

POLICIES GOVERNING MEDICAL PRACTICES

**AURORA MEDICAL CENTER
Oshkosh, Wisconsin**

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Telemedicine ICU Privileges

Policy Statement: The Medical Center utilizes Aurora eICU® to provide an enhanced level of care to patients in Intensive Care Units via an electronic telemedicine link. This service meets the standards of the Joint Commission (“JCAHO”) related to telemedicine.

Guidelines:

- A. The **originating site** for telemedicine ICU privileges shall be the Medical Center. The **distant site** shall be Aurora St. Luke’s Medical Center of Aurora Health Care Metro, Inc. (“ASLMC”), a JCAHO-accredited hospital.
- B. Only physicians granted telemedicine ICU privileges at and in good standing on the Medical Staff of ASLMC shall be eligible for telemedicine ICU privileges at the Medical Center. A physician in good standing shall not:
 - 1. Have received a suspension or curtailment of clinical privileges in the previous 12 months (other than an interim suspension for medical record completion delinquency);
 - 2. Have entered into a monitoring or proctoring agreement with Medical Staff leadership;
 - 3. Have entered into any other agreement to voluntarily restrict privileges or to restrict the right to apply for Medical Staff membership;
 - 4. Be the subject of a formal investigation that has not concluded;
 - 5. Have been denied Medical Staff membership; or
 - 6. Have withdrawn an application for Medical Staff membership to avoid being denied Medical Staff membership.
- C. Physicians on the Medical Staff at ASLMC who meet the privileging criteria established for telemedicine ICU privileges shall request such privileges at the Medical Center. Upon receipt of such a request:
 - 1. The Medical Staff Services Department at the Medical Center will verify that the physician has telemedicine ICU privileges and is a member in good standing on the Medical Staff at ASLMC.
 - 2. The Medical Center will process the privilege requests for telemedicine ICU privileges through its established credentialing and privileging

process, which results in a recommendation from the Medical Executive Committee to the Board of Directors for approval.

- D. Telemedicine ICU privileges will be provided in accordance with a contract the physician or a telemedicine services organization with which the physician is affiliated enters into with Aurora Health Care, Inc. or an affiliate thereof.
- E. Physicians who are granted telemedicine ICU privileges as their only privileges at the Medical Center shall be assigned to the Medical Center's Telemedicine Medical Staff.
- F. Physicians shall be deemed to have voluntarily resigned their Telemedicine Medical Staff membership and relinquished all clinical privileges (1) in accordance with Article IV Section 3.g. of the Medical Center's Medical Staff Bylaws; and (2) when they fail to maintain membership in good standing at ASLMC.
- G. The Medical Center shall evaluate physicians' telemedicine ICU privileges at each reappointment utilizing performance-based data and quality data from ASLMC, the Aurora Health Care Telemedicine ICU Program, and the Medical Center.
- H. The Medical Center, on an ongoing basis, shall share feedback with the Telemedicine ICU Program Director regarding the quality and effectiveness of the physicians' interactions with ICU staff and attending physicians via the telemedicine ICU link. Such information shall be considered in evaluating the physicians' eligibility for and maintenance of telemedicine ICU privileges.
- I. Submission of photo identification and documentation of TB skin tests and rubella titers will not be required if telemedicine ICU privileges are the only privileges the physician exercises at the Medical Center. ASLMC shall be responsible for maintaining documentation regarding the physician's TB skin tests and rubella titers.

References: JCAHO Standards MS. 06.01.03-06.01.13, 13.01.01 and 13.01.03, 2009

Form(s):

**Medical Executive
Committee Approval:** May 11, 2009

**Board of Directors
Approval:** May 26, 2009

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Admission, Transfer and Discharge of Patients

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

Guidelines:

A. Admission

1. A patient shall be admitted to the Medical Center only by a member of the Active, Associate, or Courtesy Medical Staff in accordance with the privileges they have been granted.

B. Responsibility

1. An appointee to the Medical Staff shall be responsible for the care and treatment of each patient in the Medical Center, for the prompt completion and accuracy of those portions of the medical record for which he or she is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the patient, to the referring practitioner, if any, and to relatives of the patient. Primary practitioner responsibility for these matters belongs to the admitting practitioner. When the admitting practitioner is a dentist, oral surgeon, or podiatrist, a physician shall be responsible for the medical care and treatment of such patient.
2. When primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another Medical Staff appointee, documentation of the transfer of responsibility and acceptance of the same shall be entered on the order sheet and progress notes.
3. Each practitioner shall assure timely, adequate professional care for his or her patients in the Medical Center by being 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. The alternate shall possess the same or similar clinical privileges at the Medical Center as the practitioner and be qualified to provide any required emergency medical treatment or services and any interventional treatment or services to the practitioner's patients. The practitioner shall notify his or her alternate of (i) when the practitioner expects to be unavailable and (ii) when the alternate shall accept responsibility for the practitioner's patients. Failure to notify the alternate of unavailability shall be considered a serious breach of these Policies Governing Medical Practices and may be a basis for disciplinary action. If

there is no qualified alternate available, the practitioner shall continue to provide twenty-four (24) hour care to practitioner's patients.

- a. Each appointee to the Medical Staff who will be out of town or unavailable in case of emergency shall indicate, in writing on the Integrated Progress Note, the name of the practitioner who shall be assuming responsibility for the care of the patient during such practitioner's absence. In the absence of such designation, the Administrator, the Chief of Staff or the applicable Clinical Chairperson has the authority to call any appointee to the Medical Staff with the requisite clinical privileges to assume care of the patient.

C. Admission Diagnoses

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

D. Emergency Admissions

1. Practitioners admitting patients as emergency admissions shall be prepared to justify the admission as a bona fide emergency. The history and physical examination shall clearly justify the patient being admitted on an emergency basis and these findings shall be recorded on the medical record as soon as possible after admission.

E. Frequency of Patient Attendance

1. All hospitalized patients will be seen on at least a daily basis by the attending physician, or his or her alternate or advanced practice professional. An advanced practice professional must have a current supervisory or collaborative agreement in place with the attending physician. For regular inpatient admissions, physicians should see their patients and document on a daily basis or may assign an alternate practitioner or advanced practice professional in their absence as defined above. For patients admitted to a nursing unit from the ER, the attending physician should see that patient within twelve (12) hours of admission. For patients admitted to the ICU from the ER, the attending physician should see that patient within six (6) hours of admission. These time frames are guidelines, and certain circumstances will require greater urgency.

F. Appointment of Staff Member

1. Each patient shall be attended by the physician, dentist, oral surgeon, or podiatrist of the patient's choice, within the scope and limits of the practitioner's privileges. A patient seeking admission to the Medical Center who does not or cannot designate his or her choice of a practitioner shall be referred to the member of the Medical Staff on emergency call who shall then arrange for appropriate care.

G. Admission Information

1. Practitioners admitting patients shall be held responsible for giving such information regarding 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 and Medical Center personnel and Medical Staff from patients who may be a source of danger to themselves or others, from any cause whatever.
2. All gunshot wounds, poisonings, self-inflicted wounds and attempted suicides, child abuse and animal bites shall be reported, if required by law, to the appropriate law enforcement agency.

H. Continued Stay

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

I. Transfer

1. A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. Patients who are not stabilized may be transferred to another facility if the attending physician certifies that the benefits outweigh the risks of the transfer. Such certification shall contain a summary of the risks and benefits upon which it is based. A transfer demanded by an emergency or critically ill patient or his or her family is

not permitted until the attending physician has explained the seriousness of the condition and the risks of transfer.

2. All pertinent medical information necessary to ensure continuity of care shall accompany the patient to the receiving facility.

J. Discharge

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

K. Death

1. In the event of a patient's death, the deceased shall be pronounced dead by the attending physician or physician designee. The body shall not be released until the attending physician, or authorized alternate, has authorized such release. Exceptions shall be made in those instances of terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Except in cases of terminal illness, the physician shall be responsible for notifying immediate family of a patient death.

References:

- EMTALA 42 U.S.C. §1395dd
- 42 C.F.R. § 489.24
- JCAHO Standards MS. 6, 2003

Form(s):

Medical Executive

Committee Approval:

October 22, 2003; March 14, 2005; April 14, 2014

Board of Directors

Approval:

October 23, 2003; April 1, 2005; April 21, 2014

PROVIDER ORDERS

POLICY STATEMENT

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

1. GENERALLY

1.1 Ordering Providers.

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

1.2 Form, Legibility and Timeliness.

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

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

1.4 Incomplete, Unclear, Illegible or Unacceptable Orders.³

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

¹ JCS MM.04.01.01, EP 9 (Jan. 2010).

² JCS NPSG.02.02.01, EP 3 (Jan. 2010).

³ JCS MM.04.01.01, EP 5 (Jan. 2010).

1.5 Correction of Incomplete or Inaccurate Orders.

An existing order may not be corrected, altered, added to, or modified in any way. If a change is necessary, the order must be discontinued and a new order must be entered by the Ordering Provider.

1.6 Non-Specific Orders Prohibited.⁴

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

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

1.7 Authentication and Co-Signature.⁵

- (a) Authentication. All orders must be dated, timed (using military time), and authenticated (by written signature, identifiable initials, or computer key) by the Ordering Provider.⁶ The use of an electronic signature is only acceptable if the individual has an attestation statement on file in the Health Information Services Department acknowledging that he or she is the only individual authorized to use the electronic signature. An order may not be authenticated by use of a rubber stamped signature.⁷ See also Section 2.4(d) regarding authentication of verbal orders.
- (b) Co-Signature. In certain circumstances, orders must be co-signed by a Physician Medical Staff Member (e.g., certain entries by an Advanced Practice Professional must be co-signed by the Advanced Practice Professional’s supervising or collaborating Physician, and certain entries made by a Dentist or Podiatrist must be co-signed by a Physician).⁸ Refer to Aurora’s Hospital Co-Signature Requirements Chart. The co-signing Physician accepts full professional and legal responsibility for the content of the order.

⁴ JCS MM.04.01.01, EP 8 (Jan. 2010).

⁵ 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008); JCS RC.01.02.01, EP 2 (2009)

⁶ 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008); JCS RC.01.01.01, EP 11; RC.01.02.01, EP 3-4 (Jan. 2010).

⁷ See CMS Manual System, Pub 100-08 Medicare Program Integrity, Transmittal 248, March 28, 2008; CMS MLN Matters Memo No. SE0829, CR 5971 Clarification related to Signature Requirements; CMS Memo, S&C-09-10, “Standing Orders” in Hospitals – Revisions to S&C Memoranda, October 24, 2008.

⁸ 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008). Aurora’s Hospital Co-Signature Requirements Chart.

2. ENTRY OF ORDERS

2.1 Computerized Physician Order Entry.

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

2.2 Written Orders.

- (a) Restrictions on Use of Written Orders. Written orders may NOT be used, unless:
- i. a patient emergency precludes the Ordering Provider from directly entering and initiating the order in CPOE;
 - ii. the CPOE is not functioning;
 - iii. the Ordering Provider is unable to access CPOE because he/she is physically remote from the Medical Center and does not have access to CPOE; or
 - iv. the Ordering Provider is in the process of performing a procedure precluding direct order entry (e.g., OR/cath lab).
- (b) Issuing a Written Order. A written order must be entered into the medical record on the physician order sheet.

2.3 Pre-Printed Order Sets.⁹

Pre-printed order sets may be used if they have been reviewed and approved under the Aurora Order Set Development and Governance System Policy.¹⁰ If an Ordering Provider uses a preprinted paper order set, the Ordering Provider must: (a) sign, date, and time the last page of the order set (the last page must identify the total number of pages in the order set); and (b) initial each place in the preprinted order set where changes, such as additions, deletions, or strike-outs of components that do not apply, have been made. It is not necessary to initial every preprinted box that is checked to indicate selection of an order option, as long as there are no changes made to the option(s) selected.

2.4 Verbal Orders.

- (a) Restrictions on Use of Verbal Orders.
- i. Verbal orders are **strongly discouraged** and should NOT be used, unless it would be permissible for the Ordering Provider to issue a written order (see Section 2.2(a) above), but it is impossible or impractical for the Ordering Provider to write the order.¹¹
 - ii. Verbal Orders are not to be used merely for the convenience of the Ordering Provider.¹²

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

¹⁰ JCS MM.04.01.01, EP 7 (Jan. 2010).

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

¹² Department of Health and Human Services, Final Rule, Federal Register, November 27, 2006, page 68679.

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- iii. Verbal Orders may only be issued to an individual who is authorized to receive verbal orders. The following persons are authorized by the Medical Staff to receive verbal orders: physician assistants, registered nurses, chiropractors, respiratory therapists, pharmacists, physical therapists, occupational therapists, speech therapists, radiologic technicians, respiratory technicians, psychologists, dietitians and social workers. Such authorized individuals may receive a verbal order and enter it into the patient's medical record, if the verbal order relates to the clinical area in which such authorized individual is trained.
- iv. Only physician assistants and registered nurses are authorized to receive verbal Do Not Resuscitate orders. (Refer to the Medical Center's DNR Policy.)
- v. Only physician assistants, registered nurses, respiratory therapists, radiological technicians, and pharmacists are authorized to receive verbal orders for drugs and/or biologicals.

(b) Issuing a Verbal Order.

- i. An Ordering Provider must communicate a verbal order, in person or over the telephone, only to a duly authorized individual and such verbal order must relate to the clinical area in which such authorized individual is trained.¹³
- ii. The Ordering Provider must clearly enunciate the verbal order to the individual accepting the order. The following elements shall be included in all verbal orders:
 - Name of Ordering Provider;
 - Name of patient;
 - Age and weight of patient, when appropriate;
 - Date and time of order;
 - Purpose or indication for the order; and
 - All other elements required for the particular order (e.g., see Section 4.2 for minimum requirements of medication orders).

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

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

¹⁴ 42 CFR § 482.23(c)(2)(i) (Interpretive Guidelines, effective October 17, 2008); JCS NPSG.02.01.01, EP 2 (Jan. 2010); 71 FR 68680.

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Provider that he/she has received the correct order.¹⁵ Once confirmation is received, the accepting individual shall enter the verbal order into CPOE.¹⁶

(d) Authentication of Verbal Orders.

- i. Verbal orders must be promptly authenticated in CPOE by the Ordering Provider (or a practitioner assuming care of the patient) as soon as possible, and in all events within forty-eight (48) hours¹⁷ (except for Verbal Do Not Resuscitate Orders which must be authenticated within twenty-four (24) hours) of the Ordering Provider's communication of the verbal order.
- ii. When an individual practitioner other than the Ordering Provider authenticates a verbal order, such individual accepts professional and legal responsibility for the order and validates that the order is complete, accurate, and final based on the patient's condition. The authenticating provider should be responsible for the care of the patient and have knowledge of the patient's hospital course, medical plan of care, condition and current status. An individual who does not possess this knowledge about the patient should not authenticate a verbal order.¹⁸
- iii. A Physician Assistant (PA) or Advanced Practice Nurse Prescriber (APNP) may only authenticate a verbal order issued by another practitioner if all of the following requirements are met:
 - the PA or APNP has the authority to issue the order itself (if the PA or APNP is not authorized to issue the order in need of authentication, he or she cannot authenticate it);
 - the PA or APNP has physician-delegated functions with regard to the care of the patient; and
 - the PA or APNP has knowledge of the patient's hospital course, medical plan of care, condition and current status.¹⁹

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

¹⁵ JCS NPSG.02.01.01, EP 3 (Jan. 2010).

¹⁶ JCS NPSG.02.01.01, EP 1 (Jan. 2010).

¹⁷ Wis. Admin. Code DHS § 124.12(5)(b)11.; Although the code section provides that a verbal order must be authenticated within 24 hours, the Wisconsin Department of Health Services (DHS) has granted a variance providing that the authentication must occur within 48 hours. See Wisconsin Department of Health and Family Services, DQA Memo 07-019, October 30, 2007.

¹⁸ Wisconsin Department of Health and Family Services, DQA Memo 07-019, October 30, 2007.

¹⁹ Wisconsin Department of Health and Family Services, DQA Memo 07-019, October 30, 2007.

3. REQUIREMENTS FOR CERTAIN TYPES OF ORDERS

3.1 Admission Orders.

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

3.2 Orders for Therapeutic Services (Treatment).

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

3.3 Orders for Diagnostic Testing.

In addition to basic requirements for orders, all orders for diagnostic testing shall include: (a) the reason, purpose or indication (orders for outpatient diagnostic tests must include the symptoms, diagnosis or ICD-10-CM code); (b) the type of testing; (c) any specific requirements or instructions; (d) the frequency, schedule and duration of testing; and (e) if the test requires the administration of medications or other substances (e.g., contrast dye), the order must include the necessary elements for medication orders. An order for imaging studies (X-ray, CT Scan, MRI, etc.) must include a concise statement describing the reason for the imaging study.²⁰

3.4 Medication Orders.

- (a) Requirements.²¹ In addition to basic requirements for orders (form, timeliness, authentication), all orders for medications must include:
- i. Drug name;
 - ii. Purpose, diagnosis, condition or indication (as applicable) if not elsewhere in the patient's medical record (e.g., physician note), or if needed for purposes of clarification;
 - iii. Dosage form (e.g., tablets, capsules, inhalants);
 - iv. Exact strength or concentration;

²⁰ Wis. Admin. Code DHS § 124.18(e)(2).

²¹ JCS MM.04.01.01, EPs 2, 3, and 9 (Jan. 2010).

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- v. Dose, frequency and route of administration (e.g., p.o., IV, IM, rectal, etc.);
 - vi. Quantity and/or duration; and
 - vii. Specific instructions for use.
- (b) Acceptable Types of Medication Orders.²² The following types of medication orders are acceptable:
- i. PRN (as needed) Orders: Orders acted upon based on the occurrence of a specific indication or symptom. Such orders should include the indications for use and specific time intervals.
 - ii. Standing Orders: A prewritten medication order and specific instructions to administer a medication to a patient in clearly defined circumstances.
 - iii. Automatic Stop Orders: Orders that include a date or time to discontinue a medication.
 - iv. Titrating Orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status. Whenever possible, such orders should include objective parameters for titration.
 - v. Taper Orders: Orders in which the dose is decreased by a particular amount with each dosing interval.
 - vi. Range Orders: Orders in which the dose or dosing interval varies over a prescribed range, depending upon certain objective criteria related to the patient's status or situation (e.g., insulin dosages for specific blood glucose ranges).
 - vii. Other Orders: Orders for compounded drugs or drug mixtures not currently available, medication-related devices (nebulizers, catheters), investigational medications, herbal products, discharge or transfer medications.
- (c) High Alert and Hazardous Medications.²³ The Medical Center maintains a list of high-alert and hazardous medications and utilizes specific strategies for avoiding errors related to such medications. Orders must be written in accordance with the requirements set forth in such policies.
- (d) Look-Alike or Sound-Alike Medications.²⁴ Medications with look-alike or sound-alike names ("LASA medications") may result in medication errors. The Medical Center utilizes specific safety strategies to avoid errors related to LASA medications. A list of LASA medications shall be maintained by the Medical

²² JCS MM.04.01.01, EP 1 (Jan. 2010).

²³ JCS MM.01.01.03 (Jan. 2010).

²⁴ JCS MM.04.01.01, EP 4 (Jan. 2010).

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Center's pharmacy.²⁵ Staff Members shall comply with Aurora's Look-Alike Sound-Alike Medications Policy.

- (e) Medications that Require Weight-Based Dosing. Certain medications (including medications administered to pediatric patients) require weight-based dosing. The Medical Center maintains guidelines for weight-based dosing and all medication orders must be entered in compliance with such guidelines.²⁶
- (f) Labor-Inducing Medications. Only a Physician with OB privileges or a Certified Nurse Midwife may order the administration of a labor-inducing medication,²⁷ and such orders must include parameters providing for the discontinuation of the labor-inducing medication by a registered nurse.²⁸
- (g) Formulary Drugs. Ordering Providers are encouraged to use Medical Center formulary drugs. In extenuating circumstances, non-formulary drugs shall be provided when ordered by the attending practitioner and when approved alternatives are unacceptable. All non-formulary medications shall be reviewed by the Aurora Pharmacy and Therapeutics Committee.
- (h) Review. All medication orders shall be reviewed by the attending Practitioner at least every thirty (30) days.
- (i) Automatic Cancellation. All existing medication orders shall be automatically cancelled when a patient undergoes a procedure requiring general anesthesia or moderate sedation. Following the procedure, an Ordering Provider must re-enter orders for each individual medication (as noted in Section 1.7, an order stating "resume previous medications" or other non-specific orders are unacceptable).²⁹
- (j) Stop Orders. The Medical Center's stop order policy does not prevent the Ordering Provider from ordering medication for any reasonable length of time that the Ordering Provider may choose, and is intended to cover only those situations in which drug administration orders do not state a specific length of time or duration. If the following medications are ordered without specific limitations as to dosage and time, such medications shall be automatically discontinued as follows, unless specifically reordered by the attending Practitioner:

²⁵ NPSG.03.03.01 (Jan. 2010).

²⁶ JCS MM.04.01.01, EP 10 (Jan. 2010).

²⁷ Wis. Admin. Code DHS § 124.20(5)(i)8.a.

²⁸ Wis. Admin. Code DHS § 124.20(5)(i)8.c.

²⁹ Wis. Admin. Code DHS § 124.15(7)(b).

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Antibiotics	10 days
Controlled Substances	5 days
All pre-op and/or prenatal medication	must be renewed post- op/postpartum
Transfer medication orders	must be renewed when transferring to a higher or lower level of care (e.g., transferring into or out of ICU)
IV Fluids	3 days

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

3.5 Standing Orders.

- (a) All standing orders shall be listed on a "Physician Order Sheet" sheet that must be included in the patient's medical record and signed and dated by the Ordering Provider or the attending Practitioner.
- (b) Standing orders shall be followed in the absence of other specific orders by the Ordering Provider or the attending practitioner, insofar as the proper treatment of the patient will allow. Each Practitioner shall review his or her standing order regimens at least annually and revise as necessary. Notwithstanding the foregoing, new orders shall be entered and initiated in CPOE for each patient upon transfer into and out of the ICU/CCU, post-operatively and at each Medical Center admission, regardless of frequency of admission.

3.6 Transfer Orders.

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

3.7 Discharge Orders.

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

3.8 Blood Transfusion Orders.

All orders for blood transfusions must be entered in accordance with the Medical Center's policies on blood and blood components.

3.9 Restraint and Seclusion Orders.

All orders for restraints and seclusion must be entered in accordance with the Medical Center's policy regarding restraints and seclusion.

3.10 Do-Not-Resuscitate Orders.

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

3.11 Therapeutic Diet Orders.

(a) A registered dietitian may issue the following for a patient's nutritional care:

- i. Changes in therapeutic diets (i.e., macro- and micro-nutrient levels, timing of meals, etc);
- ii. Modification in diet textures;
- iii. Nutrition supplements;
- iv. Tube feedings when directed per a physician order, or changes in tube feeding products, rates, schedules, and flush;
- v. Parenteral nutrition macro- and micro-nutrients, when directed by the attending physician;
- vi. Weight, including daily weight;
- vii. Collaboration with and referral to other allied health professionals including speech therapists and home health care;
- viii. Nutrition education;
- ix. Vitamin and mineral supplements;
- x. Nutrient intake analysis;
- xi. Nutrition-related lab work (i.e., prealbumin, potassium, etc.).

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

REFERENCES:

Federal Regulations and Other Guidance

- 42 CFR § 482.23 (Interpretive Guidelines, effective October 17, 2008).
- 42 CFR § 482.24 (Interpretive Guidelines, effective October 17, 2008).
- CMS Transmittal 47, June 5, 2009.
- CMS Manual System, Pub 100-08 Medicare Program Integrity, Transmittal 248, March 28, 2008.
- CMS MLN Matters Memo No. SE0829, CR 5971 Clarification related to Signature Requirements.
- CMS Memo, S&C-09-10, “Standing Orders” in Hospitals – Revisions to S&C Memoranda, October 24, 2008.
- Department of Health and Human Services, Final Rule, Federal Register, November 27, 2006, page 68679.

Wisconsin Statutes

- None.

Wisconsin Administrative Code and Other Guidance

- Wis. Admin. Code DHS § 124.12.
- Wis. Admin. Code DHS § 124.15.
- Wis. Admin. Code DHS § 124.18.
- Wis. Admin. Code DHS § 124.20.
- Wisconsin Department of Health and Family Services, DQA Memo 07-019, October 30, 2007.

Joint Commission Standards

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

FORM(S): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 03/12/2018

BOARD OF DIRECTORS APPROVAL: 03/19/2018

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Consultations

Policy Statement: It is the policy of the Medical Staff to assure that a consultation with a qualified Medical Staff member is ordered when the attending practitioner's expertise does not meet the clinical needs of the patient, or when the best interests of the patient will be thereby served.

Guidelines:

- A. Except in an emergency, the circumstances which require consultation include, but are not limited to, the following:
 - 1. Any patient known or suspected to be suicidal;
 - 2. When required by this Policy or the rules of any clinical unit, including any intensive or special care units of the Medical Center;
 - 3. Problems of critical illness in which any significant question exists of appropriate procedure or therapy;
 - 4. When the patient is not a good risk for operation or treatment;
 - 5. Cases of difficult or equivocal diagnosis or therapy;
 - 6. When a surgery or procedure may interrupt a known or suspected pregnancy;
 - 7. When the condition of the patient or scope of clinical problem exceeds the physician's granted privileges;
 - 8. When required by state law; and
 - 9. When requested by the patient or family.

- B. Definition of a Consultant
 - 1. Any qualified practitioner may be called as a consultant regardless of such practitioner's Medical Staff category assignment. A consultant shall 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 extensive experience. In either case, a consultant shall have demonstrated the skill and judgment requisite for evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges.

C. Medical Record Documentation

1. Appropriate documentation on the use and results of consultants shall be maintained as follows:
 - a. When requesting consultation, the attending practitioner shall indicate in writing on the consultation record 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.”
 - b. The consultant shall prepare and sign a report of the consultant’s findings, opinions and recommendations that reflects an actual examination of the patient and the medical record. Such report shall become part of the patient’s medical record. When operative procedures are involved, the consultation report should be recorded prior to surgery.
 - c. In cases of elective consultation when the attending practitioner elects not to follow the advice of the consultant, he or she shall either seek the opinion of a second consultant or record in the progress notes such attending practitioner’s reasons for electing not to follow the consultant’s advice.
 - d. In cases of required consultation when the attending practitioner does not agree with the consultant, he or she shall either seek the opinion of a second consultant or refer the matter to the applicable Clinical Chairperson for final advice. If the attending practitioner obtains the opinion of a second consultant and does not agree with it either, the attending practitioner shall refer the matter to the applicable Clinical Chairperson, for final advice.

D. Request for Consultation

1. The physician requesting the consultation shall be responsible for: (a) providing the consulting physician with adequate information to enable the consulting physician to provide the consultation; and (b) ensuring that the consultation occurs as requested.

E. Response to Request for Consultation

1. The consulting physician shall be responsible for 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 physician.

References:

Wis. Admin. Code HFS § 124.12(5)(b)(10)
JCAHO Standards MS. 2.20 and LD.3.50, 2007

Form(s):

**Medical Executive
Committee Approval:**

October 22, 2003 March 14, 2005 February 12, 2007

**Board of Directors
Approval:**

October 23, 2003 April 1, 2005 February 23, 2007

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Medical Records/Patient Health Information

Policy Statement: It is the policy of the Medical Staff to maintain complete and accurate medical records and to use and disclose patients' health information in accordance with the requirements set forth below.

Guidelines:

- A. The attending practitioner and other Medical Staff members, as applicable, shall be responsible for the preparation of a complete and legible medical record for each patient. The record's content shall be pertinent, legible, accurate, timely and current. The record shall include, as appropriate:
1. Emergency care, treatment, and services provided to the patient before his or her arrival, if any;
 2. Documentation and findings of assessments;
 3. Identification data (i.e., the patient's name, sex, address, date of birth, occupation, and authorized representative, if any; the legal status of the patient if receiving behavioral health care services; and the patient's language and communication needs);
 4. Personal and family medical histories;
 5. Description and history of present complaint and/or illness;
 6. History and physical examination report;
 7. Conclusions or impressions drawn from medical history and physical exam;
 8. Diagnosis, diagnostic impression, or conditions (the final diagnosis without the use of symbols or abbreviations);
 9. Reason(s) for admission of care, treatment and services;
 10. Goals of the treatment and treatment plan;
 11. Diagnostic and therapeutic orders;
 12. Diagnostic and therapeutic procedures, tests, results and reports (including but not limited to clinical laboratory, pathology, radiology, radiotherapy,

tissue, EEG, ECG, consultation, pre- and post-anesthesia, operative and postoperative);

13. Progress notes and other clinical observations, including results of therapy;
14. Reassessments and plan of care revisions, when indicated;
15. Relevant observations;
16. Treatment provided;
17. Response to care, treatment, and services provided;
18. Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia;
19. Allergies to foods and medicines;
20. Medications ordered or prescribed;
21. Doses of medications administered, including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions;
22. Relevant diagnoses/conditions established during the course of care, treatment, and services;
23. Advance directives, if any;
24. Evidence of appropriate informed consent;
25. Condition on transfer (if applicable), including any instructions to the patient or recipient hospital, including any forms or information required by the Medical Center policies regarding EMTALA compliance;
26. Discharge summary, including condition on discharge, and instructions, if any, to the patient or significant other on post-hospital care;
27. Medications dispensed or prescribed on discharge;
28. Autopsy report, if performed;
29. Anatomical gift information, if applicable;
30. Records of communications with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail, if applicable); and

31. Patient generated information, if applicable (e.g., information entered into the record over the Web or in pre-visit computer systems).

B. General History and Physical Examinations Requirements

1. The physician who admits the patient to the Medical Center shall be ultimately responsible for the completion of the history and physical examination (“H&P”) and required updates, although a different Medical Staff member or qualified Allied Health Professional may perform the H&P. In addition, the admitting practitioner shall personally write an admission note within twenty-four (24) hours of admission, indicating the reason for hospitalization and the diagnostic/therapeutic plan. When a H&P (or update) and an initial admission note are not recorded and available on the medical record before an operative or invasive procedure, the procedure will not be permitted unless a Medical Staff member or qualified Allied Health Professional documents in the medical record that the procedure is being performed as an emergency.
2. When an attending physician who is a Medical Staff member chooses to utilize a H&P performed by a physician who is not a Medical Staff member, the attending physician does so accepting full responsibility for the content and timeliness of the H&P, and the attending physician or a qualified Allied Health Professional must perform an update as set forth in Section C.2. or D.2. below, as applicable. In addition, an update to the H&P need not be performed by the same practitioner who performed the original H&P within the past thirty (30) days, but a Medical Staff member or qualified Allied Health Professional performing the update accepts responsibility for the content of the entire H&P.

C. Inpatient H&P

1. A H&P shall be recorded in the medical record either: (1) within twenty-four (24) hours of an inpatient admission; or (2) prior to surgery (except emergency situations); whichever occurs first.
2. If a complete H&P has been performed and recorded by a Medical Staff member or qualified Allied Health Professional within thirty (30) days of an inpatient admission, a durable legible copy may be used in the patient’s inpatient hospital record, but must contain an update of the patient’s condition based upon an assessment performed within twenty-four (24) hours of the inpatient admission or prior to surgery (except emergency situations) whichever occurs first. An appropriate update of the patient, including a physical examination, is conducted to: (1) update any components of the patient’s current medical status that may have changed since the prior H&P; (2) address any areas where more current data is needed; or (3) confirm the necessity of any procedures or care. The update is documented in the patient’s medical record and attached to the

H&P. If a H&P is more than thirty (30) days old, it will need to be repeated.

3. The H&P is good for the entire length of the inpatient stay. However, if a procedure is performed on an inpatient before the dictated H&P or update is available on the medical record, a pre-procedure H&P or update must be handwritten and documented in the medical record by a Medical Staff member or qualified Allied Health Professional before the procedure is initiated.

B. Required Elements of Inpatient H&P

- a. Reason for admission
- b. Physical assessment
- c. Review of systems
- d. Co-morbid conditions
- e. Mental status
- f. Medical history, including past response to treatment, known allergies, current medications and dosages, relevant social and family history appropriate to the age of the patient;
- g. Diagnostic impression; and
- h. Treatment plan and goals.

C. Outpatient H&P

1. A H&P shall be recorded in the medical record prior to the procedure. If a complete H&P has been performed and recorded by a Medical Staff member or qualified Allied Health Professional within thirty (30) days of an outpatient admission, a durable legible copy may be used in the patient's outpatient hospital record, but must contain an update of the patient's condition based upon an assessment performed prior to the procedure. An appropriate update of the patient, including a physical examination, is conducted to: (1) update any components of the patient's current medical status that may have changed since the prior H&P; (2) address any areas where more current data is needed; or (3) confirm the necessity of any procedures or care. The update is documented in the patient's medical record and attached to the H&P. If a H&P is more than thirty (30) days old, it will need to be repeated.
2. The H&P is good for the entire length of the outpatient stay. However, if a procedure is performed on an outpatient before the dictated H&P or update is available on the medical record, a pre-procedure H&P or update must be handwritten and documented in the medical record by a Medical Staff member or qualified Allied Health Professional before the procedure is initiated.

3. Required Elements Outpatient H&P

- a. Chief Complaint
- b. History
- c. Allergies
- d. Medications
- e. Physical exam (essential elements)
- f. Physical exam (as pertinent to specific procedure)
- g. Treatment plan and goals

D. Dental, Oral and Maxillofacial, and Podiatric Surgery

1. A physician shall be responsible for the H&P when the admitting practitioner is a dentist or podiatrist. Dentists are responsible for the part of their patient's H&P that relates to dentistry. Podiatrists are responsible for the part of their patients' H&P that relates to podiatry. Podiatrists may complete the H&P prior to outpatient podiatry surgery performed under local anesthesia. Podiatrists may perform the H&P prior to outpatient podiatry surgery requiring general anesthesia provided the podiatrist has satisfactory documentation of training and education to perform this task, and provided that an anesthesia provider performs the pre-anesthesia evaluation.
2. Admitting oral surgeons may perform the H&P if: (1) they have been granted such privileges; and (2) the patient is admitted only for oral surgery and is without underlying health problems.

E. Surgery

1. H&P and required consultation reports shall be placed in the medical record before surgery.
2. All currently required laboratory, EKG, and x-ray studies shall be performed and documented prior to surgery using these guidelines:
 - a. EKG and x-ray results are accepted for thirty (30) days; and
 - b. Lab results are accepted for six (6) weeks, except pregnancy tests which must be performed the day of surgery.
3. The following anesthesia evaluations/examinations shall be conducted and documented in the medical record (if the evaluations/examinations are performed by a certified registered nurse anesthetist, they must be countersigned by either the supervising anesthesiologist and/or the surgeon):
 - a. Pre-anesthesia Evaluation. The anesthesia provider shall conduct a pre-anesthesia evaluation of the patient within forty-eight (48)

hours prior to the patient's transfer to the operating area and before preoperative medication has been administered, except in emergencies. The pre-anesthesia evaluation shall include, at a minimum: (1) pertinent information relative to the choice of anesthesia and the procedure anticipated; (2) notation of anesthesia risk; (3) pertinent previous drug, anesthesia and allergy history; (4) other pertinent anesthetic experience; (5) potential anesthetic problems; (6) ASA patient status classification; and (7) orders for preoperative medication.

- b. Re-evaluation Examination. The anesthesia provider shall conduct a re-evaluation immediately prior to induction.
 - c. Intraoperative Anesthesia Examination. The anesthesia provider shall conduct an intraoperative anesthesia examination documenting pertinent events taking place during anesthesia. The intraoperative anesthesia examination shall include, at a minimum: (1) the patient's name and hospital identification number; (2) name of practitioner who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner; (3) name, dosage, route and time of administration of drugs and anesthesia agents; (4) IV fluids; (5) blood or blood products, if applicable; (6) oxygen flow rate; (7) continuous recordings of patient status noting blood pressure, heart and respiration rate; and (8) 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-anesthetic Follow-up Examination. The anesthesia provider shall conduct a post-anesthetic follow-up examination with findings recorded within forty-eight (48) hours after surgery. The post-anesthetic follow-up examination shall include, at a minimum: (1) the patient's cardiopulmonary status; (2) level of consciousness; (3) any complications during post-anesthesia recovery; and (4) any follow-up care and/or observations.
4. A post-procedure note containing the following elements shall be recorded immediately after the procedure even if the procedure report is dictated:
- a. Preoperative diagnosis;
 - b. Postoperative diagnosis;
 - c. Surgeon;
 - d. Surgical Assistant(s);

- e. Procedures performed;
- f. Findings during procedure;
- g. Specimens removed;
- h. Complications; and
- i. Estimated blood loss, as appropriate.

F. Electrocardiograph Reports

- 1. Electrocardiograph reports shall be filed as a permanent record with the patient's chart.
- 2. The attending physician may retain an unmounted record if so requested, but the original shall remain in the patient's chart.

G. Progress Notes

- 1. Pertinent progress notes shall be recorded at the time of observation and shall be sufficient to permit continuity of care and transfer of the patient.
- 2. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner.
- 3. 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 and treatment.
- 4. Progress notes by the attending practitioner shall be written at least daily on acutely and critically ill patients and on those where there is difficulty in diagnosis or management of the clinical problem.

H. Consultation Reports

- 1. Consultation reports shall show evidence of a review of the patient's record, the consultant's opinion, and the consultant's recommendations. Consultation reports shall be authenticated by the consulting practitioner.

I. Discharge Summary

- 1. A discharge summary shall be recorded for all patients. The physician who discharges the patient shall be ultimately responsible for the discharge summary although a different Medical Staff member may write it.
- 2. The discharge summary should include, but is not limited to:

- a. Date of admission and discharge;
- b. Reason for hospitalization;
- c. Discharge diagnosis;
- d. Condition on discharge;
- e. Disposition on discharge;
- f. Consultations;
- g. Procedures performed/treatment rendered;
- h. Significant findings including ancillary studies;
- i. Information provided to the patient and family, as appropriate; and
- j. Discharge instructions, including:
 - 1) Medications
 - 2) Activity
 - 3) Diet, and
 - 4) Follow-up.

J. Abbreviations, acronyms, symbols and dose designations

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

K. Authentication of Clinical Entries

- 1. All clinical entries in the patient's record shall be legible, accurately dated, timed and individually authenticated. "Authentication" means to establish authorship by written signature, identifiable initials or electronic signature.
- 2. The use of an electronic signature is only acceptable if the individual has an attestation statement on file in the Health Information Services Department acknowledging that he or she is the only individual authorized to use the electronic signature.

L. Allied Health Professional Entries in the Medical Record

1. An Allied Health Professional may make medical record entries relating to acts for which the Allied Health Professional has been granted clinical privileges and in accordance with co-signature requirements, if any.

M. Use and Disclosure of Patient Health Information

1. All Medical Staff members and Allied Health Professionals agree to comply with the Medical Center’s policies and procedures governing the use and disclosure of patient health information (commonly referred to as “Protected Health Information or PHI”), as may be amended from time to time.
2. The Medical Staff members and Allied Health Professionals of the Medical Center participate in an organized health care arrangement with Aurora Health Care, Inc. (“Aurora”). Participation means the Medical Staff members and Allied Health Professionals 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 the patient with the patient’s acknowledgment (unless an exception applies), meets the federal notice requirement for both the practitioner and Aurora for care provided at an Aurora facility.
3. Inappropriate use and disclosure of Protected Health Information shall subject the practitioner to corrective action as outlined in the Medical Staff Bylaws and the Policies Governing Medical Practices.

References:

- Medicare Conditions of Participation, 42 C.F.R. §§ 482.22, 482.24, and 482.52
- Health Insurance Portability and Accountability Act’s Privacy Regulations, 45 C.F.R. §§ 160 and 164
- Wis. Stat. §§ 51.30, 146.81 et. seq. and 252.15
- Wis. Admin. Code HFS §§ 124.12, 124.14 and 124.20(3)(b) and Chapter HFS 92
- JCAHO Standards IM.3.10, 6.10, 6.20 and 6.50 and MS.2.10, 2007 and National Patient Safety Goal 2B

Form(s):

Medical Executive

Committee Approval:

October 22, 2003	March 14, 2005	February 11, 2008
February 8, 2010		

Board of Directors

Approval:

October 23, 2003	April 1, 2005	February 29, 2008
February 23, 2010		

Aurora Medical Center Laboratory	
<i>Tissue</i>	<i>Solution</i>
Amputated Limbs	Fresh to laboratory
Bone Biopsy	Send in Formalin immediate WITH patient's x-ray. If cultures are needed, send separate piece of bone in sterile specimen container.
Breast Tissue	In container with 10% Formalin. Send to lab immediately. If frozen section or gross examination is needed, send fresh.
Bronch	Brush - In normal saline > To Lavage - On ice always > Lab Lukens Trap - Washings > Immediately
B & T Cell Markers (for Lymphoma)	Fresh in normal saline soaked gauze in sterile specimen container. Send to lab immediately with H&P and Addressograph plate.
Cervical Conization	Send in Formalin in specimen container to lab immediately.
Cultures Urine	Fresh in a sterile specimen cup to lab immediately.
Cultures Others	In sterile cup, syringe, bronch trap, culture tube.
Cultures Suction	In suction canister liner.
Cytology	See Directory of Services for specific sites.
Frozen Sections	Fresh. Put small specimens in normal saline soaked gauze to lab immediately.
Implanted Devices	In plastic bag to lab or to patient as ordered.
Lymph Node Biopsies	Fresh. Put small specimens in normal saline soaked gauze in sterile specimen container to lab immediately.
Muscle/Nerve Biopsy	Notify lab two days prior to biopsy. Fresh in normal saline soaked gauze, not floating in normal saline . DO NOT squeeze with forceps. Copy of H&P. To lab immediately.
Pap Smear	Clear slides, fixed for cytology.
Renal Biopsy	Notify lab two days prior to biopsy. Fresh in normal saline soaked gauze, not floating in normal saline . DO NOT squeeze with forceps. Copy of H&P. To lab immediately.
Synovial Fluid	In green top tube (from med. room or lab).
Teeth or Calculi	In container dry and # of teeth on slip.
Tissue & Routine Biopsy Specs	In container with 10% Formalin.
Kidney & Ureteral Stones for Analysis	In a dry specimen container. DO NOT add formalin.

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Emergency Department On-Call

Policy Statement: To define guidelines for those practitioners responsible to cover emergency on-call for patients without a self designated primary care physician.

Guidelines:

- A. All physicians, dentists, oral surgeons, and podiatrists who are members of the active staff are responsible to participate in emergency room back-up as requested to do so by the Medical Executive Committee. Other members of the non-active Medical Staff shall participate in emergency department back-up call if requested to do so by the Medical Executive Committee. General and vascular surgeons who are required to participate in emergency room back-up call are required to achieve and maintain Advanced Trauma Life Support (ATLS) certification in accordance with State of Wisconsin requirements for level 3 trauma centers. The following response times and requirements shall also apply to dentists, oral surgeons, and podiatrists if the Medical Center implements an on-call schedule for their services.
- B. All physicians are required to respond via phone within fifteen (15) minutes of being paged and to provide instruction to the emergency staff.
- C. All physicians are required to respond in person within thirty (30) minutes of answering the page, if requested to so do, to care for the patient.
 1. In the event the on-call physician does not answer or is unable to present to the Medical Center, attempts should be made to contact one of the on-call physician's practicing partners within such specialty. In the event no other physician is available to present to the Medical Center, the patient should be prepared for transfer pursuant to Section E Below.
- D. After initial notification from the ED, an on-call physician has the option of sending a licensed, non-physician practitioner (i.e. PA, APNP) as his/her representative to appear at the hospital and provide further assessment or stabilizing treatment to an individual. This determination is based on the following:
 1. Individual's medical needs
 2. Capabilities of the hospital
 3. Applicable State scope of practice laws

4. Hospital bylaws and policies

However, the designated on-call physician is ultimately responsible for providing the necessary services to the individual in the ED regardless of who makes the in-person appearance. In the event that the treating physician disagrees with the on-call physician's decision to send a representative and requests the actual appearance of the on-call physician, then the on-call physician is required under EMTALA to appear in person.

- E. When it is necessary to transfer a patient because a Medical Staff member fails or refuses to appear within a reasonable time to provide necessary stabilizing treatment, the Emergency Department physician must list the name and address of such Medical Staff member in the transfer documentation sent to the receiving hospital in accordance with the Emergency Medical Treatment and Labor Act ("EMTALA"). Failure to do so is a violation of EMTALA that may result in penalties to the Medical Center and on-call Medical Staff member.
- F. Emergency department on-call schedules shall be coordinated and distributed by the Medical Staff Services Office. Physicians who are unable to provide coverage for the emergency department on-call rotation schedule are responsible for making prior arrangements with a qualified practitioner 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 physician(s) covering shall be given to the emergency department and Medical Staff Services Office.

References:

- EMTALA 42 U.S.C. § 1395dd
- EMTALA 42 C.F.R. § § 489.20 (r) and 489.24 (j)
- Wis. Admin. Code Chapter HFS 124.12 and 124.24(2)(c)(3)

Form(s):

Medical Executive

Committee Approval:

October 22, 2003, July 19, 2004, April 12, 2010,
February 10, 2014, September 8, 2014, October 13, 2014

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Credentials Committee

Policy Statement: It is the policy of the Medical Staff that the Credentials Committee shall take a leadership role in conducting reviews of the credentials for all Medical Staff and Allied Health Professionals requesting initial membership, privileges and re-appointment.

Guidelines:

A. Composition:

1. The Credentials Committee may consist of at least one active Medical Staff member from each clinical department appointed by the Medical Executive Committee.
2. The Chief of Staff shall designate one (1) of the members of the Credentials Committee to serve as the Chairperson.
3. The Administrator and the Manager of Medical Staff Services shall be invited to attend all meetings of the Credentials Committee.

B. Duties and Responsibilities:

The purpose and responsibilities of the Credentials Committee shall be:

1. To review the credentials of all applicants and to make recommendations to the Medical Executive Committee for staff appointment, assignments to departments and delineation of clinical privileges;
2. To review periodically all information available regarding the performance and clinical competence of staff appointees and other individuals with clinical privileges at the Medical Center and, as a result of such reviews, to make recommendations to the Medical Executive Committee for reappointments and renewal or changes in clinical privileges;
3. To report at each general Medical Executive Committee meeting and at other meetings as requested by the Medical Executive Committee; and
4. To perform such other duties as requested from time to time by the Medical Executive Committee.

C. Meetings:

The Credentials Committee shall meet as often as necessary, but in no event less than quarterly, to fulfill its responsibility and maintain a permanent record of its proceedings and actions. The Chairperson of the Credentials Committee may call special meetings of the Credentials Committee at any time.

D. Quorum:

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

E. Voting requirements:

If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless the Medical Staff Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number of affirmative votes.

F. Attendance Requirements:

Members of the Credentials Committee are expected to attend at least seventy percent (70%) of the meetings held.

References: Bylaws Article VIII, Committees Section 3 Committee Assignments

Form(s): None

Medical Executive Committee Approval: April 5, 2004 April 11, 2005

Board of Directors Approval: April 30, 2004 April 29, 2005

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Bylaws Committee

Policy Statement: It is the policy of the Medical Staff that the Bylaws Committee shall review the Medical Staff Bylaws no less frequently than annually and report recommendations to the Medical Executive Committee and the Medical Staff.

Guidelines:

A. Composition:

1. The Bylaws Committee shall consist of at least two (2) but not more than six (6) active Medical Staff members appointed by the Chief of Staff.
2. The Chief of Staff shall designate one (1) of the members of the Bylaws Committee to serve as the Chairperson.
3. The Hospital Administrator and Manager of Medical Staff Services shall be invited to attend all meetings of the Bylaws Committee.
4. Nonmembers from both within and outside the Medical Center may be consulted by the Bylaws Committee to provide expertise as required for the Bylaws Committee to perform its duties.

B. Duties and Responsibilities:

1. Knowledge of Medical Staff's Governing Documents.

All members of the Bylaws Committee should be familiar with the governing documents of the Medical Staff which consist of the Medical Staff Bylaws and Policies Governing Medical Practices. In addition, the Bylaws Committee should be familiar with other applicable Medical Center policies, standards established by the Joint Commission on Accreditation of Health Care Organizations and other applicable legal requirements.

2. Review and Make Recommendations Regarding the Bylaws.

The Bylaws Committee shall review the Bylaws and proposed amendments to the Bylaws. Following its review, the Bylaws Committee shall report its recommendations to the Medical Executive Committee and to the Medical Staff at their next regular meetings or at special meetings called for such purpose.

3. Other Duties

The Bylaws Committee shall perform such other duties as requested from time to time by the Medical Executive Committee.

C. Meetings:

The Bylaws Committee shall meet as often as necessary, but in no event less than annually, to fulfill its responsibility and maintain a written record of its proceedings and actions.

D. Quorum:

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

E. Voting Requirements:

If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless the Medical Staff Bylaws, the Policies Governing Medical Practices, or any law, ordinance, or governmental rule or regulation requires a greater number of affirmative votes.

F. Attendance Requirements:

Members of the Bylaws Committee are expected to attend at least seventy percent (70%) of the meetings held.

References: Medical Staff Bylaws Articles VIII and XIII

Form(s): None

Medical Executive Committee Approval: June 14, 2004 April 11, 2005 December 11, 2017

Board of Directors Approval: June 25, 2004 April 29, 2005 December 18, 2017

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Cancer Committee

Purpose: It is the policy of the Medical Staff that the Cancer Committee shall be responsible for goal setting, planning, initiating, implementing, evaluating and improving all cancer-related activities at the Medical Center.

Guidelines:

A. Composition

1. The Cancer Committee is a multidisciplinary committee of the Medical Center's Medical Staff. The Cancer Committee shall include at least one (1) physician member from each of the following specialties: diagnostic radiology, pathology, general surgery, medical oncology and radiation oncology. In addition, the Cancer Committee shall include at least one (1) non-physician member from each of the following: cancer program administration, oncology nursing, social services, cancer registry and quality improvement.
2. Nonmembers from both within and outside the Medical Center may be consulted by the Cancer Committee to provide expertise as required for the Cancer Committee to perform its duties properly. Such consultants shall serve in a nonvoting capacity.
3. The Medical Executive Committee shall designate one (1) member of the Cancer Committee to serve as the Cancer Committee Chair and one (1) member to serve as the Cancer Liaison Physician who provides a direct link between the cancer program and the American College of Surgeons. The Cancer Committee Chair shall advise the Chief of Staff and the Medical Executive Committee of all cancer-related activities.

B. Duties and Responsibilities

The duties and responsibilities of the Cancer Committee are to:

1. Follow the requirements outlined in the most current Commission on Cancer ("CoC") Program Standards.
2. Be accountable for all cancer program activities at the Medical Center;
3. Designate one (1) coordinator for each of the four (4) areas of Cancer Committee activity: cancer conference, quality control of

cancer registry data, quality improvement and community outreach;

4. Develop annual goals and objectives for clinical, community outreach, quality improvement and programmatic endeavors related to cancer care;
5. Evaluate annual goals and objectives for clinical, community outreach, quality improvement and programmatic endeavors on an annual basis;
6. Establish the frequency, format and multidisciplinary attendance requirements for cancer conferences on an annual basis;
7. Ensure that the required number of cases is discussed at each cancer conference and that at least seventy-five percent (75%) of such cases are presented prospectively;
8. Monitor and evaluate the cancer conferences' frequency, multidisciplinary attendance, total case presentation and prospective case presentation on an annual basis;
9. Establish and implement a plan to evaluate the quality of cancer registry data and activity on an annual basis;
10. Complete site-specific analysis that includes comparison and outcome data and disseminate the results of the analysis to the Medical Staff;
11. On an annual basis, review ten percent (10%) of the analytic caseload to ensure that American Joint Committee on Cancer (AJCC) staging is assigned by the managing physician and recorded on a staging form in the medical record on at least ninety percent (90%) of eligible analytic cases;
12. On an annual basis, monitor that a ten percent (10%) review of the analytic caseload is completed to ensure that ninety percent (90%) of cancer pathology reports include the scientifically validated data elements outlined in the College of American Pathologists ("CAP") protocols;
13. Provide a formal mechanism to educate patients about cancer-related clinical trials;
14. Review the percentage of cases accrued to cancer-related clinical trials each year;
15. Monitor community outreach activities on an annual basis;

16. Offer one (1) cancer-related educational activity each year;
17. Complete and document the required studies that measure quality and outcomes;
18. Implement two (2) improvements that directly affect patient care;
19. Review Cancer Registry policies and procedures; and
20. Perform such other duties as requested from time to time by the Medical Executive Committee.

C. Meetings

1. The Cancer Committee shall meet as often as necessary to fulfill its duties and responsibilities, but in no event less than quarterly each calendar year. The Cancer Committee Chair may call special meetings of the Cancer Committee at any time.
2. The Cancer Committee shall keep written minutes to document its findings, conclusions, recommendations, actions and any follow-up required.

References: American College of Surgeons Cancer Manual

Form(s):

Medical Executive Committee Approval: August 13, 2007

Board of Directors Approval: August 24, 2007

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Peer Review Policy and Peer Review Committee

Policy Statement: 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 and Allied Health Professional Staff members (collectively, “Member” or “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 to improve the quality of health care. Such activities will be conducted in a manner consistent with the Wisconsin Statutes §§ 146.37 and 146.38.

Guidelines:

A. Definitions

1. 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:
 - a. The term “peer” means a Medical Staff member who is in the same or similar specialty as the review subject.
 - b. The term “peer review” means the study, review, investigation, evaluation, or assessment of the training, experience, skill, professional conduct, qualifications, or current competence of one or more Members by one or more of his/her peers.
 - c. The term “external peer review” means the study, review, investigation, evaluation, or assessment of the training, experience, skill, professional conduct, qualifications, or current competence of one or more Members by an individual or individuals who are not Medical Staff members but who, in the case of peer review of a Medical Staff member shall: (i) have the same professional licensure (e.g., physician, dentist, podiatrist, etc.) as the Medical Staff member review subject; and (ii) are in the same or a similar specialty as the Medical Staff member review subject or are in a different specialty but the individual’s core or specialized training significantly overlaps the primary elements of the type of care or technique that will be subject to review.

- d. The term “review subject” means the Medical Staff member or the Allied Health Professional Staff member whose services or conduct is being reviewed.
- e. The “standard of care” against which the review subject is measured means the standard of care of the Medical Staff of the Medical Center.

B. Peer Review Committee

1. The Peer Review Committee shall be composed of at least five (5), but no more than eight (8), Medical Staff members from different specialties or departments designated by the Medical Executive Committee to serve as the Peer Review Committee. The Medical Executive Committee shall designate one (1) of the Peer Review Committee 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 Quality Enhancement Director and Medical Director for Quality shall be invited to attend all meetings of the Peer Review Committee in a nonvoting capacity.
2. The Peer Review Committee shall perform case reviews and oversight functions related to physician performance in accordance with such guidelines as the Peer Review Committee shall implement from time to time.
3. Members of the Peer Review Committee shall act as initial physician reviewers. If additional clinical expertise is needed, the Peer Review Committee may request assistance from other Members as it deems appropriate.
4. Department Clinical Chairpersons are responsible for working with the Members in their department who are under review to implement recommendations of the Peer Review Committee.
5. The Peer Review Committee shall meet as needed at the call of its Chairperson.
6. A quorum shall consist of at least fifty percent (50%) of the voting members of the Peer Review Committee. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless the Medical Staff Bylaws, Policies Governing Medical Practices, Medical Center policies, or any law, ordinance, or governmental rule or regulation requires a greater number of affirmative votes.

C. General Procedures for Peer Review

1. Any person (including, without limitation, Members, patients, family members, etc.) may forward for peer review any issues or concerns relating to a Member's training, experience, skill, professional conduct, qualifications, or current competence to the Medical Executive Committee, the Clinical Chairperson of the appropriate department, or the Medical Staff Chief of Staff. The issue or concern may be immediately referred to the Peer Review Committee.
2. A peer may decline to participate in peer review only if the Chief of Staff excuses him/her from service.
3. Peer review will be based upon medical records and reports, participation by the review subject, and other information set forth in Sections D.2. and E.5. below and as determined necessary or relevant by the body conducting the peer review.
4. Unless the matter is submitted for external peer review, the peer review will generally be completed within sixty (60) days of the date the matter was referred to the Peer Review Committee. This timeframe may be used as a general guide, but may also be expanded on a case-by-case basis subject to the particular case in review.
5. When issues regarding a Member are identified during peer review, such Member shall be notified of the same in writing.
6. A written report containing findings and conclusions shall be made and filed in the Member's quality assurance file for all focused peer review, external peer review, and ongoing peer review. Conclusions should reference, as appropriate, any literature and relevant clinical practice guidelines upon which the Peer Review Committee based its decision. Majority and minority opinions of the Peer Review Committee, if any, will be considered and included in the report. When follow-up action by another body is warranted, the report will also be forwarded to the appropriate person or committee for follow-up as is deemed appropriate.
7. In the event the initial peer review of a Medical Staff Member results in consideration of a request for a corrective action, and if the initial peer review body did not contain (i) a peer who is in the same or similar specialty as the review subject, or (ii) a peer who is in a different specialty but whose core or specialized training significantly overlaps the primary elements of the type of care or technique that will be subject to review, then further peer review will be undertaken involving at least one peer who meets the above qualifications.
8. The information resulting from peer review is used to determine whether to reappoint a Member and/or to continue, modify or revoke a Member's

existing clinical privilege(s). Such information is also integrated into performance improvement activities, consistent with the Medical Center's policies and procedures that are intended to preserve the confidentiality and privilege of information. The Quality Enhancement Manager will complete the Practitioner Profile and submit the same to Medical Staff Services for the reappointment process.

D. Ongoing Peer Review

1. Ongoing peer review allows the Medical Center to identify professional practice trends that impact quality of care and patient safety. Such identification may require intervention by the Medical Staff. Ongoing peer review is factored into the decision to permit a Member to maintain existing privilege(s), to modify his or her existing privilege(s), or to revoke his or her existing privilege(s) prior to or at the time of reappointment and renewal or modification of clinical privileges.
2. Ongoing peer review may include, without limitation, periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussions with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing and administrative personnel, etc.).
3. It is the responsibility of the Peer Review Committee to conduct a primary retrospective review of selected completed records of discharged patients and other pertinent sources of medical data relating to patient care.
4. Each department shall develop objective criteria that reflect current knowledge and clinical experience to be used in monitoring and evaluating patient care. Pursuant to these criteria, the Peer Review Committee shall review and consider problems in:
 - a. Operative and other clinical procedure(s) performed and their outcomes;
 - b. Pattern of blood and pharmaceutical usage including, without limitation, use of blood and blood components;
 - c. Requests for tests and procedures;
 - d. Length of stay patterns;
 - e. Morbidity and mortality data;
 - f. Use of consultants;
 - g. Medical assessment and treatment of patients;

- h. Use of medications;
 - i. Efficiency of clinical practice patterns;
 - j. Significant departures from established patterns of clinical practice;
 - k. The use of developed criteria for autopsies;
 - l. Sentinel event data;
 - m. Patient safety data; and
 - n. Such other instances as are believed to be important, such as patients currently in the Medical Center with unsolved clinical problems.
5. The Peer Review Committee shall meet on a regular basis to review and analyze on a peer-group basis the quality of clinical performance and shall make recommendations to improve the quality of patient care.

E. Focused Peer Review

- 1. Focused peer review is a process whereby the Medical Center evaluates a specific aspect of a practitioner's performance.
- 2. As of January 1, 2008, focused peer review shall be conducted for all Members upon obtaining clinical privileges at the Medical Center to validate their competency in performing the requested privileges at the Medical Center.
- 3. Focused peer review is also conducted whenever a question arises as to whether the care provided by or the conduct of a Member met or meets the standard of care and/or when a pattern of cases or circumstances arise that are potentially indicative of a problem with a Member's clinical judgment, expertise, or professional conduct. Examples include, but are not limited to:
 - a. Cases referred by a Medical Staff department or the Peer Review Committee, as a result of ongoing peer review; and
 - b. Cases referred by a Member, Medical Center staff member or patient complaint;
 - c. Cases referred by the Utilization Review Committee;
 - d. Any sentinel event involving a Member; and

- e. A pattern of cases or circumstances potentially indicative of a problem with a Member's clinical judgment, expertise, or professional conduct.
4. Focused peer review is conducted through the appropriate Clinical Chairperson and/or the Peer Review Committee and shall continue until the Member demonstrates, to the satisfaction of the applicable Clinical Chairperson and/or the Peer Review Committee, appropriate clinical competence, practice behavior and ability to perform privileges. A peer's participation in focused peer review shall not imply the peer's participation in or direction of any given case of the Member being evaluated.
 5. Focused peer review may include, without limitation, chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussions with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing and administrative personnel, etc.).
- F. External Peer Review
1. External peer review may be performed whenever deemed appropriate. Examples include, but are not limited to:
 - a. Lack of internal expertise - An insufficient number of appropriate peers are available or able to serve as reviewers;
 - b. Litigation - The Medical Center faces a potential medical malpractice suit;
 - c. Conflict of interest - The internal reviewers submit conflicting or vague recommendations, or fail to reach a common understanding, that will affect a Member's membership or privileges; and
 - d. Medical Staff recommendation - The Medical Executive Committee, the Peer Review Committee, and/or the applicable Clinical Chairperson may at any time request external peer review.
 2. Due to the fact that external peer review is conducted by an individual who is not a member of the Medical Staff, the timing within which an external peer review shall be completed is determined on a case-by-case basis, depending upon the availability of the external reviewer, the scope of the review, and other relevant factors.
 3. Results of external peer review will be forwarded to the applicable Clinical Chairperson, the Medical Executive Committee and/or the Peer Review Committee, as appropriate, for consideration in determining the standard of care.

G. Confidentiality and Immunity

1. All peer review 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 this Policy and conducted in good faith are intended to be protected by the civil immunity protections of Wisconsin Statutes § 146.37.
3. The confidentiality and immunity provisions of this Section G of this Policy apply to individuals involved in peer review activities as well as other individuals designated to assist in carrying out the peer review duties and responsibilities.

References:

- Medicare Conditions of Participation, 42 C.F.R. §§ 482.21 and 482.22(b)
- Wis. Stat. §§ 146.37 and 146.38
- Wis. Admin. Code HFS § 124.10
- JCAHO Standards MS. 3.10, 3.20, 4.30, 4.40 and 4.45, 2007
- 2005. Effective Peer Review: A Practical Guide to Contemporary Design. HCPro, Inc.: Massachusetts.

Form(s):

Medical Executive

Committee Approval: October 22, 2003 April 11, 2005 February 13, 2006 May 13, 2008

Board of Directors

Approval: October 23, 2003 April 29, 2005 March 31, 2006 May 30, 2008

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Distribution of Significant Amendments to the Medical Staff of Bylaws and Policies Governing Medical Practices and Compliance with Medical Center Policies

Policy Statement: It is the policy of this Medical Staff that amendments to the Medical Staff bylaws and Policies Governing Medical Practices shall be circulated and that Medical Staff and Allied Health Professionals shall comply with Medical Center Policies.

Guidelines:

- A. Amendments to the Medical Staff bylaws or Policies Governing Medical Practices are made in the manner described in the body of the Medical Staff bylaws. If significant changes are made to the Medical Staff bylaws or Policies Governing Medical Practices, Medical Staff members and other individuals who have delineated clinical privileges will be provided with revised texts of the written material by the Medical Staff Services Office.
- B. All Medical Staff members and Allied Health Professionals shall comply with the Medical Staff bylaws and Policies Governing Medical Practices as well as other Medical Center policies, as same may be amended from time to time.

References: JCAHO Standards MS. 2.1 and MS. 2.4, 2003

Form(s):

Medical Executive Committee Approval: October 22, 2003 April 11, 2005

Board of Directors Approval: October 23, 2003 April 29, 2005

MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Unenforceable Oral Agreements and Arrangements

Policy Statement: The Medical Center is committed to establishing policies and developing effective internal controls that will promote adherence to applicable legal requirements and ensure compliance with the principles and guidelines established under the Medical Center's Compliance Program. These ongoing efforts require Medical Center compliance with all laws, not only with respect to the delivery of health care, but also with respect to its business affairs and dealings with physicians.

Guidelines:

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 Section 12.3.1, the terms "physician" and "member of a physician's immediate family" shall have the meanings prescribed to such terms in 42 CFR §411.351.

References: None

Form(s):

Medical Executive Committee Approval: August 13, 2012

Board of Directors Approval: October 29, 2012