must contain the following:

i. Agreement by the practitioner to follow the individual treatment plan described in the Agreement;

ii. As applicable, agreement by the practitioner to maintain total abstinence from all psychoactive and/or mood altering substances, including alcohol;

iii. As applicable, agreement by the practitioner to provide observed biological fluid samples or to submit to alcohol breath analysis on a random basis at the request of the Practitioner Health Committee;

iv. Agreement by the practitioner to submit to additional assessments with such physicians or other treatment personnel as may from time to time be required and designated by the Practitioner Health Committee;

v. Agreement as to the level of professional practice that is appropriate during the different stages of treatment and recovery and to the Practitioner Health Committee’s monitoring of the same;

vi. Agreement by the practitioner to participate in face-to-face conferences with the Practitioner Health Committee at such frequency and for such period of time as deemed appropriate by the Practitioner Health Committee;

vii. Agreement as to re-entry guidelines for return to professional practice at the Medical Center, if this has been interrupted or curtailed;

viii. An authorization and release, signed by the practitioner, directing that the Practitioner Health Committee and all practitioners or individuals involved in the treatment and assessment of the subject practitioner may disclose confidential information to each other regarding the subject practitioner’s condition and treatment;

ix. Agreement by the practitioner to notify the Practitioner Health Committee within three (3) days if s/he fails to comply with the Agreement;

x. Agreement by the practitioner to bear all expenses in connection with his/her recovery and performance under the Agreement; and

xi. Agreement that failure of the practitioner to comply with the Agreement will result in an immediate and automatic termination of the practitioner medical or allied practice professional membership and all privileges at the Medical Center, and that in this event the practitioner waives all hearing and appeal rights under the Medical Staff Bylaws.

H. Generally

1. The Practitioner Health Committee shall reevaluate the Agreement at such intervals as they deem appropriate to keep it tailored to current circumstances.

2. Nothing in this policy shall limit the Practitioner Health Committee’s authority to make referrals for, or the authority of the Medical Center to take appropriate corrective action, including summary suspension, in accordance with the Medical Staff Bylaws.

3. The Practitioner Health Committee shall keep confidential any and all information it receives about the subject practitioner, pursuant to the Agreement unless disclosed;
a. To pursue a corrective action in accordance with Medical Staff Bylaws;

b. To the extent necessary to enforce compliance with the Agreement and to facilitate treatment; and/or

c. As otherwise permitted by law.

4. Report to the Wisconsin Medical Examining Board and/or the National Practitioner Data Bank shall be made as required by state and federal law.

5. All requests for information concerning the impaired practitioner shall be forwarded to the Medical Center President.

Cross References: Policy MS-013 Impaired Practitioner; Medical Staff Bylaws

Owner: Medical Staff

References: None

Review Dates: 04/2013
I. PURPOSE

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.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

Emergency Department Call Coverage

1. Participating Staff Members

As provided in the Medical Staff Bylaws: (a) all Active 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.

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 or she is involved in an emergency, the on-call Staff Member will designate an alternate to be contacted.

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.

(b) Teleservice Consults: Must respond to requests for a teleservice consult either by telephone or video connection within twenty (20) minutes of a request for consultation.

(c) In Person Response: Must respond in person within sixty (60) minutes of answering the page, or sooner if requested to do so by the Staff Member responsible for the medical screening examination. 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:

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 possess 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 Centers EMTALA policy).

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.

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.

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.

IV. General Inpatient and Outpatient Call Coverage

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 alternate Staff Member to respond to requests for assistance or guidance when such Staff Member is unavailable.

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 or she is involved in an emergency, the on-call Staff Member will designate an alternate to be contacted.

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.

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.

5. **Contact Information; On-Call Schedule**

   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.

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**CROSS REFERENCES:**
- 42 U.S.C. § 1395dd(d)(1)(c)
- Contract with BayCare Clinic, LLP

**OWNER:** Medical Staff

**REFERENCES:**

**PRIOR REVIEW / REVISION DATES:**
ADMISSION, TRANSFER AND DISCHARGE

I. PURPOSE

It is the policy of the Medical Staff to ensure the following guidelines for admission, transfer and discharge of patients are consistently observed.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

IV. POLICY

A. Admission

1. Generally

All other capitalized terms not defined herein shall have the meaning set forth in the Medical Staff Bylaws. Patients are to be admitted to the Medical Center regardless of sex, race, color, religion, or ability to pay the costs. A patient may only be admitted to the Medical Center 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.

The Medical Center shall accept patients for care and treatment except for the following disease categories: acute chemical dependency treatment and acute mental illness.

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.
3. 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.

4. Admission Note

For each Medical Center inpatient, within twenty-four (24) hours of admission, the admitting or attending Practitioner shall complete and 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;
(b) The reason(s) for admission for care, treatment, and services, including the patient’s initial diagnosis(es), diagnostic impression(s), or condition(s);
(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 may be 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 Medical Staff Physician who will be responsible for the medical aspects of care for such patient during the inpatient stay.

If an admission note is entered by an Allied Health Professional, the Medical Center’s privilege form criteria for co-signature must be followed.

5. 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; and (4) the transmission of reports regarding the patient’s condition to the patient, the referring practitioner (if any), and the patient’s representatives (if any).

6. 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 Coverage and Response policy.

7. **Frequency of Patient Attendance**

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 or 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 four (4) hours of admission. After the initial visit, all Medical Center inpatients should be seen at least on a daily basis by the admitting or attending Practitioner, or his or her designee. These timeframes are guidelines, and certain circumstances will require greater urgency.

8. **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 Medical Center’s Medical Records policy.

B. **Transfer**

1. **Transfer of Care to an Alternate Provider Within the Medical Center.**

Refer to Section 1.6 above.

2. **Transfer Between Setting 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.

3. **Transfer to Another Medical Facility**

Refer to Section 3.6 below.

C. **Discharge**

1. **Discharge Planning**

The admitting or attending Practitioner’s decisions regarding the provision of ongoing care, treatment and services, discharge, or transfer of his or her patients must be based on the assessed needs of the patient, regardless of the recommendations of any Medical Center internal or external review process. Upon request, a physician may request a discharge evaluation. This discharge planning evaluation entails a more detailed review of the individual patient’s post-hospital needs that must be addressed in the discharge plan. 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 (if any) 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.

2. Discharge Order

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

3. Discharge Instructions

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

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. Refer to applicable departmental policies to identify specific documentation requirements.

(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:

   i. Date of discharge;
   
   ii. Definitive final diagnosis(es) expressed in the terminology of a recognized system of disease nomenclature;
   
   iii. Reason(s) for the patient’s admission/registration and transfer or discharge;
   
   iv. Significant finding and complications (if any);
   
   v. Summary of the care, treatment and services provided (including the procedures performed, treatments rendered, the outcome(s) of such procedures and treatment and progress towards goals);
   
   vi. Condition of the patient upon discharge (including the patient’s physical and psychosocial status) stated in a manner that allows specific comparison to the patient’s condition upon admission/registration;
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 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 Leaves 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 in the Medical Center, please refer to the Medical Center’s Care of the Deceased Patient policy. It shall be the duty of all Medical Staff members to secure meaningful autopsies whenever appropriate. Established Medical Center criteria for autopsies shall be followed as listed in the Medical Center’s Autopsy policy. A diagnosis shall be recorded on the medical record within forty-eight (48) hours and the complete protocol should be made a part of the record within sixty (60) days, unless exceptions for special studies are established by the Medical Staff.

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 the Medical Center’s EMTALA policy.

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

(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).
7. Discharge of Infants

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.

8. Objections to Discharge

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

Cross References: None

Owner: Medical Staff

References:

Federal Regulations: 42 CFR § 482.13 (a) (Interpretive Guidelines, effective October 17, 2008); 42 CFR § 482.24 (c)(2)(vii-viii) (Interpretive Guidelines, effective October 17, 2008)

Wisconsin Statutes: Wis. Stat § 146.37 (2009)


Joint Commission: JCS LC.04.02.05 (Jan. 2010)
JCS PC.02.02.01 (Jan. 2010)
JCS PC.02.04.01 (Jan. 2010)
JCS PC.04.01.01 (Jan. 2010)
JCS PC.04.01.03 (Jan. 2010)
JCS PC.04.01.05 (Jan. 2010)
JCS PC.04.02.01 (Jan. 2010)
JCS RC.01.01.01 (Jan. 2010)
JCS RC.02.01.01 (Jan. 2010)
JCS RC.02.01.03 (Jan. 2010)
JCS RC.02.04.01 (Jan. 2010)

Review Dates:
PROTECTION OF PATIENTS

I. PURPOSE

It is the policy of the Medical Staff to ensure patient safety and protection.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

IV. POLICY

A. Generally

The admitting practitioner shall provide such information to the hospital and nursing staff as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his or her patients might be a source of danger due to any cause whatsoever.

B. Potential Suicide Patients

For the protection of patients and the medical and nursing staff at the Medical Center precautions to be taken in the care of the potentially suicidal patient include:

1. Any patient known or suspected to be suicidal in intent shall be stabilized and transferred to a medical center with an inpatient psychiatric unit; or

2. When transfer is not possible, the patient may be admitted to a general area of the Medical Center and as a temporary measure, special companionship provided. Such patients should spend the daytime hours in the area where special observation and therapy are available. Any patient known or suspected to be suicidal must have consultation by a member of the psychiatric staff. Transfer of potentially suicidal patients shall be undertaken as soon as circumstances permit according to department policies.

C. Restraints

Special treatment procedures such as the use of restraints shall follow the Medical Center’s policy on Restraints.
MEDICAL RECORDS / PATIENT HEALTH INFORMATION

I. PURPOSE

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 the patient. The confidentiality, use and disclosure of protected health information contained in medical records is addressed in the Medical Center’s Use and Disclosure Policy.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

IV. POLICY

A. General Requirements

1. Form

Where available, caregivers, physicians, and other authorized to record in the medical record shall use electronic documentation tools provided by Aurora. When electronic documentation tools are not available, it is permissible to use paper forms and records. All handwritten entries must be made with a black ink (pencils and felt tip pens are not permitted). Every page included in a medical record must be clearly labeled with the patient’s complete name and assigned medical record number.

2. Authority to Make Entries

Only those individuals authorized by Aurora may make entries into a patient’s medical record and must do so only through a password-protected electronic system, or on approved Medical Record forms.

3. Legibility

All handwritten entries in the medical record must be legible in order to prevent medical errors or other adverse events.

4. Date, Time, Authentication and Co-Signature

(a) Date, Time, Authentication. All medical record entries must be dated and authenticated (by written signature, identifiable initials (i.e., where a log exists that
cross-references the signer’s full name), computer key, or other code) by the individual who made the entry. A medical record entry may not be authenticated by use of a rubber stamped signature. All medical record entries in the Medical Center must also be timed. 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) 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.

5. Use of Copy/Paste and Carry Forward

Information created by using copy/paste or carry forward functionality in the electronic health record is not allowed.

6. 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) Include the current date and time (i.e. 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) Validate the source of additional information as is feasible in the case of omissions (i.e. document where you obtained the information to write the late entry). For example, use of supporting documentation on other Medical Center worksheets or forms; and

(e) Be made as soon as possible to ensure reliability.

7. Completeness

All entries in the medical record must be complete. In general, 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 and billed; (d) document the course and results of care, treatment and services; and (e) promote continuity of care among providers. Requirements for specific content vary by the type of entity and/or service being provided. All medical records must be completed within thirty (30) days after the patient’s discharge.

8. Symbols and Abbreviations

A list of unacceptable abbreviations, acronyms, symbols and dose designations shall be identified and approved. Only those symbols, abbreviations, acronyms and dose designations not on such list may be used.
9. Correction of Errors

(a) Correcting Electronic Errors. When an error needs to be corrected or a change needs to be made to an electronic medical record entry, the change shall be made through the electronic system and the following principles 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 must communicate the correction to the original author when feasible.

ii. Entries that have already been authenticated by the author shall be addended, in order to preserve the history of the information that was changed, unless editing functionality is available that clearly displays the original and revised information.

iii. Documentation electronically filed to the incorrect patient’s medical record shall be displayed in a manner that protects the privacy of the patient to whom the information belongs while avoiding misunderstanding for the care of the patient being seen or treated.

(b) Correcting Handwritten Errors. When an error needs to be corrected or a change needs to be made to a handwritten medical record entry, the following principles 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 when feasible.

ii. The original entry must not be altered nor obliterated by blacking out with marker, using white out, writing over an entry, or otherwise obscuring the original text of the entry; rather, a line must be drawn through the entry, making sure the original information is still legible.

iii. The correction must be signed or initialed, timed and dated and must include the reason for the error.

(c) Alterations/Corrections Requested by the Patient. Refer to the Medical Center’s Confidentiality/Information Privacy Policy for requirements regarding corrections or addenda to a medical record requested by a patient or a patient’s representative (i.e. amendment requests.)

B. 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) and any additional required documentation as may be described in Departmental policies.

1. General Requirements

The medical record must contain information such as notes, documentation, records, reports, recordings, images, scans, films, test results, and assessments to: (a) identify the patient and document relevant demographics; (b) justify admission; (c) justify continued hospitalization or treatment; (d) support the diagnosis; (e) describe the patient’s progress; and (f) 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. The medical record must also provide documentation that supports the charges on the billing claim.

2. **Specific Requirements**

Each Aurora entity and/or department that maintains and/or contributes to a medical record must be aware of, adhere to, monitor, and enforce requirements as set forth by federal and state laws and regulations, Medicare and Medicaid coverage decisions, and by accreditation agencies. In general, the Health Information Services department or function within the Aurora entity, shall oversee compliance with medical record requirements.

3. **Demographic/Identification Information**

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.

4. **Time and Means of Arrival**

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 or 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.

5. **Advance Directives**

The medical record must contain copies of any advance directives as specified in the Medical Center’s Advance Directives Policy.

6. **Allergies**

The medical record must identify the existence of any allergies to food, medications, latex, or other substances.

7. **Medications**

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: (a) used by the patient prior to arrival; (b) ordered, prescribed or administered after the patient’s arrival; and (c) dispensed or prescribed on discharge.

8. **Emergency Department Records**

The Emergency Department Record must be completed immediately for all admitted patients. All other records are preferentially completed during the same shift, but no later than 48 hours following the date of service.

The following information will be found in the Emergency Department Record:

(a) Pertinent history of illness or injury, physical findings;

(b) All emergency care received prior to arrival (ambulance record);

(c) Diagnostic and therapeutic orders;

(d) Clinical observations including result of treatment;
(e) Reports of procedures carried out;

(f) Diagnostic impression and disposition of patient at discharge or transfer; and

(g) Discharge instructions

9. 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.

10. Progress Notes

(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 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 or 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 co-signature requirements listed in Section 1.4 of this policy.

(b) Need for Continued Hospitalization. The medical records must contain documentation describing the need for continued hospitalization after specific periods of stay. 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) and all patient reassessments and clinical observations with response to the care provided. This documentation may also contain: The estimated period of time the patient shall need to remain in the Medical Center; plans to provide access to appropriate educational services for each child/adolescent patient when treatment necessitates a significant absence from school; and plans for post-hospital care which meet the identified needs of the patient and availability of appropriate services.

11. Practitioner Orders

Refer to the Medical Center’s CPOE Policy.

12. 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. Interpretations of imaging reports shall be dictated and shall be signed by a qualified physician or another individual authorized by the Medical Staff to interpret the image.

13. Consultation Reports

The attending practitioner is primarily responsible for requesting a consultation when indicated and for calling a qualified consultant and will provide written authorization to permit another attending practitioner to attend or examine his or her patient. 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.
Consultation reports shall contain evidence of a review of the patient’s record, pertinent finds, and the consultant’s opinion and recommendation and shall be made part of the patient’s record. A limited statement such as “I concur” does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall (except in emergency situations so verified on record) be recorded prior to the operation.

14. 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.

15. 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.

(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.

(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: (i) prior to any non-emergency surgery, or any inpatient procedure requiring anesthesia services, or (ii) within twenty-four (24) hours of the patient’s admission, whichever occurs first.

(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).

Outpatient operative or invasive procedures and/or moderate sedation (problem focused history and assessment) must include:

i. Indications for the procedure;

ii. Current medications and dosages (or state none);

iii. Allergies, include medication reactions;

iv. Co-morbid conditions;

v. Evaluation of procedural site;

vi. Exam of heart and lungs by auscultation (required only for cases with planned conscious sedation); and

vii. Evidence of informed consent (if applicable)

Medical outpatients or outpatients undergoing an operative or invasive procedure with local anesthetic (problem focused history and assessment) must include:
i. Indications for the procedure;

ii. Mental status;

iii. Exam specific to the procedure being performed;

iv. Co-morbid conditions;

v. Evaluation of procedural site;

vi. Exam of heart and lungs by auscultation (required only for cases with planned conscious sedation);

vii. Evidence of informed consent (if applicable)

(e) Normal Newborn Combined Summary and Assessment (H&P). A single, combined note that contains all required elements of an admission H&P and Discharge Summary for any newborn that meets the definition of a “normal newborn” is acceptable. Normal newborn is defined as: A healthy newborn that does not require a second physician examination. The final decision of the health of the newborn is the physician’s clinical judgment. However, the following criteria should apply:

i. 37 or greater weeks gestational age;

ii. May have been delivered via cesarean section or vaginally with or without instrumentation;

iii. Normal vital signs on day of discharge;

iv. Normal glucose hemeostasis;

v. Normal pulse oximetry screening (if done);

vi. Normal feeding, stooling, and voiding patterns;

vii. Appropriate screening and management of jaundice;

viii. Appropriate parent/guardian disposition and follow-up physician identified

(f) 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 clinical status. A complete H&P shall be performed and recorded as soon as possible.

(g) 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 on 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 or her clinical judgment, based upon his or 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 or 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: (i) after registration and prior to any non-emergency surgery, or any inpatient or outpatient procedure requiring anesthesia services, or (ii) 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 as indicated in Section 1.4 of this Policy. The co-signing Physician accepts responsibility for the content of the pre-admission H&P and the updated H&P.

(h) 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.

(i) 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.

(j) Consultation and Co-Signature Requirements.

   i. Dentists, Podiatrists, and 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 privileges 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). 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, it shall be reviewed and co-signed as indicated in Section 1.4 of this Policy. The co-signing Physician accepts responsibility for the content the H&P.

16. Pre- and Post-Procedure Documentation

(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).
(b) Procedure (Operative) Report.

i. The performing Practitioner must either:

- Enter or dictate 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); or
- Enter a progress note immediately after the procedure and dictate or write a full procedure report within twenty-four (24) hours of the procedure; or
- Accompany the patient from the procedure room to the next unit or area of care, and enter or dictate a full procedure report in the new unit or area of care.

ii. The full procedure report must be signed by the performing Practitioner and must include the following information:

- 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;
- As applicable: 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;

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.

17. Anesthesia Evaluations and Reports
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 privileging criteria for applicable co-signature requirements.

(a) **Pre-Procedural 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 and 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.

(d) **Post-Procedural 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.

18. **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. Refer to the Medical Center’s Policy(ies) regarding anatomical gifts.

19. **Maternity and Newborn Records**

(a) **Prenatal Findings.** Except in an emergency, before a maternity patient may be admitted, 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.

(b) **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.

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

20. **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.

21. 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.

22. 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.

23. 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.

24. 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.

25. 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.).

26. 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.

27. 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.

28. Ongoing Ambulatory Care Services

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.

C. Medical Record Audits

The Medical Center 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.

D. 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 Member 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, eff. October 17, 2008)
42 CFR § 482.24 (Interpretive Guidelines, eff. October 17, 2008)
42 CFR § 482.51 (Interpretive Guidelines, eff. October 17, 2008)
42 CFR § 482.52 (Interpretive Guidelines, eff. October 17, 2008)


Joint Commission: 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)

Review Dates: 10/2014; 02/2015
GENERAL RULES REGARDING OBSTETRICAL CARE

I. PURPOSE

It is the policy of the Medical Staff to provide consistent obstetrical care.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

IV. GENERAL RULES

A. Consultations – Complicated Cases

Consultation is appropriate in all complicated obstetrical cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized.

B. Sterilization

The operation for sterilization of either male or female patients shall be done only under such circumstances as may be outlined by Wisconsin law. A sterilization consent form shall be signed prior to surgery by the patient and dated with a calendar day and year and the hour. The consent form shall be witnessed and shall be filed in the patient's medical record at the time of admission.

(a) Minors and Incompetent Adults. Sterilization shall not be performed on minor or incompetent adult patients regardless of whether the consent of the parents or guardian of the minor, or the consent of the guardian of the incompetent adult has been obtained, until the procedure is authorized by the Medical Center President after seeking legal advice.

(b) Medicaid Patients. The following requirements must be met before a non-emergent, non-therapeutic sterilization is performed on a Medicaid patient:

   i. The patient must be at least twenty-one (21) years old;

   ii. The patient must be mentally competent to give consent to the procedure and must not be institutionalized;

   iii. The patient must have voluntarily given informed written consent to the procedure;
iv. Except in cases of emergency abdominal surgery or premature delivery, the
procedure must be performed during the period commencing thirty (30) days
after the patient’s consent was obtained and ending one hundred-eighty (180)
days after consent was obtained. In cases of emergency abdominal surgery,
sterilization must be performed at least seventy-two (72) hours after consent was
given. In cases of premature delivery, sterilization consent must have been
obtained at least seventy-two (72) hours prior to the performance of the
procedure and at least thirty (30) days prior to the expected date of delivery.

v. The patient must be informed of the following prior to consenting to the
sterilization procedure:

1) Advice that the patient is free to withhold or withdraw consent to the
procedure at any time before the sterilization without affecting the right to
future care of treatment and without loss or withdrawal of any federally
funded program benefits to which the patient might be otherwise entitled;

2) A description of available alternative methods of family planning and birth
control;

3) Advice that the sterilization procedure is considered to be irreversible; and

4) Advice that the sterilization will not be performed for at least thirty (30) days
except possibly in the case of a premature delivery or an emergency
abdominal operation.

vi. The consent of the patient must be documented on the Department of Health and
Family Services Sterilization Consent Form.

(c) Abortions. See System Policy General Rules Regarding Abortions.

Review Dates: 10/2014
I. PURPOSE

It is the policy of the Medical Staff to provide consistent surgical care.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

IV. GENERAL RULES

A. Pre-Operative Diagnosis – Test Prior to Surgery

Except in emergencies, the pre-operative diagnosis and appropriate laboratory tests must be recorded on the patient’s medical record prior to any surgical procedure. If not recorded, the operation shall be cancelled. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient’s condition prior to induction of anesthesia and start of surgery.

The prenatal history taken at the physician’s office and the limited physical exam as written on the labor notes shall constitute an acceptable history and physical as required by the Medical Staff Bylaws for maternity patients requiring surgery.

B. Dentist-Physician Duties

A dentist with clinical privileges may, with the concurrence of an appropriate physician member of the Medical Staff, initiate the procedure for admitting a patient. This concurring Medical Staff member shall assume responsibility for the overall aspects of the patient’s care throughout the stay at the Medical Center, including the medical history and physical examination. Patients admitted to the hospital for dental care must be given the same basic medical appraisal as patients admitted for other services.

(a) Dentist’s Responsibilities:

i. A detailed dental history justifying Medical Center admission and need for performing procedure under general anesthesia;

ii. A detailed description of the examination of the oral cavity and a pre-operative diagnosis;

iii. A complete operative report, describing the findings and techniques. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and
fragments removed and count shall be corroborated by surgery staff. All tissue, excluding teeth and fragments, shall be sent to the Medical Center pathologist for examination;

iv. Progress notes as are pertinent to the oral condition; and

v. Clinical resume (or summary statement).

(b) Physician’s Responsibilities:

i. Medical history pertinent to the patient’s general health;

ii. A physical examination to determine the patient’s condition prior to anesthesia and surgery; and

iii. Supervision of the patient’s general health status while hospitalized.

(c) Admission: A patient admitted for dental care is a dual responsibility involving the dentist and physician member of the Medical Staff.

(d) Discharge: The discharge of the patient shall be on written order of the dentist member of the Medical Staff.

(e) Dentists with surgical privileges will follow the method of patient management as listed above. Admission is detailed in an earlier section. The discharge of the patient shall be on the written order of the dentist member of the Medical Staff.

C. Podiatrist Duties

A podiatrist with clinical privileges may, with the concurrence of an appropriate physician member of the Medical Staff, initiate the procedure for admitting a patient. This concurring Medical Staff member shall assume responsibility for the overall aspects of the patient’s care throughout the Medical Center staff, including the medical history and physical examination. Patients admitted to the Medical Center for podiatric care must be given the same basic medical appraisal as patients admitted for other services.

(a) Podiatrist’s Responsibilities:

i. A detailed history justifying Medical Center admission and need for performing procedure under general anesthesia;

ii. A detailed description of the examination of the extremity involved and a pre-operative diagnosis;

iii. A complete operative report describing the findings and techniques;

iv. Progress notes as are pertinent to the condition; and

v. Clinical resume (or summary statement).

(b) Physician’s Responsibilities:

i. Medical history pertinent to the patient’s general health;

ii. A physical examination to determine the patient’s condition prior to anesthesia and surgery; and

iii. Supervision of the patient’s general health status while hospitalized.

(c) Admission: A patient admitted for podiatric care is a dual responsibility involving the podiatrist and physician member of the Medical Staff.
(d) **Discharge**: The discharge of the patient shall be on written order of the podiatrist member of the Medical Staff.

(e) Podiatrists with surgical privileges will follow the method of patient management as listed above. Admission is detailed in an earlier section. The discharge of the patient shall be on the written order of the podiatrist member of the Medical Staff.

D. **Patient’s Consent to Surgery**

Written, signed, and informed surgical consent shall be obtained prior to any operative procedure, except in those situations wherein the patient’s life is in jeopardy and written consent cannot be obtained due to the condition of the patient. In emergencies involving a minor for whom consent for surgery cannot be immediately obtained from parent(s) or a legal guardian, the circumstances should be fully explained on the patient’s medical record. If time permits, a consultation in such instances may be desirable before the emergency operative procedure is undertaken.

A separate written, informed consent shall be obtained for each surgical procedure performed on a patient. If it is known prior to surgery that two (2) or more specific procedures are to be carried out at the same time, they may all be described and consented to on the same form.

E. **Anesthesia**

The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic assessment and post-anesthetic follow-up of the patient’s condition. There shall be a physician’s written pre-anesthesia assessment, or his or her acceptance of, and countersigning of the anesthesia department’s evaluation.

Orders for anesthesia medications shall be written by the certified registered nurse anesthetist (CRNA) and signed by the attending physician. For those CRNAs with Advanced Practice Nurse Prescriber (APNP) certification, a physician need not countersign as prescriptive authority is granted in accordance with Wisconsin State Statute 441.16.

F. **Unusual Surgical Hazards – Assistance**

An assistant surgeon is recommended to be present for all major surgical procedures, but the ultimate decision for the need for a surgical assistant remains with the operating surgeon. In any case, an assistant surgeon can be used at the surgeon’s discretion.

G. **Tissue Removed – Examination**

The tissue removed during a surgical procedure shall be handled in accordance with the current established Pathology and Laboratory Guidelines. The Medical Center pathologist shall examine the tissue within the established policy and procedure to arrive at a tissue diagnosis.

H. **Admission Time**

Except in cases of emergency, patients being admitted for elective surgery shall present to the Medical Center in a timely manner, not less than two (2) hours prior to surgery, or as instructed.

I. **Patient Safety Considerations**

1) Surgical site will be marked involving the patient;

2) A time out to verify correct patient, correct procedure, and correct site will be taken; and

3) Conduct pre-operative verification procedure using checklist to confirm all documents are there.

**Review Dates:**
GENERAL RULES REGARDING EMERGENCY SERVICES

I. PURPOSE

It is the policy of the Medical Staff to provide consistent emergency services.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

IV. GENERAL RULES

A. Medical Coverage

The Medical Staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accord with the Medical Center’s basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care. The professional activities committee or other special committee created for this purpose shall have overall responsibility for the quality of emergency medical care. Participation in emergency room back-up call or other specialty coverage programs is required for Active Medical Staff members and is optional for Courtesy Medical Staff members. Refer to the Medical Center’s On Call Coverage and Response Policy.

B. Define Duties and Responsibilities of All Personnel

The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to the Medical Center.

C. Appropriate Medical Records

An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient’s hospital record if such exists. Refer to the Medical Center’s Medical Records/Patient Health Information Policy.

D. Physician Signature

Each patient’s medical record shall be signed, dated and timed by the attending practitioner that is responsible for its clinical accuracy. Refer to the Medical Center’s CPOE and Medical Records/Patient Health Information Policies.
E. Emergency Room Review of Records

There shall be a systematic review of emergency room medical records to assess quality of emergency medical care. Reports shall be submitted to the Utilization Review Committee of the Medical Staff as designated. Medical records will first be reviewed for the adequacy as medical documents. If the contents reasonably reflect what has transpired, the review committee will then utilize them for QI purposes. In addition, the records of all patients dying within twenty-four (24) hours of admission to the emergency service area shall be routinely reviewed.

F. Mass Casualty Plan Criteria

There will be a plan for the care of mass casualties at the time of any major disaster, based upon the Medical Center’s capabilities, in conjunction with other emergency facilities in the community. It will be developed by the Medical Center’s Administration and approved by the Medical Staff and Governing Body.


The disaster plan will make provisions within the Medical Center for:

(a) Availability of adequate basic utilities and supplies including gas, water, food, and essential medical and supportive materials;

(b) An effective system of notifying and assigning personnel;

(c) Unified medical command under the direction of a designated physician (the chairman of the committee or designated substitutes);

(d) Conversion of all usable space into clearly defined areas for efficient triage for patient observation and for immediate care;

(e) Prompt transfer, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care;

(f) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty patient as he or she is moved;

(g) Procedures for the prompt discharge or transfer of patients in the Medical Center who can be moved without jeopardy;

(h) Maintaining security in order to keep relatives and curious persons out of the triage area; and

(i) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will help to provide organized dissemination of information.

H. Mass Casualty Physician Assignments and Policy Responsibility

All physicians will be assigned to posts (either in the Medical Center or in the auxiliary hospital or in mobile casualty stations). The assigned physician in the Medical Center and the Disaster Coordinator will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Medical Center to another or evacuation from the Medical Center premises, the assigned physician during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the Chief of Staff and the Director of Patient Care Services. In their absence, the Vice President of the Medical Staff and alternate in Administration are next in line of authority, respectively.
I. Mass Casualty Plan Rehearsals

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

Review Dates:
CONFLICT MANAGEMENT

I. PURPOSE

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.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. 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.

IV. Informal Conflict Management

1. Generally

Most Conflict situations can be informally resolved in a manner consistent with the Medical Center’s values and Code of Conduct.

2. Informal Process

Individuals and/or groups involved in a Conflict and other stakeholders will participate in the informal Conflict Management process by:
(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 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 V 2(a)).

V. Formal Conflict Management

1. Generally

Situations 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.

2. Formal Process

Formal Conflict resolution 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 President, 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 to 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 in managing the Conflict. External facilitators (including mental health, legal or human resource professionals) 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;
   
   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.
Conflict Management Checklist

1. Identify who will participate in the Conflict Management process. Participants necessary to the management of the Conflict may include not only the individuals engaged in the Conflict, but also their supervisors or others who may be affected by the Conflict or its consequences. (For example, a dispute between administration and Physicians may affect the finances and mission of the Medical Center to the extent that the Governing Body should be represented in the Conflict Management).

2. Review and distribute to all participants the applicable Medical Center policies, documents, bylaws, or other materials, including the Medical Center’s Conflict Management Policy.

3. Gather facts relating to the Conflict. Consider whether to request written materials from the participants, in the form of either a statement of facts or a position statement.

4. Advise participants to be prepared to discuss the Conflict and to obtain the appropriate organizational authority to move the process forward, if not to fully settle all relevant issues related to the Conflict.

5. Schedule the place, date, time and duration of the Conflict Management session(s).

6. Explain the role of the Facilitator. The Facilitator:
   a. Is neutral as to the process;
   b. Will guide the discussion, balance the participation of all the participants, model mutual respect and integrity for the participants, and help the participants work towards resolution of the Conflict;
   c. Will emphasize the importance of confidentiality within the process to promote candor and the effectiveness of the process, but will not guarantee confidentiality due to the need to be ultimately accountable to the Medical Center; and
   d. May use various techniques such as caucusing (dividing like-minded participants into separate groups to clarify or modify their position in response to an offer from the other side), “homework assignments” (i.e. re-writing a policy, rule, or bylaw to address the situation giving rise to Conflict so that it can be considered at a subsequent session), and other methods the Facilitator deems appropriate.

7. Outline the expectations of participants. The participants will:
   a. Demonstrate mutual respect during the process;
   b. Cooperate in good faith with the intervener;
   c. Focus on facts and advocate in a reasoned and civil manner;
   d. Attempt to define and narrow issues; and
   e. Try to view issues with an open mind or from a different perspective.

8. Provide to the participants either an oral or written summary of what was accomplished (“the outcome”) during the Conflict Management session. The summary could include additional facts, definition or clarification of issues, agreement on options for resolution, agreement to meet again, or the barriers to reaching resolution.

9. Obtain responses (oral or written) to the summary from the participants.

10. Assist with implementation of the outcome as appropriate.

11. Ensure ongoing communication with the Medical Center’s senior leadership regarding the process, participants, and outcome.
1. PURPOSE
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.

2. SCOPE
This policy applies to Medical and Advance Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

3. ONGOING AVAILABILITY
Each Staff Member shall assess 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 the Staff Member’s patients when the Staff Member is unavailable.

4. DESIGNATION OF ALTERNATE STAFF MEMBERS

4.1 Name of Alternate Must Be On File. Each Medical Staff Member with Clinical Privileges shall have on file in the Medical Staff Office the name of his or her current alternate.

i. Limited Exemption for Certain Specialties: In the event a Medical Staff Member practices in a specialty with two or fewer total Medical Staff Members within such specialty, the Medical Staff Member shall be exempt from the requirement to keep the name of an alternate on file with the Medical Staff Office. However, such Medical Staff Members are not exempt from the requirement to name an alternate when the Medical Staff Member has patients at the Medical Center and knows he or she will be out of town or otherwise unavailable.

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

i. 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 Physician who has the capabilities to determine the appropriate care for the patient and/or facilitate transfer;

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

iii. Is qualified to provide any required emergency medical treatment or services and interventional treatment or services to the Staff Member’s patients;
iv. 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

v. 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.

vi. 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.

vii. 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.

5. 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 Medical Center President, 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)

CROSS REFERENCES:

OWNER: Medical Staff Office

REFERENCES: Joint Commission Standard

PRIOR REVIEW / REVISION DATES: 7/29/2013;
EMERGENCIES AT OFF-CAMPUS LOCATIONS

I. PURPOSE

It is the policy of the Medical Staff that all off-campus hospital locations provide initial assessment and treatment of emergencies to the extent possible, with referral as warranted.

II. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

III. DEFINITIONS

ACLS is defined as Advanced Cardiac Life Support.
AED is defined as Automated External Defibrillator.
BLS is defined as Basic Life support.
Medical Center is defined as Aurora Medical Center – Manitowoc County.
Off-Campus: An outpatient hospital department not located within the hospital building.
Staff Member is defined according to current Bylaws definition.

IV. PROCEDURE

A. Responding to a Medical Emergency – Medical Emergency Code Blue Outside an Aurora Building but on Aurora Property (including a parking lot, sidewalk, etc.).

1. Call for help
   a. Call for help to any bystanders
   b. Ask someone to call 911 to activate local EMS
   c. Ask bystander to obtain AED (AED in the Medical Center is located behind the Information Desk at the main entrance).
2. Begin BLS and incorporate AED use when it arrives
3. Coordinate efforts with local EMS to transport victim as soon as possible
4. Incorporate ACLS protocols when in Emergency Department with use of crash cart and ACLS certified staff members.

B. Responding to a Medical Emergency – Medical Emergency Code Blue in an Outpatient Hospital Department Not Located Within the Hospital Building (including a parking lot, sidewalk, cafeteria, gift shop, etc.).
Departments/Facilities Included:
- Aurora Health Center, 5300 Memorial Drive, Two Rivers, WI departments of:
  - Radiation Oncology
  - Diabetes Education
  - Rehabilitation
- Aurora Rehabilitation Center – Dewey Street, Manitowoc, WI facility
- Aurora Rehabilitation Center – State Street, Manitowoc, WI facility
- Aurora MRI Services of the Medical Center – 10th Street, Manitowoc, WI facility

1. Call for help
   a. Call for help to any bystanders
   b. Ask someone to call 911 to activate local EMS
   c. Ask someone to obtain AED, pocket mask, and/or ambu bag
2. Begin BLS and incorporate AED use when it arrives
3. Coordinate efforts to transport victim when EMS arrives

C. Responding to a Medical Emergency – Medical Emergency Code Blue at the Aurora Surgery Center (including the parking lot, cafeteria, etc.).

1. Call for help
   a. Call for help to any bystanders
   b. Ask someone to call 911 to activate local EMS
   c. Ask bystander to obtain the crash cart
2. Begin BLS and incorporate ACLS protocols as appropriate to the patient’s condition
3. Coordinate efforts to transport victim when EMS arrives

Cross References:  Medical Emergency Code Blue – Policy PCS-232
                    EMTALA – Policy #179

Owner:             Medical Staff
References:        Centers for Medicare and Medicaid (CMS) (2014) 482.12(f) 3
                   The Joint Commission (2014) MS.03.01.01, EP 14

Review Dates:      
MEDICAL STAFF COMMITTEES

1. PURPOSE

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.

2. SCOPE

This policy applies to all Medical and Allied Practice Professional Staff members of Aurora Medical Center – Manitowoc County.

3. DEFINITIONS

Medical Center is defined as Aurora Medical Center – Manitowoc County.

4. PRACTITIONER HEALTH COMMITTEE

4.1. Composition

The Practitioner Health Committee shall be composed of three (3) to five (5) members of the medical staff appointed by the Medical Executive Committee, one of who shall be appointed as the chairperson. Individual members of the Practitioner Health Committee shall serve a two (2) year term unless the Medical Executive Committee specified otherwise at the onset of the individual's appointment of the Practitioner Health Committee.

4.2. Functions

The functions of the Practitioner Health Committee shall be:

4.2.1 Education of the Medical and Allied Practice Professional Staff about illness and impairment recognition issues specific to practitioners;

4.2.2 Address prevention of physical, psychiatric, emotional illness, or chemical dependency among practitioners;

4.2.3 Facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition as more specifically set forth in Medical Staff policy MS-014, Practitioner Health Committee; and
4.2.4 Consult with internal and external specialists and resources and make referrals to same, as it deems necessary to carry out its functions.

4.3. Meetings

The Practitioner Health Committee shall meet as necessary and shall make reports to the Medical Center President and Chief of Staff. The Practitioner Health Committee shall not make reports to the Medical Executive Committee except as necessary to pursue a corrective action, including summary suspension, when (i) it is believed that the practitioner is unable to safely perform the clinical privileges he or she has been granted, (ii) the impairment requires that action be taken immediately in the best interest of patient care, or (iii) the practitioners fails to reach or comply with an agreement with the Practitioner Health Committee regarding a program of treatment and recovery.

4.4. Quorum

A quorum shall consist of voting members in attendance. Per Medical Staff Bylaws, the chairperson of a Medical Staff Committee may vote.

5. INFECTION PREVENTION AND CONTROL COMMITTEE

5.1. Composition

The Infection Prevention and Control Committee is an interdisciplinary medical staff professional activities committee, which oversees activities related to the surveillance, prevention and control of infections. Membership includes representation from Medical Staff, Administration, Nursing, Surgery, Lab, Employee Health, Environmental Services, Plant Operations, Pharmacy, and Public Health. The Chairperson of the Infection Prevention and Control Committee is a member of the Medical Staff and appointed by the Medical Executive Committee. The Infection Prevention and Control Committee works in collaboration within the Aurora Health Care System Infection Prevention Charter to ensure system initiatives are implemented.

5.2. Objectives

The objectives of the Infection Prevention and Control Committee shall be:

5.2.1 Review and approve annual surveillance plan and methodology, including criteria and goals;

5.2.2 Review and approve policies and procedures related to the surveillance, aseptic technique, sterilization and disinfection, prevention and control of infections (DHS 124.08 2(c)3);

5.2.3 Prepare for response to an influx of potentially infected patients (IC.01.06.01);

5.2.4 Review surveillance data to identify any trends and make recommendations for improvements;

5.2.5 Initiate control measures in the event of a suspected or confirmed cluster/outbreak; and

5.2.6 Ensure needed resources are allocated for the Infection Prevention and Control program (IC.01.02.01).
5.3 Meetings

The Infection Prevention and Control Committee shall meet as required to accomplish its duties.

5.4 Quorum

A quorum shall consist of voting members in attendance. Per Medical Staff Bylaws, the chairperson of a Medical Staff Committee may vote.

6. MEDICAL EXECUTIVE COMMITTEE

Refer to the Medical Staff Bylaws.

7. PERFORMANCE IMPROVEMENT COUNCIL

7.1 Composition

The Performance Improvement Council shall be composed of two (2) members of the Medical Staff, Site President, Chief Nursing Office, Chief Clinical Services Officer, and the Director of Quality. The Performance Improvement Council shall be chaired by an active member of the Medical Staff.

7.2 Responsibilities

Responsibilities include, but are not limited to:

7.2.1 Annual review and selection of key performance indicators, which demonstrate the overall quality of care and services and comply with accrediting agencies;

7.2.2 Initial prioritization/logging and final review of all facility-wide performance improvement projects;

7.2.3 Review and approval of work done by the Data Analysis Team, Stroke Steering Committee, Ortho Steering Committee, Emergency Preparedness Committee, and Trauma Committee;

7.2.4 Ensure that at least one proactive risk assessment is conducted at least every 18 months (Failure Mode and Effects Analysis – FMEA);

7.2.5 Review of action plans created from root cause analysis activities and approved by System Risk Management/RCA Event Committee; and

7.2.6 Forward meeting minutes and other pertinent information to the Medical Executive Committee.

7.3 Meetings

The Performance Improvement Council shall meet as required to accomplish its duties.

7.4 Quorum

A quorum shall consist of voting members in attendance. Per Medical Staff Bylaws, the chairperson of a Medical Staff Committee may vote.
8. CASE MANAGEMENT COMMITTEE & UTILIZATION REVIEW COMMITTEE

8.1 Composition

The following individuals shall be designated by the Medical Executive Committee to serve as the Case Management Committee/Utilization Review Committee:

8.1.1 The Director of Quality; and

8.1.2 At least three (3) Medical Staff members, including at least two (2) physicians (MD or DO).

Utilization Review Committee members may not have an ownership interest in the Medical Center. The Medical Executive Committee shall designate one (1) Utilization Review Committee physician to serve as the chairperson.

Individuals from both within and outside the Medical Center may serve as consultants to the Utilization Review Committee to provide expertise as required for the Utilization Review Committee to perform its duties properly. Such consultants may advise the Utilization Review Committee, but may not serve as a voting member of the Utilization Review Committee. Examples of consultants include: Hospital President; Patient Care Managers and Supervisors (ICU, Medical/Surgical); Director, Patient Care Services/CNE Chief Nursing Officer; Social Workers; Health Information Services Manager; Coding Manager; System RAC Coordinator; Quality Director; and contracted physician advisory services.

8.2 Duties and Responsibilities

The duties and responsibilities of the Case Management Committee/Utilization Review Committee shall include, but are not limited to:

8.2.1 Oversee utilization review activities, including review with respect to the medical necessity of: (i) inpatient admissions; (ii) continued stays; (iii) extended stays; and (iv) certain professional services; all as more specifically described in the Medical Center’s Utilization Review Plan and the Care Management/Quality/Clinical (Patient Safety Plan);

8.2.2 Work in collaboration with other individuals and committees responsible for utilization review, quality, and focused and ongoing professional practice evaluations to ensure that any delays in the provision of services and potential safety and quality problems that need further evaluation, investigation, or intervention are promptly addressed;

8.2.3 Make regular reports to the Board of Directors, Medical Executive Committee, Hospital President, and the Performance Improvement Council, including documentation of findings and recommendations and specific actions taken to correct undesirable practice patterns or other utilization review problems, and evaluations of the effectiveness of such actions;

8.2.4 Immediately refer a case for peer review or corrective action if a potential quality issue is identified during any utilization review activity. Depending on the type of problem and its urgency, the Hospital President may also be notified; and
8.2.5 Immediately refer potential risk management issues identified during the performance of any utilization review activity to the Risk Manager.

8.3 Meetings

The Case Management Committee/Utilization Review Committee shall meet as needed at the call of its chairperson, but in no event less than twice annually, to fulfill its duties and responsibilities.

8.4 Quorum

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

8.5 Conflict of Interest

No person will participate in the utilization review of any case in which such person has been directly or indirectly involved in the provision of care to the patient whose case is being reviewed or who has a direct financial interest (for example, an ownership interest) in the Medical Center or any other hospital.

Cross References:  Practitioner Health Committee Policy MS-014, Infection Prevention and Control Program Structure (Policy INF-102), Medical Staff Bylaws, AMCMC Organizational Performance Improvement Plan, Case Management Committee & Utilization Review Plan Policy,

Owner:  Medical Staff Services Office

References: 

Review Dates:
Purpose

To define the medical staff mechanism to review a new procedure or treatment, which are not covered by an existing privilege delineation form and to establish a process to determine whether sufficient space, equipment, staffing and financial resources are in place or available within a specified period of time to support each requested privilege.

Scope

This policy applies to Aurora Medical Center Manitowoc County.

Definitions

Medical Center is defined as Aurora Medical Center – Manitowoc County.
Medical Staff is defined according to current Bylaws definition.

Policy

4.1 In General

A new procedure or treatment, which is not covered by an existing privilege delineation form, may not be performed without prior determination by the relevant department/service line, the Medical Executive Committee, and the Governing Body that the procedure or treatment would be appropriate to include among the services available to patient at the Medical Center. An application to perform a new procedure or treatment will not be processed until threshold criteria have been established defining the qualifications that an individual must possess to be eligible to request the clinical privilege(s) in question.

Procedures

5.1 Overview by Appropriate Parties

A. Prior to the establishment of a clinical privilege, the Medical Staff and the Medical Center will assure the following:

1. That criterion has been developed defining current competence for practitioners who may request the privilege;

2. That the setting in which the privilege may or may not be performed has been determined;

3. That the privilege is within the scope of services provided by the organization;

4. That appropriate policies, when necessary, have been developed to support the privilege;
5. That the organization has the appropriate equipment and supplies to support the privilege;

6. That the organization has an adequate number of qualified staff to support the privilege;

7. That the financial resources necessary to support the privilege have been committed; and

8. That the Medical Staff Office is informed regarding the potential new service in order to address clinical privilege revisions as appropriate.

5.2 Form Submission

A. A practitioner who is requesting that a new procedure or treatment be considered must submit the following information to the hospital prior to requesting the privilege(s) (use the attached form)

1. A description of the procedure or treatment, including the indications and contraindications for it.

2. A description of any new equipment or other resources that would have to be obtained, and/or any special support staff training or orientation that would have to be provided in connection with the new procedure or treatment.

3. A description of the results, complications, and other pertinent information reported in relevant scientific literature, with citations as appropriate.

4. A description of the background and training that should be required to qualify a practitioner for privileges to perform the procedure or treatment, with reference to scientific literature and other sources of guidance as appropriate, including other specialties that might also request these privileges.

5. A proposed monitoring and quality review plan to assess both the practitioner and the medical staff’s overall experience with the new procedure or treatment for a reasonable period or number of cases after it comes into use, taking into account anticipated results, comparative data from other institutions, and other relevant factors.

5.3 Approval Process

A. The appropriated designated group/individual shall consider the proposal and conduct such additional inquiries or proceedings as is deemed appropriate. This may include, among other options, consultation with outside experts, additional literature review, and/or presentation for general discussion at a department meeting or service line committee who is involved with privileging. The designated committee/department/group/individual shall make a written recommendation to the Medical Executive Committee, with relevant documentation.

B. The Medical Executive Committee shall review the recommendations and determine whether to recommend the new procedure or treatment to the Governing Body. If the Medical Executive Committee decides to recommend the new procedure or treatment, it shall develop threshold credentialing criteria based on the information provided and any additional research or consultation with experts, including those on the Medical Center’s Medical Staff and those outside the Medical Center. Based
thereon, the Medical Executive Committee shall develop recommendations regarding:

1. The minimum education, training, and experience necessary to perform the technique, procedure or service;

2. The extent of monitoring and supervision that should be required if privileges are granted; and

3. The criteria and/or indications for when the technique, procedure or service is appropriate.

The Medical Executive Committee shall then make a written recommendation to the Governing Body, which shall make a final decision.

C. Following the Governing Body’s approval of a new procedure or treatment, requests for privileges to perform it may be submitted by individual practitioners and processed in accordance with this Policy.

Cross References: Medical Staff Bylaws

Owner: Medical Staff Office

References:

Review Dates:
REQUEST FOR NEW PROCEDURE OR TREATMENT

To be completed by requesting physician (may be typed or clearly handwritten)

1. Name of requesting physician/date: ______ ______
2. New privilege to be considered: ______
3. SETTINGS – Note the care setting(s) at AMCMC where this privilege can be performed (include the Surgery Center if applicable):
4. DESCRIPTION – Describe the procedure or treatment, including the indications and contraindications: ______
5. EQUIPMENT – List any new equipment required, or write NA: ______
6. ADDITIONAL RESOURCES – List any additional resources required, or write NA: ______
7. HOSPITAL STAFF – List any training required for hospital, or write NA: ______
8. OUTCOME DATA – Describe any results, complications and/or other pertinent information reported in relevant scientific literature, with citations or attachments as appropriate:
9. TRAINING – Describe background and training required for qualifications to apply for this privilege (include any manufacturer guidelines, requirements and/or scientific literature and other sources of guidance as applicable). Check the following that apply:
   - hands on training
   - didactic course
   - proctoring
   - special certification
   - board certification
   - demonstration of previous performance (supervised, numbers performed, outcome)
10. PREVIOUS EXPERIENCE – List any previous organization/s where you had this privilege. Name/Mailing Address/Contact Phone Number: ______
11. PROCTORING/EVALUATION – Verify competence once practitioners are granted privileges to perform the new procedure or treatment; e.g., number of cases to be observed, retrospective review, etc. – please specify): ______
12. REAPPOINTMENT – Describe any requirements for privileging at reappointment that should be considered; e.g., minimum number to maintain competence over the past two years, CME, other. ______
13. MONITORING/PERFORMANCE REVIEW – Describe review plan to assess overall experience once implemented for evaluation of anticipated results, comparative data, and other relevant factors, including attaching any relative literature. ______

To be completed by the Department Director/Manager

1. Can this privilege be performed within the scope of services provided by this organization? YES ☐ NO ☐
2. Does the organization have or commit to the equipment and supplies necessary to support the privilege? YES ☐ NO ☐
3. Does the organization have or commit to the appropriate number of qualified staff to support privilege? YES ☐ NO ☐
4. Have the cost benefit analysis been completed and/or necessary financial resources been committed to support this privilege? YES ☐ NO ☐
5. Is Administration aware of proposed privilege/service and supportive of implementation? YES ☐ NO ☐

Date service is expected to be implemented: ______

If any of above answers is “No”, please explain: ______

PRINTED NAME: __________________________________________________________       DATE: ________________
SIGNATURE: __________________________________________________________
To be completed by the Medical Department Committee Chairperson

Determination:

☐ Considered part of existing privilege. Not necessary to add privilege to listing.
   If checked, list part of what existing privilege: 

☐ CORE privilege. To be added to “___” privilege form which does not require additional training/education.

☐ SUPPLEMENTAL privilege. To be added to “___” privilege form with defined criteria.
   ☐ Defined above ☐ Defined as above plus the following ___
   ☐ Defined as the following ___

Check One:

☐ I have reviewed all of the information for this privilege request, done any additional inquiries necessary, agree with the requirements stated with/without additional recommended criteria defined below and recommend approval of the privilege requested.

☐ I have reviewed all of the information for this privilege request, done any additional inquiries necessary, reviewed the requirements stated and DO NOT recommend approval of the privilege requested. Reason for non-recommendation: ___

____________________________________________   ___ ________________________
Chairperson Name and Title      Date

___________________________________________
Signature

Medical Executive Committee Action: ☐ Recommend ☐ Not Recommended Date: ____

Governing Board Action: ☐ Approve ☐ Not Approved Date: ____

Medical Staff Services Action:

Incorporate into privilege listing. Date: ____

Notify appropriate parties of action. Date: ____
I. **Purpose**

A. To define appropriate work-place behaviors.

B. To create a mechanism to call for help when threatening or abusive behaviors are perceived.

C. To create a positive work environment for all staff, free from intimidation, abuse or other disruptive conduct.

II. **Policy**

A. Definitions:

1. **Threatening or Abusive Behavior**: Behaviors in which non-verbal, verbal or physical conduct, because of its severity and/or persistence:
   
   a. Disrupt operations
   
   b. Affect ability of others to do their jobs
   
   c. Create a hostile or intimidating work environment
   
   d. Interfere with our individual ability to work competently

2. **Acceptable Professional Conduct**: CODE OF CONDUCT
   
   a. Treat all individuals with courtesy, dignity or respect.
   
   b. Work together as a team.
   
   c. Be fair and honest.
   
   d. Cooperate with patients in their care and with colleagues at all levels, recognizing that we need one another to reach our goals.
   
   e. Support an environment in which ideas and concerns may be expressed freely.
   
   f. Value difference of opinion, and when conflicts occur, deal with them directly and constructively.

3. **Unacceptable Professional Conduct**:

   a. Non-verbal, verbal or physical attacks leveled at other individuals, that are personal, irrelevant, or beyond the bounds of fair professional conduct.
b. Impertinent and inappropriate comments (or illustrations) made in patient medical record or other official documents, impugning the quality of care in the hospital, or attacking particular physicians, nurses or hospital policies.

c. Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.

d. Refusal to follow hospital policy or disruptive acceptance of hospital policy.

e. Disrespectful behavior of any kind ranging from inappropriate humor and subtle hints to overt acts, threats or physical contact.

f. Other behaviors perceived to be inappropriate.

g. Behaviors included but not limited to, the spectrum of disruptive behaviors:

   Aggressive
   Inappropriate anger, threats
   Yelling, publicly degrading team members
   Intimidating staff, patients, colleagues, etc.
   Pushing, throwing objects
   Swearing
   Outbursts of anger and physical abuse

   Passive Aggressive
   Hostile notes, emails
   Derogatory comments about institution, hospital, group etc.
   Inappropriate joking
   Sexual harassment
   Complaining, blaming

   Passive
   Chronically late
   Failure to return calls
   Inappropriate/inadequate chart notes
   Avoiding meetings and individuals
   Non-participation
   Ill-prepared, not prepared

B. Aurora Medical Center Manitowoc County shall be committed to providing a work environment that is free from harassment, intimidation and abuse, where dignity of every employee, physician and other individuals associated with the hospital is respected.

C. Behaviors perceived to be threatening, intimidating or abusive, will not be tolerated and will be dealt with immediately.

D. Anyone who feels threatened, harassed or abused is requested to tell the sender that this is an abusive situation and request that the behavior stop.

E. If the behavior does not stop, departmental staff may be called for help. If additional help is desired, Security Assistance may be called according to the Emergency Preparedness Plan.

F. The summoned help will go to the scene and render whatever assistance is appropriate.

G. All incidents of unacceptable professional conduct will be documented in the incident reporting system.

H. Risk Management will report incidents involving physicians to the Medical Staff President, Hospital President and Chief Medical Officer. The Hospital President, Medical Staff President and the Chief Medical Officer will take appropriate action according to the algorithm included. (Attachment I).

I. Incidents involving employees will be forwarded to the employee’s Manager for appropriate follow-up.
Medical Staff Member Unprofessional Conduct

This algorithm depicts the procedure to follow for reporting unprofessional conduct of Medical Staff Members.

1. **Report Filed**
2. **Enter into incident reporting system**
3. **Received by Risk Manager & investigates**
4. **Medical Director/Department Chair as appropriate**
5. **Notify Hospital President and Medical Staff President if unresolved**
6. **May speak to Medical Staff Member and decide it does not need to go to the Medical Executive Committee**

- **To MEC Executive Session**
  - **Unfounded**
    - No further action
  - **Founded**
    - **Significant Incident**
      - **First incident**
        - Yes: Discussion with Medical Staff Member initiated by Medical Staff President and/or Chief Medical Officer
          - A copy of the report and the outcome of the discussion will be filed in the Medical Staff Member file and will be considered at the time of reappointment.
        - No: Second incident
      - No: Multiple incidents on file
        - Second: Medical Staff President and/or Chief Medical Officer will discuss matter with Medical Staff Member.
          - Follow-up letter
          - Copy of letter and rebuttal filed in Medical Staff Member file.
        - Third: Final Letter provided verbally and in writing by Medical Staff President and/or Chief Medical Officer. Copy of letter will be filed in Medical Staff Member file.

Rev 12/16