MEDICAL STAFF POLICIES GOVERNING MEDICAL PRACTICES

Aurora Medical Center Sheboygan County
Sheboygan, Wisconsin
AURORA MEDICAL CENTER SHEBOYGAN COUNTY  
Medical Staff Policies Governing Medical Practices

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ADMISSION, TRANSFER AND DISCHARGE

POLICY STATEMENT

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

1. **ADMISSION**

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

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

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

1.4 **Admission Order.**
All Medical Center inpatients must be admitted upon the recommendation of a Physician, Dentist, Oral Surgeon or Podiatrist.\(^1\) The admitting Practitioner must enter an admission order that includes the following:

(a) admission diagnosis(es) and reason(s) for admission;
(b) admission status (inpatient or outpatient)
(c) name of the admitting Practitioner;
(d) name of the attending Physician (as applicable); and
(e) if the admitting Practitioner is a Dentist, Oral Surgeon, or Podiatrist, the name of the Medical Staff Physician who will be responsible for the medical aspects of care for such patient during the inpatient stay.\(^2\)

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

(a) a concise statement of the patient’s complaints, including the chief complaint, and the date of onset and duration of each;³

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

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

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

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

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

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

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

1.8 Frequency of Patient Attendance.

⁴ Wis. Admin. Code DHS § 124.14(3)(a)5 (2009); JCS RC.01.01.01, EPs 5 & 6 (Jul. 2015); JCS RC.02.01.01, EP 2 (Jul. 2015).
⁵ Wis. Admin. Code DHS § 124.05(2)(g)1 (2016).
In order to ensure timely care and treatment of all Medical Center inpatients, the attending Practitioner must come to the Medical Center and evaluate his/her patients as soon as reasonably possible after admission. As a general guideline, for patients admitted from the Emergency Department to an inpatient unit, the attending Practitioner should evaluate the patient within twenty four (24) hours of admission. For patients admitted from the Emergency Department to an Intensive Care Unit, the attending Practitioner should evaluate that patient within six (6) hours of admission. After the initial visit, all Medical Center inpatients should be seen on at least a daily basis by the admitting or attending Practitioner, or his or her designee; provided, however, all behavioral health services patients must be seen by a psychiatrist at least every forty-eight (48) hours. These timeframes are guidelines, and certain circumstances will require greater urgency.

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

2. Transfer

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

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

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

3. Discharge

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

6 JCS PC.04.01.01, EP 2 and JCS PC.02.02.01, EP 1-3 (Jul. 2015).
7 JCS RC.02.04.01, EP 3, Note 2 & JCS PC.04.01.01, EP 2 (Jul. 2015).
8 Wis. Admin. Code DHS § 124.20(2)(n)4 (2016); JCS RC.02.01.03 EP 9 (Jul. 2015).
9 JCS PC.04.01.01, EP 2 and JCS PC.02.02.01, EP 1-3 (Jul. 2015).
Center internal or external review process.\textsuperscript{10} The admitting or attending Practitioner may request a discharge planning evaluation, and the Medical Center will perform the evaluation upon request. In addition, the admitting or attending Practitioner shall cooperate with the Medical Center’s discharge planning staff to:

(a) Identify any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer;\textsuperscript{11}

(b) Include the patient, the patient’s family, Practitioners, clinical psychologists, and other staff involved in the patient’s care, treatment, and services in planning for the patient’s discharge or transfer;\textsuperscript{12}

(c) Assist in arranging the services required by the patient after discharge in order to meet the patient’s ongoing needs for care and services;\textsuperscript{13} and

(d) Provide the patient and the patient representative information regarding:
   i. why he or she is being discharged or transferred;\textsuperscript{14}
   ii. any alternatives to transfer or discharge;\textsuperscript{15}
   iii. the types of continuing care, treatment, and services the patient will need after discharge;\textsuperscript{16} and
   iv. how to obtain any continuing care, treatment, and services that the patient will need.\textsuperscript{17}

3.2 Discharge Order.

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

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

3.3 Discharge Instructions.

The admitting or attending Practitioner must ensure that the patient or his/her patient representative receives appropriate written discharge instructions.\textsuperscript{18}

\textsuperscript{10} JCS LD.04.02.05, EP 1 (Jul. 2015).
\textsuperscript{11} JCS PC.04.01.03, EP 2 (Jul. 2015).
\textsuperscript{12} JCS PC.04.01.03, EP 3 (Jul. 2015).
\textsuperscript{13} JCS PC.04.01.03, EP 4 (Jul. 2015).
\textsuperscript{14} JCS PC.04.01.05, EP 3 (Jul. 2015).
\textsuperscript{15} JCS PC.04.01.05, EP 5 (Jul. 2015).
\textsuperscript{16} JCS PC.04.01.05, EP 2 (Jul. 2015).
\textsuperscript{17} JCS PC.04.01.05, EP 7 (Jul. 2015).
\textsuperscript{18} JCS PC.04.01.05, EP 8 (Jul. 2015).
3.4 **Discharge Summary.**

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

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

i. date of discharge;

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

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

iv. significant findings and complications (if any);

v. summary of the care, treatment and services provided22 (including the procedures performed, treatments rendered, the outcome(s) of such procedures and treatments and progress towards goals23);

vi. condition of the patient upon discharge (including the patient’s physician and psychosocial status24) stated in a manner that allows specific comparison to the patient’s condition upon admission/registration;25

vii. the method of transport (if any);

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

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19 CFR § 482.24(c)(2)(vii) (Interpretive Guidelines, effective October 17, 2008).
20 JCS RC.02.04.01 (Jul. 2015).
21 42 CFR § 482.24(c)(2)(viii) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(3)(a)13 (2016); JCS RC.02.01.01, EP 2 (Jul. 2015).
22 JCS PC.02.04.01, EP 3 (Jul. 2015).
23 JCS PC.04.02.01, EP 1 (Jul. 2015).
24 JCS PC.04.02.01, EP 1 (Jul. 2015).
25 42 CFR § 482.24(c)(2)(vii) (Interpretive Guidelines, effective October 17, 2008).
living facilities, and community resources or referrals made or provided to the patient); and
ix. any other specific instructions given to the patient and/or the patient’s representatives upon discharge (e.g., activity, diet, medications, follow-up care, etc.). If no discharge instructions were required, the discharge summary shall indicate as such.

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

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

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

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

3.6 Discharge/Transport from Medical Center Inpatient/Outpatient Departments.
Medical Center patients may be discharged from any Medical Center inpatient or outpatient department and transported to another non-Medical Center facility if the Practitioner ensures that:

(a) the receiving facility has the capability to manage the patient’s condition;
(b) the receiving facility has consented to the admission and appropriate transfer arrangements have been made;
(c) the patient is considered sufficiently stabilized for transport; and

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

3.7 **Discharge of Infants.**

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

3.8 **Objections to Discharge.**

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

**REFERENCES:**

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

**Wisconsin Statutes**
- Wis. Stat § 146.37 (2016).

**Wisconsin Administrative Code**

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

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

FORM(S):  None

MEDICAL EXECUTIVE COMMITTEE APPROVAL:  3/19/2013, 7/23/13, 9/26/17, 2/7/23

BOARD OF DIRECTORS APPROVAL:  4/18/2013, 8/12/13, 12/18/17, 2/20/23

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

POLICY STATEMENT

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

1. STAFF MEMBERSHIP

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Wis. Adm. Code Med § 8.10(2).
Clinical Privileges shall not exceed those granted to the collaborating or supervising Physician(s) (if any).

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

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

**REFERENCES:**

- **Wisconsin Statutes & Administrative Code**

- **Code of Federal Regulations**
  - None

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

**FORM(S):**

- **MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 3/19/13; 7/22/14, 9/26/17, 2/7/23
- **BOARD OF DIRECTORS APPROVAL:** 4/18/13; 8/18/14, 12/18/17, 2/20/23
- **POLICY STEERING COMMITTEE APPROVAL:** 10/25/17
Compliance and Integrity

Compliance Communication of Regulatory Requirements

Wisconsin Hospital Co-Signature Requirements

This table does not provide any guidance regarding the documentation necessary to support billing or reimbursement for any services ordered or provided.

The purpose of the following chart is to set forth a consistent, system-wide approach to the authority of certain professionals to perform certain tasks in the hospital setting, including provider-based locations. The chart does not authorize any individual to make any of the medical record entries noted below. Nothing in this table is intended to prevent an individual from serving as a scribe for a provider. However, a scribe must clearly identify their role in the documentation.

An individual may only perform those tasks that are:

1. Within the scope of his/her employment, license, certification, training, experience, collaboration/supervision agreement
2. Within the clinical privileges or clinical functions specifically granted by the hospital, job descriptions; and
3. In accordance with applicable hospital or medical staff bylaws, polices and procedures. Hospital and medical staffs may have specific requirements that are more restrictive than the guidance set forth in the following table. Be sure to check your site medical staff bylaws and medical staff policies.

The same restrictions for an individual that govern the need for co-signature on an order, apply to that individual’s authority to diagnose the patient’s condition. Diagnosing a patient must be done within the individual’s licensure and scope of practice. A diagnosis is typically documented within an order or notes entry to the medical record.
PA: Physician Assistants – the PA must have a Supervisory Agreement in place

APNP: Advanced Practice Nurse Prescribers: Advanced Practice Nurses (APN) with prescriptive authority, including Nurse Practitioners (NPs), Certified Nurse Midwives (CNM), Certified Registered Nurse Anesthetists (CRNAs), and Clinical Nurse Specialists (CNSs) – the APNP must have a Collaborative Agreement in place

APN: Advanced Practice Nurses: including NPs, CNM, and CNSs

CRNA: Certified Registered Nurse Anesthetist

RN: Registered Nurses

Ancillary Staff: Physical Therapists, Occupational Therapists, Speech Pathologists, Audiologists, Respiratory Therapists, Surgical Technicians, Orthopedic Technicians, Radiology Technicians, Laboratory Technicians, Dietitians, Genetics Counselors, Blood Center Technicians, Psychologists

R.Ph: Pharmacist

AA: Anesthesiologist Assistants – the AA must have a Supervisory Agreement in place
<table>
<thead>
<tr>
<th>Entry</th>
<th>PA &amp; APN&lt;sup&gt;26&lt;/sup&gt;</th>
<th>APN</th>
<th>RN</th>
<th>Ancillary Staff</th>
<th>R.Ph</th>
<th>Resident / Fellow</th>
<th>Medical Student</th>
<th>Podiatrist</th>
<th>DDS</th>
<th>Chiropractor</th>
<th>CRNA &amp; AA</th>
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<tbody>
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<td>Admission Order (Inpatient)</td>
<td>No authority to issue; May receive/enter a verbal order only.&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No authority to issue; May receive/enter a verbal order only.&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No authority to issue; May receive/enter a verbal order only.&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>No authority to issue; May receive/enter a verbal order only.&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No authority to issue; May not receive/enter a verbal order for admission.</td>
<td>No authority to issue unless privileged to do so. If privileged, no co-signature required.</td>
<td>No authority to issue; May enter order as posted as part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order.</td>
<td>May co-admit.</td>
<td>May co-admit, but staff physician must provide all care not specifically dental.</td>
<td>May co-admit with a collaborating physician.</td>
</tr>
<tr>
<td>Transfers from ED to outside facility</td>
<td>If designated as a Qualified Medical Person (QMP) by Medical Staff Bylaws as qualified to administer one of more types of Medical Screening Exams (MSE) and/or complete and sign a transfer certification in consultation with a physician.</td>
<td>If designated as a Qualified Medical Person (QMP) by Medical Staff Bylaws as qualified to administer one of more types of Medical Screening Exams (MSE) and/or complete and sign a transfer certification in consultation with a physician.</td>
<td>No authority to issue unless an OB nurse who is designated as a QMP by Medical Staff Bylaws as qualified to administer one of more types of MSE and/or complete and sign a transfer certification in consultation with a physician.</td>
<td>No authority to issue; May not receive/enter a verbal order for admission.</td>
<td>No authority to issue; May not receive/enter a verbal order for admission.</td>
<td>No authority to issue; May not receive/enter a verbal order for admission.</td>
<td>No co-signature required.</td>
<td>No authority to issue; May enter order as posted as part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order.</td>
<td>May co-admit.</td>
<td>May consult with physician on staff regarding transfer.</td>
<td>May co-transfer with a collaborating physician.</td>
</tr>
<tr>
<td>Transfer I/P to I/P to another hospital</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
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<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>May co-admit.</td>
<td>May co-admit.</td>
<td>May co-admit with a collaborating physician.</td>
</tr>
<tr>
<td>Entry</td>
<td>PA &amp; APNP</td>
<td>APN</td>
<td>RN</td>
<td>Ancillary Staff</td>
<td>R.Ph</td>
<td>Resident / Fellow</td>
<td>Medical Student</td>
<td>Podiatrist</td>
<td>DDS</td>
<td>Chiropractor</td>
<td>CRNA &amp; AA</td>
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<tr>
<td><strong>Transfer In-house (between units)</strong></td>
<td>No co-signature required.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>No authority to issue; May not receive/enter a verbal order for admission.</td>
<td>No authority to issue; May not receive/enter a verbal order for admission.</td>
<td>No co-signature requirement</td>
<td>No authority to issue; May enter order as pended as part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order.</td>
<td>No co-signature requirement</td>
<td>No co-signature requirement</td>
<td>No co-signature requirement</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
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</tbody>
</table>

**Exception:** IP transfer to BH unit may receive/enter a verbal order only.  

**Medication Order** | PA: No co-signature requirement, unless the PA’s written guidelines require co-signature. Guidelines must be reviewed at least annually (Supervisory Agreement).  

**APNP:** No co-signature requirement. | No authority to issue; May receive/enter a verbal order only. | No authority to issue; May receive/enter a verbal order only. | No authority to issue; May not receive/enter a verbal order for medications.  

**Exceptions:** Respiratory Therapists and Radiology Technicians employed by the Hospital may receive/enter verbal orders for certain medications to be administered by the therapist/technician during the administration of respiratory therapy of radiology tests.  

**Exceptions:** Dietitians may order vitamin or mineral supplements if approved by the site Medical Executive Committee | May issue pursuant to a valid delegation of medical acts by a physician to the ordering pharmacist. May receive/enter a verbal order. | May issue medications within scope of practice | May issue medication orders within scope of practice | May issue medication orders within scope of practice | No authority to order medications independently.  

**AA:** No authority to issue; May receive/enter a verbal order only.
<table>
<thead>
<tr>
<th>Entry</th>
<th>PA &amp; APN²⁸</th>
<th>APN</th>
<th>RN</th>
<th>Ancillary Staff</th>
<th>R.Ph</th>
<th>Resident / Fellow</th>
<th>Medical Student</th>
<th>Podiatrist</th>
<th>DDS</th>
<th>Chiropractor</th>
<th>CRNA &amp; AA</th>
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</thead>
<tbody>
<tr>
<td>Prescription</td>
<td>PA: No co-signature requirement, unless the PA's written guidelines require co-signature. Guidelines must be reviewed at least annually (Supervisory Agreement).¹ APNP: No co-signature required except may not issue a prescription order for any Schedule I controlled substance. May not prescribe, dispense or administer any amphetamine, sympathomimetic amine drug or compound designated as a Schedule II controlled substance to any person (with exceptions): May not prescribe, order, dispense or administer any anabolic steroid for the purpose of enhancing athletic performance or for other non-medical purpose.² APNP: requires waiver to prescribe or dispense buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000).²⁹,³⁰</td>
<td>No authority to issue.</td>
<td>No authority to issue.</td>
<td>No authority to issue; May not receive/enter a verbal order.</td>
<td>No co-signature required.</td>
<td>No authority to issue; May enter order as pending for part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order.</td>
<td>May issue prescription orders within scope of practice.</td>
<td>May issue prescription orders within scope of practice.</td>
<td>No authority to order prescriptions independently.</td>
<td>No authority to issue; May receive/enter a verbal order only</td>
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<tr>
<td>Order Type</td>
<td>Requirement</td>
<td>Issue Authority</td>
<td>Details</td>
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<tr>
<td>Diagnostic Testing Order (Inpatient and outpatient)</td>
<td>No co-signature requirement</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>For blood products ordered in the OR, the lab technician cannot accept a verbal order from a nurse.</td>
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<td>No co-signature required</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>PIs are allowed to provide Direct Access (practice without referral) services under specific conditions.</td>
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<td>No authority to issue; May enter a verbal order or protocol co-sign</td>
<td>No authority to issue; May not receive/enter a verbal order.</td>
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<td>No authority to issue</td>
<td>No authority to issue</td>
<td>May issue order within scope of practice.</td>
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<td>No authority to issue</td>
<td>No authority to issue; May enter order as pended as part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order.</td>
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| Rehab Services Order (Inpatient and outpatient) (PT, OT, ST, audiology) | No co-signature requirement | No authority to issue; May receive/enter a verbal order only. | Licensed Acupuncturists must be under the supervision of an employing or sponsoring member of the medical staff. |
| | No co-signature requirement | No authority to issue; May receive/enter a verbal order only. | |
| | No authority to issue | No authority to issue | May issue order within scope of practice. |
| | No authority to issue | No authority to issue; May enter order as pended as part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order. |

| Acupuncture | No co-signature requirement | No authority to issue; May receive/enter a verbal order only. | May issue order within scope of practice. |
| | No co-signature requirement | No authority to issue | May issue order within scope of practice. |
| | No authority to issue | No authority to issue; May enter order as pended as part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order. |

**AA:** No authority to issue.
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<tbody>
<tr>
<td>No co-signature required, May receive/enter a verbal order only.</td>
<td>No co-signature required, May receive/enter a verbal order only.</td>
<td>No co-signature required for dieticians if approved by site Medical Staff.</td>
<td>No co-signature required for dieticians if approved by site Medical Staff.</td>
<td>Speech Therapists can order diet consistency changes for particular types of patients if approved by site Medical Staff.</td>
<td>No authority to issue; May not receive/enter a verbal order.</td>
<td>No authority to issue; May not receive/enter a verbal order.</td>
<td>No authority to issue; May enter order as pended as part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order.</td>
<td>No authority to issue.</td>
<td>May issue order within scope of privilege</td>
<td>No authority to issue.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
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<tbody>
<tr>
<td>No co-signature required</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>No co-signature required for dieticians if approved by site Medical Staff.</td>
<td>No authority to issue; May enter order as pended as part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order.</td>
<td>No authority to issue.</td>
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<td>No authority to issue.</td>
<td>No authority to issue.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
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<tr>
<th>Respiratory Therapy Services Order</th>
<th>Respiratory Therapy Services Order</th>
<th>Respiratory Therapy Services Order</th>
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<th>Respiratory Therapy Services Order</th>
<th>Respiratory Therapy Services Order</th>
<th>Respiratory Therapy Services Order</th>
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<tbody>
<tr>
<td>No co-signature requirement, May receive/enter a verbal order only.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
<td>No authority to issue; May not receive/enter a verbal order.</td>
<td>No authority to issue; May not receive/enter a verbal order.</td>
<td>No authority to issue; May not receive/enter a verbal order.</td>
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<td>No authority to issue; May not receive/enter a verbal order.</td>
<td>No authority to issue; May not receive/enter a verbal order.</td>
<td>No authority to issue; May not receive/enter a verbal order.</td>
</tr>
</tbody>
</table>

Created by: Shelly Reid    Created Date: 01/01/2013
<p>| DNR Order | No authority to issue; May receive/enter a verbal order only.22 Order not valid until signed by physician. | No authority to issue; May receive/enter a verbal order only.22 Order not valid until signed by physician. | No authority to issue; May receive/enter a verbal order only. | No authority to issue; May receive/enter a verbal order only. | No authority to issue; May not receive/enter a verbal DNR order. | No authority to issue. | No authority to issue. | No authority to issue. | No authority to issue. | No authority to issue. | No authority to issue. | No authority to issue. | AA: No authority to issue. |
|-----------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| Admission Note | No co-signature requirement.15, 16 | No co-signature requirement. | No authority to issue. | No authority to issue. | No co-signature requirement | No authority to issue. | No co-signature requirement | No authority to issue. | No authority to issue. | No co-signature requirement | No authority to issue; May enter order as pended as part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order. | No authority to issue. | No co-signature requirement | AA: No authority to issue. |
| Restraints (acute medical surgical) | APNP – no co-signature requirement but must notify attending physician as soon as possible.14 PA – may write restraint orders pursuant to a delegated task (in the supervisory agreement) by their supervising physician. May receive/enter a verbal order.14 | No authority to issue; May receive/enter a verbal order only.14 | No authority to issue; May receive/enter a verbal order only. | No authority to issue; May receive/enter a verbal order only. | No authority to issue; May receive/enter a verbal order only. | No authority to issue; May receive/enter a verbal order only. | No authority to issue; May not receive/enter a verbal DNR order. | No authority to issue. | No authority to issue. | No authority to issue. | No authority to issue. | No authority to issue. | No authority to issue. | AA: No authority to issue. |
| Restraints (I/P) for mental illness, developmental disabilities, alcoholism, or drug dependency | No authority to issue; May receive/enter a verbal order only.25 | No authority to issue; May receive/enter a verbal order only | No authority to issue; May receive/enter a verbal order only | No authority to issue; May receive/enter a verbal order only | No authority to issue; May not receive/enter a verbal order. | No authority to issue; May not receive/enter a verbal order. | No authority to issue; May not receive/enter a verbal order. | No authority to issue; May not receive/enter a verbal order. | No authority to issue; May not receive/enter a verbal order. | No authority to issue; May not receive/enter a verbal order. | No authority to issue; May not receive/enter a verbal order. | No authority to issue; May not receive/enter a verbal order. | No authority to issue; May not receive/enter a verbal order. | AA: No authority to issue. |</p>
<table>
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<tr>
<th>Seclusion</th>
<th>No authority to issue; May receive/enter a verbal order only.(^2)^</th>
<th>No authority to issue; May receive/enter a verbal order only</th>
<th>No authority to issue; May not receive/enter a verbal order only</th>
<th>No authority to issue; May not receive/enter a verbal order.</th>
<th>No authority to issue; May not receive/enter a verbal order.</th>
<th>No co-signature required but attending must be notified immediately</th>
<th>No authority to issue.</th>
<th>No authority to issue.</th>
<th>No authority to issue.</th>
<th>AA: No authority to issue.</th>
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</table>

**Physician Progress Note**

| No co-signature requirement.\(^7\),\(^14\) | No co-signature requirement.\(^7\) | No authority to issue. | No authority to issue. | No co-signature required.\(^23\) | Co-signature required. | No co-signature requirement within scope of practice. | No co-signature requirement within scope of practice. | AA: Co-signature required. |

**Consult Order**

| No co-signature requirement. | No co-signature requirement. | No authority to issue; May receive/enter a verbal order only | No authority to issue; May receive/enter a verbal order only | No authority to issue; May receive/enter a verbal order only | No authority to issue; May receive/enter a verbal order only | No co-signature required. | No authority to issue; May enter order as pending as part of participation in the order entry process with the attending. Also, any provider that is able to independently order the entry may sign the order. | May order within scope of practice. | May order within scope of practice. | May order within scope of practice. | AA: No authority to issue. |

**Consultation Report**

<p>| No co-signature requirement. May independently issue. Please note that some hospital policies do not allow PA/APNP to independently perform consultation reports, please review your site Medical Staff Policies. | No co-signature requirement. May independently issue. Please note that some hospital policies do not allow PA/APNP to independently perform consultation reports, please review your site Medical Staff Policies. | No authority to issue. | No authority to issue. | Co-signature required.(^23) | No authority to issue but may assist in data collection for the consulting physician. | May perform within scope of privilege. | May perform within scope of practice. | May perform within scope of practice. | AA: No authority to issue. |
| H &amp; P | If privileged to independently perform and document an H&amp;P, no co-signature requirement. | If not privileged to independently perform and document an H&amp;P, the H&amp;P must be co-signed by the supervising/collaborating physician within the time periods specified in the Hospital’s medical record policy (e.g., prior to surgery or within 24 hours of admission). This does not preclude a PA or APN from obtaining information from a patient for the consulting physician. | No authority to issue. This does not preclude a physician-employed RN from obtaining information from a patient for the physician. | No authority to issue. | Co-signature required.23 | Co-signature required and must be co-signed prior to being acted upon. | No co-signature requirement. | No co-signature requirement. Vents Medical Staff Bylaws. | Chiropractors are responsible for and may perform the portion of their patient’s history and physical pertaining to their specialty. | AA: If privileged to independently perform and document an H&amp;P, no co-signature requirement, otherwise, must be co-signed by the supervising physician within the time periods specified in the hospital’s medical record policy. This does not preclude an AA from obtaining information from a patient for the physician. |
|---|---|---|---|---|---|---|---|---|---|
| Pre-Procedure Note | No co-signature requirement.15 | No co-signature requirement.7 | Hospital employed RN: No authority to issue. Physician employed RN: May enter, but co-signature required prior to procedure. | No authority to issue. | No authority to issue. | Co-signature required.23 | Co-signature required. | No co-signature requirement. | No authority to issue. | AA: Co-signature required. |</p>
<table>
<thead>
<tr>
<th>Procedure (Operative) Report</th>
<th>Inpatient Discharge Summary</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the PA/APNP is the performing provider, no co-signature is required. If the PA/APNP is not the performing provider, the procedure (operative) report must be signed by the performing provider.</td>
<td>May enter but the attending/admitting provider must co-sign the discharge summary within 30 days of the patient’s discharge.</td>
<td>All services provided under the Medicare and Medicaid home health benefit must be ordered by a physician. Verify commercial payer guidance prior to ordering. The recent QARES Act allows advanced practice clinicians – APRNs and PMs – to: (1) order home health services; (2) establish/review plans of care; (3) certify/re-certify home health eligibility; and (4) follow the patient. While this waiver is only in effect for the duration of the COVID-19 pandemic, it applies to ALL home health patients receiving care from</td>
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<tr>
<td>If the APN is the performing provider, no co-signature is required. If the APN is not the performing provider, the procedure (operative) report must be signed by the performing provider.</td>
<td>May enter but the attending/admitting provider must co-sign the discharge summary within 30 days of the patient’s discharge.</td>
<td>All services provided under the Medicare home health benefit must be ordered by a physician.</td>
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<tr>
<td>No authority to issue.</td>
<td>Hospital employed RN: No authority to issue.</td>
<td>No authority to issue.</td>
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<tr>
<td>No authority to issue.</td>
<td>Exception: Psychologists if privileged by Medical Staff</td>
<td>No authority to issue.</td>
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<td>No co-signature requirement</td>
<td>No co-signature requirement</td>
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<td>No authority to issue.</td>
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<td>No authority to issue.</td>
<td>May issue in collaboration with attending.</td>
<td>No authority to issue.</td>
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<td>AA: No authority to issue.</td>
<td>AA: No authority to issue.</td>
<td>AA: No authority to issue.</td>
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<tr>
<td>Discharge Order</td>
<td>No authority to issue; May receive/enter a verbal/telephone order only.</td>
<td>No authority to issue; May receive/enter a verbal order only.</td>
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Certified Registered Nurse Anesthetists (CRNAs) and Anesthesiology Assistants (AA) only:

| Pre-Procedure Anesthesia Evaluation | CRNAs: No co-signature requirement.  
AA: Co-signature required \(^7,24\) |
|------------------------------------|----------------------------------------|
| Pre-Induction Anesthesia Evaluation | CRNAs: No co-signature requirement.  
AA: Co-signature required \(^7,24\) |
| Intraoperative Anesthesia Report   | CRNAs: No co-signature requirement.  
AA: Co-signature required \(^7,24\) |
| Post-Procedure Anesthesia Evaluation | CRNAs: No co-signature requirement.  
AA: Co-signature required \(^7,24\) |
RESOURCES

1. CMS Conditions of Participation: 482.12(c)(2) ... patients are admitted only by those practitioners who are currently licensed and have been granted admitting privileges by the governing body in accordance with State laws and medical staff bylaws. Currently, Aurora hospitals do not give advanced practice providers admitting privileges within the Medical Staff Bylaws.

2. Wis. Admin. Code § N 4.06(1) which provides that a CNM’s scope of practice is the overall management of women’s health care, pregnancy, childbirth, postpartum care for newborns, family planning, and gynecological services consistent with the standards of practice of the American College of Nurse-Midwives and the education, training, and experience of the nurse-midwife.

3. Wis. Adm. Code Med § 8.08(1), a PA may only order medications pursuant to his or her written guidelines for supervised prescriptive practice. The hospital must have a current, signed copy of the PA’s written guidelines for supervised prescriptive practice on file. If a particular medication is included within the scope of the PA’s written guidelines, the PA may issue the medication order and co-signature is not required, unless the individual PA’s written guidelines require co-signature by the supervising physician. If a particular medication is not included within the scope of the PA’s written guidelines for supervised prescriptive practice, the PA may not independently issue the medication order. Under Wis. Stat. §448.21(3), a PA may issue a prescription order for a drug or device in accordance with guidelines established by a supervising physician and the physician assistant and with rules promulgated by the Medical Examining Board. If any conflict exists between the guidelines and the rules, the rules shall control.

4. An APNP may only order or prescribe medications appropriate to the APNP’s areas of competence as established by his or her education, training or experience (Wis. Adm. Code N § (1)) and within the scope of his or her license, DEA registration, collaboration agreement, clinical privileges, and hospital policies and procedures. Exceptions to Schedule II dispensing: (a) use as an adjunct to opioid analgesic compounds for the treatment of cancer-related pain. (b) treatment of narcolepsy. (c) treatment of hyperkinesia, including attention deficit hyperactivity disorder. (d) treatment of drug-induced brain dysfunction. (e) treatment of epilepsy. (f) treatment of depression shown to be refractory to other therapeutic modalities. For details on prescriptions and delivery of opioid antagonists, see Wisconsin Statues, Chapter 441.18.
An Ancillary Staff member who is authorized to receive verbal orders, may only receive/enter a verbal order if the verbal order relates to the clinical area in which such authorized individual is trained. The verbal order must be authenticated within 48 hours (with some exceptions) in accordance with the hospital’s applicable authentication policy (see also the Wis. Adm. Code reference cited in Note 1). Respiratory Therapists employed by the hospital may receive/enter verbal orders for medications to be administered by the Respiratory Therapist during the administration of respiratory services (e.g., nebulizer treatment). Radiology Technicians employed by the hospital may receive/enter verbal orders for medications (e.g., contrast) to be administered by the Radiological Technician in accordance with his or her training and experience.

CMS Conditions of Participation, 482.28(b)(2) – All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff....

No co-signature required if within the APNs education, training, experience and hospital privileging.

A PA may only order or prescribe medications within the scope of his or her license, DEA registration, supervision agreement, clinical privileges, and hospital policies and procedures. Under Wis. Adm. Code Med § 8.08(1), a PA may only order medications pursuant to his or her written guidelines for supervised prescriptive practice. The hospital must have a current, signed copy of the PA’s written guidelines for supervised prescriptive practice on file. If a particular medication is included within the scope of the PA’s written guidelines, the PA may issue the medication order and co-signature is not required, unless the individual PA’s written guidelines require co-signature by the supervising physician. If a particular medication is not included within the scope of the PA’s written guidelines for supervised prescriptive practice, the PA may not independently issue the medication order. Under Wis. Stat. §448.21(3), a PA may issue a prescription order for a drug or device in accordance with guidelines established by a supervising physician and the physician assistant and with rules promulgated by the Medical Examining Board. If any conflict exists between the guidelines and the rules, the rules shall control.

Wis.Stat. 448.56(1); Wis. Admin. Code PT 6.01(1) states that Physical Therapists (PT) are allowed to provide Direct Access (practice without referral) services under the following conditions: 1. The PT provides services to an individual for a previously diagnosed medical condition (after informing the individual’s physician, chiropractor, dentist, podiatrist, or APNP who made the diagnosis, 2. The PT provides conditioning services, 3. The PT provides
services related to injury prevention and application of biomechanics; or 4. The PT provides treatment of musculoskeletal injuries, except for treatment of acute fractures or soft tissue avulsions.

While there is no co-signature requirement, PAs may write and execute orders only under the supervision of the PA’s supervising physician. APNPs may independently order and utilize diagnostic testing consistent with the APNP’s area of competence. Wis. Admin. Code N 8.10(6); Wis. Stat. § 441.16; Wisconsin Administrative Register No. 522, Board of Nursing Statement (June 15, 1999).

See 42 C.F.R. § 482.12(c)(1)(i) (recognizing the authority of a physician to delegate tasks to other qualified personnel to the extent permitted under state law); See also Wis. Stat. § 448.03(2)(e) (providing a Wisconsin licensed physician broad authority to delegate medical acts); See also Aug. 29, 2000 letter from State of Wisconsin Medical Examining Board to the State of Wisconsin Pharmacy Examining Board (confirms that § 448.03(2)(e) authorizes a physician to delegate medical acts to pharmacists pursuant to mutually approved protocols). Accordingly, the delegation of authority by the physician to the R.Ph must be documented in a delegation agreement entered into by and between a physician and an R.Ph delgee (it would be permissible for multiple physicians and multiple R.Ph’s to enter into a single delegation agreement whereby each of the physicians listed delegates to each of the R.Ph’s listed the authority set forth in the agreement). The delegation document must set forth protocols which establish specific parameters within which the R.Ph(s) may exercise the delegated authority (e.g., a delegation setting forth that an R.Ph may issue an order to discontinue metformin for any patient undergoing the intravascular administration of iodinated contrast media).

PA/APNP: Written referral according to 448.56(l), a person may practice physical therapy only upon the written referral of a physician, chiropractor, dentist, podiatrist, PA or advanced practice nurse prescriber. CMS Conditions of Participation 482.56 (b): Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures and State laws. 2017 Assembly Bill 529 Date of publication*: December 1, 2017 allows advanced practitioners working within the scope of their practice to sign orders without requiring a physician’s co-signature and allow Medicaid to pay for those services.
See Division of Quality Assurance Memo 11-004 (January 28, 2011) which creates a statewide variance to Wis. Admin. Code DHS 123.22(4): Allows licensed practitioners, who are authorized via their practice act and are granted privileges by the medical staff of the hospital, to order respiratory care services.

The order must be entered in accordance with the hospital’s restraint and seclusion policy. PAs: DQA’s original position prohibiting PAs from ordering acute medical/surgical restraints pre-dated the CMS’s revised regulations which allow “other licensed independent practitioners...responsible for the care of the patient [to order restraint if authorized to order restraint] by hospital policy in accordance with State law.” 42 C.F.R. § 482.13(e)(5).

Subsequent informal guidance provided by DQA has indicated that DQA’s position on PAs is now changed to be consistent with the revised CMS regulations. APNP: 2001 DQA memo, the only independent practitioner besides a physician who may be credentialed by a hospital to order restraints for acute medical and surgical care is an APNP under Wisconsin State Statutes, Section 441.16(2).


If the PA’s, APNP’s, or APN’s delineation of clinical privileges or clinical functions provides that he/she may independently perform and document an H&P, the PA/APNP/APN must complete and document the H&P within the time periods specified in the hospital’s medical record policy (e.g., prior to surgery or within 24 hours of admission). PAs: Under Wis. Adm. Code Med § 8.07(2)(a), medical care a PA may provide includes attending initially a patient of any age in any setting to obtain a personal medical history, perform an appropriate physical examination, and record and present pertinent data concerning the patient in a manner meaningful to the supervising physician. See also: 42 C.F.R. § 482.22(c)(5)(i) (providing that an H&P must be completed and documented by a physician, oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy).

A PA, APNP, or APN may participate in the performance and documentation of the H&P as a delegated medical act (see Wis. Stat. § 448.03(2)(e)), but the H&P must be co-signed by the supervising/collaborating physician within the time periods specified in the hospital’s medical record policy (e.g., prior to surgery, or within 24 hours of admission).
A Procedure (Operative) Report must be entered or dictated by the provider who was primarily responsible for the procedure (the “Performing Provider”). If the AHP is the Performing Provider, he or she must enter or dictate the Procedure (Operative) Report, and co-signature is not required. If the AHP is not the Performing Provider, but participates in the documentation of all or part of a Procedure (Operative) Report, the entry must be co-signed by the Performing Provider within the time periods set forth in the hospital’s medical records policy. The Performing Provider is responsible and accountable for the entry. CMS Conditions of Participation 482.51 (b)(6): An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.

Under Wis. Adm. Code Med § 8.07(2)(e), a PA may make patient rounds, record patient progress notes, and compile and record detailed narrative case summaries. See CMS State Operations Manual (Appendix A), A-0468 providing an MD/DO may delegate writing the discharge summary to other qualified health care personnel such as nurse practitioners and MD/DO assistants, but the MD/DO responsible for the patient during his/her hospital stay must co-sign and date the discharge summary to verify its content.

Operations Manual, Appendix A, A-0469 All medical records must be completed within 30 days of discharge or outpatient care.

CMS Conditions of Participation 482.28 (b)(2): All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals.

See Wis. Adm. Code DHS § 154.19(1) No person except an attending physician may issue a do-not-resuscitate order.

GME Aurora Practice Rules

Pre-anesthesia and post-anesthesia evaluations must be completed and documented by an individual qualified to administer anesthesia, 42 CFR 482.52(b), and CRNAs are the only licensees among NPs who are qualified under the CMS Conditions of Participation. Under 42 CFR 482.52(a)(4) anesthesia may be administered by a CRNA, who, unless exempted, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available, if needed. Wisconsin has opted out of the CRNA supervision requirement for CRNAs who
are also APNPs; however, Wisconsin law still requires the CRNA/APNP to work in a collaborative relationship with a physician. In addition, the SOM states that pre- or post-anesthesia evaluation may not be delegated to practitioners who are not qualified to administer anesthesia. 45 CFR 482.52(b), SOM Tag A-1004 and A-1005.

25 At 42 CFR 482.13(f)(3)(ii)(C), under the standard for seclusion and restraint for behavior management, the regulation permits seclusion or restraint only “in accordance with the order of a physician or other licensed independent practitioner permitted by the State and hospital to order seclusion or restraint.” In Wisconsin, only certain physicians may order restraints for persons receiving inpatient hospital services for mental illness, developmental disabilities, alcoholism or drug dependency. Only certain physicians may order seclusion. Under Wisconsin State Statues, Section 51.61(l)(i): The treatment director shall specifically designate physician who are authorized to order isolation or restraint.

26 Wisconsin – Administrative Code, Chapter N 8 (5) The advanced practice nurse prescriber may order treatment, therapeutics, and testing, appropriate to his or her area of competence as established by his or her education, training, or experience, to provide care management.

27 Wis. Stat. 448.56(1) - Written referral. Except as provided in this subsection and s. 448.52, a person may practice physical therapy only upon the written referral of a physician, physician assistant, chiropractor, dentist, podiatrist, or advanced practice nurse prescriber. CMS Conditions of Participation 482.56 (b): Services must only be provided under the orders of a qualified and licensed practitioner who is responsible for the care of the patient, acting within his or her scope of practice under State law, and who is authorized by the hospital’s medical staff to order the services in accordance with hospital policies and procedures and State laws. Condition of Payment should be investigated prior to service.

28 In accordance with section 1877(a)(1) and (5)(A), and section 1861(r)(5) of the Social Security Act, and 42 CFR 410.21(b)(1) and (2), doctors of chiropractic medicine are not eligible to order and refer. Medicare coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation; all other services furnished or ordered by chiropractors are not covered.

29 The Drug Addiction Treatment Act of 2000 permits qualified physicians to obtain a waiver from the separate registration requirements of the Narcotic Addict Treatment Act – 1974 (PDF | 437 KB) to treat opioid dependency
with Schedule III, IV, and V medications or combinations of such medications that have been approved by FDA for that indication.

30 The Comprehensive Addiction and Recovery Act of 2016 “(iv) The term ‘qualifying other practitioner’ means a nurse practitioner or physician assistant who satisfies each of the following: “(I) The nurse practitioner or physician assistant is licensed under State law to prescribe schedule III, IV, or V medications for the treatment of pain. “(II) The nurse practitioner or physician assistant has—“(aa) completed not fewer than 24 hours of initial training addressing each of the topics listed in clause (ii)(IV) (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, or any other organization that the Secretary determines is appropriate for purposes of this subclause; or “(bb) has such other training or experience as the Secretary determines will demonstrate the ability of the nurse practitioner or physician assistant to treat and manage opiate-dependent patients. “(III) The nurse practitioner or physician assistant is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner or physician assistant is required by State law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.

31 All services provided under the Medicare home health benefit must be ordered by a physician. Three basic requirements for ordering services are: the physician must be enrolled in Medicare; the ordering National Provider Identifier (NPI) must be for an individual physician (not an organizational NPI); and the physician must be of a specialty type that is eligible to order and refer. 42 CFR 424.22(a)(1)

32 Wis. Stat. 51.10(4m) – Voluntary admission of adults. Adult desiring admission to an approved inpatient treatment facility may be admitted to an inpatient treatment facility if a physician of the facility submits a signed request and certifies in writing, before not less than 2 witnesses, that the physician has advised the patient in the presence of the witnesses both orally and in writing of the person’s rights.

33 While there is no co-signature requirement, acupuncturists may write and execute orders only under the supervision of the acupuncturist’s supervising physician, physician assistant or advanced practice nurse. Wis. Stat. § 451.01-451.16
Wisconsin Advanced Practice Nurse Collaboration Agreement

Advanced Practice Nurse (“APN”)

Name: ___________________________  Department: ___________________________

Last          First          Middle Initial

Category of Advanced Practice Nurse:

☐ Advanced Practice Nurse Prescriber (also identify your specific practice category below):
   ☐ Certified Nurse Midwife (CNM)
   ☐ Certified Registered Nurse Anesthetist (CRNA)
   ☐ Nurse Practitioners (NP)
   ☐ Clinical Nurse Specialist (CNS)

☐ Certified Nurse Midwife (CNM) Without Prescription Authority

Address: ____________________________________________________________

Phone/Pager: ___________________________  ___________________________  ___________________________  ___________________________

Office  Home  Cell  Pager

Email Address: _______________________________________________________

Employer Name: ______________________________________________________

Employer Address: ____________________________________________________

Employer Phone: ______________________________________________________

Collaborating Physician (“Physician”)

Name: ___________________________  Department: ___________________________

Last          First

Address: ____________________________________________________________

Phone/Pager: ___________________________  ___________________________  ___________________________  ___________________________

Office  Home  Cell  Pager

Email Address: _______________________________________________________

Collaboration Agreement (the “Agreement”)

The Physician and APN attest and agree that:

1. The APN is duly licensed by the State of Wisconsin and possesses the qualifications, competencies, training and experience necessary to perform the requested Clinical Privileges.

2. The Physician and APN will work in a collaborative relationship in accordance with all applicable statutes, regulations and standards, and all policies and bylaws (as applicable) of the facilities in which the Physician and APN collaborate (the "Facilities"), including without limitation, co-signature requirements for medical record entries as set forth in the Advocate Aurora Health Care Inc. (“AAH”) Hospital Co-Signature Requirements Policy and other applicable policies. The collaborative relationship means the APN and Physician will work in each other’s presence whenever necessary to deliver health care services within the scope of the APN’s and Physician’s professional expertise. In addition:

2.1 For CNMs: If the APN named above is a CNM, the APN shall collaborate with a Physician with postgraduate training in obstetrics and in accordance with the mutually approved guidelines (including conditions of collaboration and referral) attached hereto as Exhibit A. When contacted by the CNM, Physician shall collaborate with the CNM so that the CNM does not independently manage those complications that require consultation and/or referral pursuant to Exhibit A.
3. The Physician and APN shall comply with all applicable statutes, regulations and standards, and all policies and bylaws of the Facilities, including but not limited to applicable statutes and regulations with respect to the billing for the services provided by the APN.

4. As required by law and applicable Facility policies, the Physician and APN shall participate in all quality activities of the Facilities in which each practices.

5. The Physician and APN shall ensure the prompt correction and resolution of problems that may arise with respect to the collaborative relationship.

6. If the APN is the Physician’s employee or employed by a group not affiliated with AAH, the Physician shall ensure that the APN maintains, at no cost to the Facilities, professional liability insurance coverage in the amounts specified by the Facilities.

7. The APN may provide health care services only within the APN's scope of practice, qualifications, competencies, training, Clinical Privileges, and in accordance with the requirements of the State of Wisconsin. Physician shall not request or direct the APN to perform any task beyond those limits.

8. The APN shall immediately provide written notification to the Facilities if:

   8.1 There are any changes to the qualifications, scope of practice, and/or clinical competence of the APN.

   8.2 There are any changes or proposed changes to the Physician’s and APN’s collaborative relationship and/or this Agreement.

   8.3 The APN is Physician’s employee or is employed by a group not affiliated with AAH and there are any changes to the APN’s employment status or professional liability insurance coverage.

   8.4 The APN is the subject of an inquiry or under investigation by the Wisconsin Department of Regulation and Licensing (WDRL) and/or any other licensing agency or certifying board.

9. If Physician is employed by a group that is not affiliated with AAH, Physician shall immediately provide written notification to the Facilities if there are changes to Physician’s employment status or professional liability insurance coverage.

10. The Physician and APN acknowledge that failure to work properly in a collaborative relationship, complete necessary evaluations in a timely manner as requested by the Facilities, or otherwise comply with this Agreement, may serve as the basis for corrective action.

11. This Agreement shall be reviewed annually.

12. This Agreement may be terminated by either the Physician or the APN with or without cause upon written notice to the other party.

**Advanced Practice Nurse:**

________________________________________________________________________

Print Name

________________________________________________________________________

Signature Date

**Collaborating Physician:**

________________________________________________________________________

Print Name Signature Date
Physician Assistant
Supervision Agreement
(Wisconsin)

Physician Assistant ("PA")

Name: ___________________________ ___________________________ Department: ___________________________
                   Last                        First                          Middle Initial

Address: __________________________________________________________

Phone/Pager: _______________________________________________________

      Office                      Home                      Cell                      Pager

Email Address: ______________________________________________________

Employer Name: _____________________________________________________

Employer Address: ___________________________________________________

Employer Phone: _____________________________________________________

Supervising Physician or Podiatrist ("Physician")

Name: ___________________________ Department: ___________________________
                   Last                        First

Address: __________________________________________________________

Phone/Pager: _______________________________________________________

      Office                      Home                      Cell                      Pager

Email Address: ______________________________________________________

Supervision Agreement (the "Agreement")

Physician and the PA attest and agree that:

1. The PA is duly licensed by the State of Wisconsin and possesses the qualifications, competencies, training and experience necessary to perform the requested Clinical Privileges while under the licensed Physician’s supervision.

2. The PA, under the supervision of the Physician, is responsible for his/her own conduct of and tasks. Physician shall provide such supervision in accordance with all applicable statutes, regulations and standards, and all policies and bylaws (as applicable) of the facilities in which Physician supervises the PA (the "Facilities"), including without limitation, co-signing the PA's medical record entries in accordance with the Advocate Aurora Health Care Inc.’s (“AAH”) applicable policies and Aurora’s Hospital Co-Signature Requirements policy.

3. Physician shall be responsible for:

   3.1 Ensuring that the PA complies with all applicable statutes, regulations and standards, and all policies and bylaws (as applicable) of the Facilities;

   3.2 Monitoring the conduct and clinical competence of the PA and, as requested, submitting written evaluations on forms provided or approved by the Facilities (e.g., evaluation of competency during and at the conclusion of the initial FPPE and at the time of reappointment);

   3.3 Ensuring the prompt correction and resolution of any problems that may arise with respect to the PA;
3.4 If the PA is Physician’s employee or employed by a group not affiliated with AAH, maintaining or ensuring, at no cost to the Facilities, professional liability insurance coverage for the PA in the amounts specified by the Facilities; and

3.5 Ensuring compliance with all applicable statutes and regulations with respect to the billing for the services provided by such PA under Physician’s supervision.

4. The PA may provide health care services only within the PA’s scope of practice, qualifications, competencies, training, Clinical Privileges, and in accordance with the requirements of the State of Wisconsin. This may not exceed the scope of practice of the physician or podiatrist providing supervision. Physician shall not request or direct the PA to perform any task beyond those limits; nor may a medical care task assigned by the Physician to the PA be delegated by the PA to another person. The PA may provide healthcare services only under Physician’s or a substitute physician or podiatrist’s supervision and, when necessary, in the presence of a Physician or a substitute physician or podiatrist. Subject to applicable law and this Agreement, care provided by the PA may include the following as appropriate:

4.1 Attending initially a patient to obtain a personal medical history, perform an appropriate physical examination, and record and present pertinent data concerning the patient in a manner meaningful to a supervising physician or podiatrist.

4.2 Performing, or assisting in performing, routine diagnostic studies as appropriate.

4.3 Performing routine therapeutic procedures, including, but not limited to, injections, immunizations, and the suturing and care of wounds.

4.4 Instructing and counseling a patient on physical and mental health, including diet, disease, treatment and normal growth and development.

4.5 Assisting a supervising physician by assisting in surgery. (PA acting under the supervision of a podiatrist may not provide surgical services to a patient.)

4.6 Assisting a supervising physician or podiatrist in making patient rounds, recording patient progress notes, compiling and recording detailed narrative case summaries and accurately writing or executing orders under the supervision of a supervising physician or podiatrist.

4.7 Assisting in the delivery of medical care to a patient by reviewing and monitoring treatment and therapy plans.

4.8 Performing independently evaluative and treatment procedures necessary to provide an appropriate response to life-threatening emergency situations.

4.9 Facilitating referral of patients to other appropriate community health-care facilities, agencies and resources.

4.10 Issuing acute medical/surgical restraint orders under the supervision of a supervising physician and in accordance with the procedures specified herein.

4.11 Issuing written prescription orders for drugs under the supervision of a supervising physician or podiatrist and in accordance with the procedures specified herein.

5. The PA may issue prescription orders for drugs provided the PA has had an initial and at least annual thereafter review of PA prescriptive practice by a physician. Physician is responsible for determining if the PA is qualified through training and experience to prescribe the categories of medications for which prescriptive practice is authorized. The PA and Physician must establish, and review at least annually, written guidelines for issuing prescription orders, including categories of medications for which prescribing authority has been authorized and a minimal schedule for the review of the PA’s prescribing practice. Such annual reviews must be documented in writing, signed by Physician and the PA, and made available to the Medical Examining Board upon request. The PA may prescribe from categories granted, as identified in Attachment A of this Agreement.

6. Physician understands that he/she may not concurrently supervise more than four (4) on duty physician assistants unless Physician submits a written plan for such and the Medical Examining Board approves the plan. Another licensed physician or podiatrist may be designated by Physician to supervise the PA only if: (i) such designation is made in writing, and (ii) at all times the PA is able to readily identify the physician or podiatrist currently providing supervision. Physician may use the Delegation Addendum attached hereto to make a standing delegation to other physicians or podiatrists so long as each alternate physician or podiatrist is made aware of the times in which such physician or podiatrist will be providing supervision. Either the Physician or the substitute physician or podiatrist must be available to the PA at all times for consultation either in person or within fifteen (15) minutes of contact by telecommunications or other electronic means.
Physician shall immediately provide written notification to the Facilities if:

7.1 The PA is Physician’s employee or is employed by a group not affiliated with AAH and there are any changes to the qualifications, scope of practice, and/or clinical competence of the PA;

7.2 There are any changes or proposed changes to Physician’s supervisory relationship and/or this Agreement;

7.3 Physician’s approval to supervise the PA is revoked, limited, or otherwise altered by action of the Wisconsin Department of Safety and Professional Services (DSPS), and/or any other licensing agency or certifying board;

7.4 Notification is given to Physician that Physician’s supervision of the PA is the subject of an inquiry or under investigation by the DSPS and/or any other licensing agency or certifying board;

7.5 There are any changes to Physician’s employment status;

7.6 The PA is Physician’s employee or is employed by a group not affiliated with AAH and there are any changes to the PA’s employment status;

7.7 Notification is given to Physician that the PA is the subject of an inquiry or under investigation by the DSPS and/or any other licensing agency or certifying board;

7.8 There are any changes to Physician’s professional liability insurance coverage; or

7.9 The PA is Physician’s employee or is employed by a group not affiliated with AAH and there are any changes to the PA’s professional liability insurance coverage.

8. Physician acknowledges that failure to properly supervise the PA, complete necessary evaluations in a timely manner as requested by the Facilities, or otherwise comply with this Agreement, may serve as the basis for corrective action against Physician.

This Agreement shall be reviewed annually.

Supervising Physician/Podiatrist:

Print Name

Signature

Date

Acknowledged and agreed by:

Physician Assistant:

Print Name

Signature

Date
**ATTACHMENT A**

**PHYSICIAN ASSISTANT PRESCRIPTION AUTHORIZATION**

As the Supervising Physician/Podiatrist(s) of __________________, PA-C, I authorize the writing of all scheduled and nonscheduled prescriptions listed in the American Hospital Formulary in the categories marked below with the following noted exceptions:

**A. Drugs**

<table>
<thead>
<tr>
<th>Category</th>
<th>Exceptions applicable to each category:</th>
</tr>
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<tbody>
<tr>
<td>01 Anesthetics</td>
<td></td>
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<tr>
<td>02 Anti-infective</td>
<td></td>
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<tr>
<td>03 Anti-neoplastic/Immunosuppressants</td>
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<tr>
<td>04 Cardiovascular Medications</td>
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<tr>
<td>05 Autonomic/Central Nervous System Drugs</td>
<td></td>
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<tr>
<td>06 Dermatological Drugs</td>
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<tr>
<td>07 Diagnostic Agents</td>
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<tr>
<td>08 Ear-Nose-Throat Medications</td>
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<tr>
<td>09 Endocrine Medications</td>
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<tr>
<td>10 Gastrointestinal Medications</td>
<td></td>
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<tr>
<td>11 Immunologicals &amp; Vaccines</td>
<td></td>
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<tr>
<td>12 Musculoskeletal Medications</td>
<td></td>
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<tr>
<td>13 Nutritional Products, Blood Modifiers &amp; Electrolytes</td>
<td></td>
</tr>
<tr>
<td>14 Obstetrical &amp; Gynecological Medications</td>
<td></td>
</tr>
<tr>
<td>15 Ophthalmic Medications</td>
<td></td>
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<tr>
<td>16 Respiratory Medications</td>
<td></td>
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<tr>
<td>17 Urological Medications</td>
<td></td>
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<tr>
<td>18 Poisoning &amp; Drug Dependence</td>
<td></td>
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<tr>
<td>19 Analgesics</td>
<td></td>
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<tr>
<td>20 Stimulants</td>
<td></td>
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<tr>
<td>21 Tranquilizers</td>
<td></td>
</tr>
</tbody>
</table>

Revised March 2020
B. Controlled Substances: (Check Appropriate Categories) Exceptions applicable to each category:

- [ ] Schedule II
- [ ] Schedule III
- [ ] Schedule IV
- [ ] Schedule V

1. Please indicate the process for periodic review of prescription orders prepared by the PA. (It is acceptable to write a narrative here if desired).
   - Review and countersign of a representative sample of patient care notes or prescriptive orders
   - Chart audit
   - Case discussion between supervising physician or podiatrist and physician assistant
   - Other (please specify): ________________________________

2. Please identify the representative sample of prescriptive orders or patient charts to be reviewed:

3. Please indicate the minimum schedule for this review:
   - Daily
   - Three times per week
   - Weekly
   - Monthly
   - Quarterly
   - Other (please specify): ________________________________

We have reviewed this authorization form together on ____________________________ (date).

Note: The Supervising Physician or Podiatrist may wish to maintain sufficient documentation regarding the PA’s qualifications to provide legal and professional protection when authorizing prescription writing privileges.

Physician/Podiatrist Signature(s): ____________________________

PA Signature: ____________________________

Date: ____________________________

Date: ____________________________
Delegation Addendum

This Delegation Addendum dated __________, 20___ supplements the Physician/Podiatrist Supervision Agreement (the “Supervision Agreement”) between ____________________________ (the “PA”) and ____________________________ (the “Supervising Physician/Podiatrist”).

Designation. In accordance with Section 6 of the Supervision Agreement, the Supervising Physician/Podiatrist hereby designates the undersigned alternate physicians/podiatrists (the “Alternate Physicians/Podiatrists”) as eligible to serve as the PA’s supervising physician/podiatrist from time to time. Each Alternate Physician/Podiatrist shall serve as the PA’s supervising physician/podiatrist only during specific periods communicated and agreed to by the Alternate Physician/Podiatrist and the Supervising Physician/Podiatrist. This Addendum shall serve as a standing designation until such time as the Supervising Physician/Podiatrist revokes such designation as to any or all Alternate Physicians/Podiatrists.

Readily Identifiable. At all times, the PA shall be able to readily identify which physician/podiatrist is currently providing supervision. The PA shall ensure that such identification is documented in writing.

Supervising Physician/Podiatrist:

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Signature</th>
<th>Date</th>
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PA:

<table>
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<tr>
<th>Print Name</th>
<th>Signature</th>
<th>Date</th>
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</thead>
</table>

Alternate Physician/Podiatrist Acknowledgment. By signing below, each Alternate Physician/Podiatrist agrees that, during such times that the Alternate Physician/Podiatrist is designated to supervise the PA, the Alternate Physician/Podiatrist shall be bound by the obligations and responsibilities of the Supervising Physician/Podiatrist under the Supervision Agreement. Each Alternate Physician/Podiatrist signing below acknowledges that they have been given a copy of the Supervision Agreement and understand their role as a supervising physician/podiatrist.

Alternate Physicians/Podiatrists:

| Name: ________________________ | Date:______ | Name: ________________________ | Date:______ |
| Signature: ___________________________________ | Signature: ___________________________________ |

| Name: ________________________ | Date:______ | Name: ________________________ | Date:______ |
| Signature: ___________________________________ | Signature: ___________________________________ |

| Name: ________________________ | Date:______ | Name: ________________________ | Date:______ |
| Signature: ___________________________________ | Signature: ___________________________________ |

| Name: ________________________ | Date:______ | Name: ________________________ | Date:______ |
| Signature: ___________________________________ | Signature: ___________________________________ |
CODE OF CONDUCT

POLICY STATEMENT

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

1. MINIMUM EXPECTATIONS

At a minimum, all Staff Members are expected to:

1.1 Treat all individuals with courtesy, dignity and respect;

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

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

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

1.5 Work together as a team;

1.6 Be fair and honest;

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

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

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

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

1.11 Demonstrate behaviors that support the Aurora Service Commitment Standards.

2. **Unacceptable Conduct**

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

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

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

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

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

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

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

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

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

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

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

3. **ADDRESSING PRACTICE AND CONDUCT CONCERNS**

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

**REFERENCES:**

**Joint Commission Standards**

- JCS LD.03.01.01 (Jul. 2015)

**FORM(S):** None

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 3/22/16, 2/7/23

**BOARD OF DIRECTORS APPROVAL:** 5/16/16, 2/20/23

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

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

POLICY STATEMENT

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

1. IDENTIFICATION AND COMMUNICATION

1.1 Identification of Practice and Conduct Concerns.
Individual practice or conduct concerns may arise from:
(a) Information obtained through the Ongoing Professional Practice Evaluation (OPPE) process;
(b) Information from other Staff Members, Medical Center staff, patients/families, and/or regulatory or other agencies related to specific incidents, complaints, grievances, or concerns relating to quality patient care;
(c) Recommendations from Risk Management or Utilization Review; and/or
(d) Other relevant information.

1.2 Communication of Practice and Conduct Concerns.
The Medical Staff actively encourages any individual (including a Staff Member, Medical Center employee, patient, visitor, vendor or other person) who has or becomes aware of a question or concern related to the professional practice or conduct of any individual Staff Member, to promptly communicate such question or concern to any one or more of the following persons:
(a) Director of Quality;
(b) Applicable Clinical Chairperson;
(c) Chief of Staff;
(d) Chief Medical Officer;
(e) Administrator;
(f) Any member of the Practitioner Wellness Committee;
(g) Any member of the Practice Evaluation Committee;
A Medical Center employee may also communicate questions or concerns to his/her immediate supervisor and/or a representative from human resources. To the extent possible and appropriate, the identity of an individual who communicates his or her concerns shall be kept confidential.

2. **PRELIMINARY EVALUATION AND REVIEW**

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

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

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

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

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

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

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

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

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

3. **NO RETALIATION**

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

4. **IMMUNITY**

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

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

6. **USE OF FORMS**

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

**REFERENCES:**

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

**FORM(S):**

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**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 3/22/16, 2/7/23

**BOARD OF DIRECTORS APPROVAL:** 5/16/16, 2/20/23

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

POLICY STATEMENT

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

1. DEFINITIONS

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

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

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

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

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

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

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

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

3. REQUESTS FOR DISCLOSURE

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

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

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

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

4. PERMITTED ACCESS/DISCLOSURE

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

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

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

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

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

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

**REFERENCES:**

- **Wisconsin Statutes**

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

**FORM(S):**

- Consent and Release from Liability Form

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 3/19/2013, 9/26/17, 2/7/23

**BOARD OF DIRECTORS APPROVAL:** 4/18/2013, 12/18/17, 2/20/23

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

POLICY STATEMENT

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

1. DEFINITIONS

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

“Authorized Form of Identification” includes the following forms of identification:

- A current picture hospital ID card; or
- A valid picture ID issued by a State or federal agency (for example, a driver's license or passport)

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

2. USE OF CONTRACTORS OR AURORA AFFILIATES FOR VERIFICATION

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

3. METHOD OF CONFIRMATION

Medical Staff Services (or its designee) may verify an Applicant is the same individual identified in the credentialing documents by using one of the following methods:

(a) comparing the Authorized Form of Identification against the Applicant either (1) in person or (2) via real-time electronic visual communication (for example, Skype or FaceTime), or

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

REFERENCES:

JCS MS.06.01.03, EP 5 (January 2018)

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 5/22/18, 2/7/23

BOARD OF DIRECTORS APPROVAL: 6/18/18, 2/20/23
# IDENTIFICATION VERIFICATION FORM (NOTARY ATTESTATION)

## SECTION A.

Place a copy of your Authorized Form of Identification in this box

*must be legible*

## SECTION B. APPLICANT ATTESTATION

Please check type of identification copied in Section A.

- [ ] Hospital Photo ID Card
- [ ] Driver’s License
- [ ] Passport
- [ ] Other Government-issued ID: __________________________

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

Print Name ____________________________ Date ____________

Signature ____________________________

## SECTION C. NOTARY ATTESTATION

Sworn to and subscribed before me this _____ day of ________ 20____ in the State of ____________________ and County of ____________________.

After presentation of the same identification copied above in Section A, the above statement was signed before me by ____________________________ (applicant name).

Notary Public’s Printed Name ____________________________

Notary Public’s Signature ____________________________

My Commission Expires ____________________________

**FOR OFFICE USE ONLY**

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

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

Name of Person Verifying ____________________________ Date ____________
CONFLICT MANAGEMENT

POLICY STATEMENT

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

1. DEFINITIONS

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

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

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

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

2. INFORMAL CONFLICT MANAGEMENT.

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

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

1 JCS LD.02.04.01, EP 1 and LD.01.03.01, EP 7 (Jul. 2015).
2 JCS LD.02.04.01, EP 3 (Jul. 2015).
acknowledging the Conflict and respectfully listening to and considering the positions of others;

(b) providing an opportunity for key stakeholders to openly discuss the situation at hand, ask questions of one another, and evaluate pertinent information;

(c) demonstrating acceptance and tolerance of different perspectives and a commitment to fundamental fairness;

(d) refraining from behaviors and/or language that would be inconsistent with the Medical Center’s Code of Conduct Policy and/or could potentially escalate the Conflict; and

(e) requesting the assistance of a competent Facilitator whenever necessary.

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

3. **FORMAL CONFLICT MANAGEMENT**

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

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

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

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

(c) **Identify Necessary Supportive Resources.** The senior leader(s) will identify an appropriate internal or external Facilitator to assist with the Conflict Management. External facilitators (including mental health, legal, or human resource professionals)
may be considered when the Conflict involves key organizational leaders, a particularly sensitive issue, and/or there are no unbiased internal resources.

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

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

ii. Gather pertinent information about the Conflict;

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

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

**REFERENCES:**

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

**FORM(S):** None

**MEDICAL EXECUTIVE COMMITTEE APPROVAL: 9/26/17, 2/7/23**

**BOARD OF DIRECTORS APPROVAL: 12/18/17, 2/20/23**

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

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

POLICY STATEMENT

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

1. INDICATIONS FOR REQUIRED CONSULTATION; QUALIFIED CONSULTANT

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

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

¹ Wis. Admin. Code DHS § 124.12(5)(b)10 (2016); JCS MS.03.01.03, EP 4 and 5 (Jul. 2015).
Circumstance Consultant

| Problems of critical illness in which a significant question exists with respect to the appropriate procedure or therapy | An appropriately qualified consultant |
| Cases of difficult or equivocal diagnosis or therapy | An appropriately qualified consultant |
| Admission to Behavioral Health Services | Psychiatrist |

2. REQUEST, RESPONSE AND DOCUMENTATION

2.1 Request.
The Staff Member requesting the consultation must:

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

(b) enter an order requesting the consult; and

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

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

REFERENCES:

Federal Regulations

- None.

Wisconsin Statutes

- None

Wisconsin Administrative Code


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

FORM(S): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013, 9/26/17, 2/7/23

BOARD OF DIRECTORS APPROVAL: 4/18/2013, 12/18/17, 2/20/23

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

POLICY STATEMENT

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

1. DEFINITIONS

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

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

2. QUALIFIED MEDICAL PERSONNEL

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

<table>
<thead>
<tr>
<th>Medical Screening Examination</th>
<th>Qualified Medical Personnel</th>
<th>Additional Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor/False Labor</td>
<td>Nurse Practitioners</td>
<td>Must complete labor and delivery orientation competencies</td>
</tr>
<tr>
<td>Rule Out Rupture of Membranes</td>
<td>Registered Nurses</td>
<td>Must have minimum of one (1) year of labor experience following completion of orientation</td>
</tr>
<tr>
<td>Decreased Fetal Movement</td>
<td>Physician Assistants</td>
<td>Registered Nurses must complete a competency checklist</td>
</tr>
<tr>
<td>Second or Third Trimester Vaginal Bleeding</td>
<td>Nurse Practitioners</td>
<td>Must have clinical privileges</td>
</tr>
<tr>
<td></td>
<td>Physician Assistants</td>
<td>Must practice within their scope</td>
</tr>
</tbody>
</table>

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

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

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

REFERENCES:

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

FORM(S): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013, 9/26/17, 5/25/21, 1/25/22, 2/7/23

BOARD OF DIRECTORS APPROVAL: 4/18/2013, 12/18/17, 6/21/21, 2/21/22, 2/20/23

POLICY STEERING COMMITTEE APPROVAL: 10/25/17
Policy and Procedure for Expansion ("Train Up") of Privileges for Advanced Practice Professionals (APP)

1. Purpose

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

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

APPs who do not meet all established eligibility criteria and cannot demonstrate the requisite competence for the requested expansion of privileges may be allowed to "train up" via this policy under the direct supervision of their collaborating or supervising physician, provided specific educational requirements for special request privileges have been met. Applicants who have not completed the Aurora Health Care education and/or certification requirements to function in a defined role, such as a first surgical assistant, are not eligible under this policy to "train up" for the specific privilege that has a certification and/or defined role requirements.

For the purposes of this policy, direct supervision means that the collaborating or supervising physician is acting as a preceptor\(^1\) and is therefore required to be physically present for the

\(^1\) Precepting and proctoring are not interchangeable terms. Precepting is a process through which a practitioner gains experience and/or training on new skills and knowledge. Proctoring is a different activity that confirms previously acquired competency.
duration of the procedure or patient encounter that is the subject of a privilege given through this policy so that the physician is able to provide expert review, commentary and, ultimately, attestation of the APP’s ability to perform the privilege in a safe and competent manner.

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

3. **Definitions**
   For the purposes of this Policy, the term *Advanced Practice Professional Staff* includes:
   - Advance Practice Nurses
     - Certified Registered Nurse Anesthetists (CRNAs)
     - Certified Nurse Midwives (CNMs)
     - Nurse Practitioners (NPs)
     - Clinical Nurse Specialists (CNSs)
   - Physician Assistants (PAs)
   - Psychologists (Ph.D or Psy.D)
   - Chiropractors (DCs)
   - Optometrists (ODs)

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

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

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

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

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

**MEDICAL EXECUTIVE COMMITTEE APPROVAL: 4/4/17, 2/7/23**

**BOARD OF DIRECTORS APPROVAL: 4/17/17, 2/20/23**
Expansion ("Train Up") of Privileges for Advanced Practice Professionals (APP) Addendum
Preceptorship Plan Details

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

<table>
<thead>
<tr>
<th>Preceptorship Plan for:</th>
<th></th>
</tr>
</thead>
</table>

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

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

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

4. **Specific number of procedures/patient encounters proposed to attain competency.** Please be specific as to how many procedures/patient encounters will be observed and how many procedures/patient encounters will be performed under direct supervision.
5. **Competency measures.** Identify tools you will use to measure competency. Is there an education component, such as NIH Stroke Scale found on the Aurora’s Learning Connection or will the APP be required to review Clinical Practice Guidelines. Be specific as to what competency measures will be utilized in addition to the required completion of preceptorship forms.

________________________________________________________________________

________________________________________________________________________

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

________________________________________________________________________

Applicant Name  Signature  Date

Preceptor(s):

Print Name  Signature  Date

Print Name  Signature  Date

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

POLICY STATEMENT

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

1. **GENERALLY**

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

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

2. **REFERRAL TO THE PRACTITIONER WELLNESS COMMITTEE**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 3/19/2013; 3/22/16, 2/7/23

**BOARD OF DIRECTORS APPROVAL:** 5/16/16, 2/20/23

**POLICY STEERING COMMITTEE:** 4/27/16
MEDICAL RECORDS

POLICY STATEMENT

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

1. GENERAL REQUIREMENTS

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

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

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

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

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1 42 CFR § 482.24 (Interpretive Guidelines, effective October 17, 2008).
2 JCS RC.01.02.01, EP 1 (Jan. 2010).
4 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008); JCS RC.01.01.01, EP 11 (Jan. 2010); JCS RC.01.02.01, EPs 2-4 (Jan. 2010); JCS RC.01.03.01, EPs 1 & 3 (Jan. 2010).
Information Services Department acknowledging that he or she is the only individual authorized to use the electronic signature or code. Delegation of an electronic signature or authentication code to another individual is prohibited.\(^5\) A medical record entry may not be authenticated by use of a rubber stamped signature.\(^6\)

(c) **Co-Signature.** In certain circumstances, medical record entries must be co-signed by a Physician Medical Staff Member (e.g., certain entries by an Advanced Practice Professional must be co-signed by the Advanced Practice Professional’s supervising or collaborating physician).\(^7\) Such co-signature requirements may be set forth in this Policy, the Aurora System Hospital Co-Signature Requirements document, other Medical Staff and Medical Center policies, and/or in the designation of Clinical Privileges or Clinical Functions. The co-signing Physician accepts responsibility for the content of the medical record entry.

### 1.4 Late Entries.

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

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

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

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

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

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

### 1.5 Completeness.

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

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\(^5\) 42 CFR § 482.24(c)(1) (Interpretive Guidelines, effective October 17, 2008).


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

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

1.7 Correction of Errors.

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

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

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

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

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

iv. Initial and date the entry;

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

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

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

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

2. CONTENT

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

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

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

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

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

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

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\(^{11}\) JCS RC.01.01.01, EP 1 (Jan. 2010).

\(^{12}\) 42 CFR § 482.24(c) (Interpretive Guidelines, effective October 17, 2008).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.14 **History and Physical Examinations.**

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

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

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

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

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

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\(^{23}\) 42 CFR § 482.24(c)(2)(v) (Interpretive Guidelines, effective October 17, 2008); JCS RC.02.01.01, EPs 4 & 21 (Jan. 2010).

\(^{24}\) 42 CFR § 482.22(c)(5)(i) (Interpretive Guidelines, effective October 17, 2008).


\(^{26}\) 42 CFR § 482.22(c)(5)(i) (Interpretive Guidelines, effective October 17, 2008); 42 CFR § 482.24(c)(2) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(3)(a)9 (2009); JCS RC.02.01.03, EP 3 (Jan. 2010).

\(^{27}\) 42 CFR § 482.22(c)(5)(i); 42 CFR § 482.24(c)(2)(i)(B) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS §124.14(3)(a)9 (2009).
clinical and status. A complete H&P shall be performed and recorded as soon as possible.

(f) **Pre-Admission H&Ps and Updates.** An H&P performed by a qualified physician or Advanced Practice Professional no more than thirty (30) days prior to the patient’s admission or registration may be used (even if such pre-admission H&P is performed by a provider who is not a current Medical Staff or Advanced Practice Professional Staff member); however, when a pre-admission/registration H&P is used, a qualified Staff Member must complete and document an updated examination of the patient, including any changes in the patient’s condition that may be significant for the planned course of treatment. The qualified Staff Member shall use his/her clinical judgment, based upon his/her assessment of the patient’s condition and co-morbidities (if any), in relation to the patient’s planned course of treatment, to decide the extent of the update assessment needed as well as the information to be included in the update note in the patient’s medical record. If, upon examination, the Staff Member finds no change in the patient's condition since the pre-admission H&P was completed, he/she may indicate in the patient’s medical record that the pre-admission H&P was reviewed, the patient was examined, and that “no change” has occurred in the patient's condition since the pre-admission H&P was completed. The updated H&P examination must be completed and documented in the patient’s medical record: (a) prior to any non-emergent surgery, or any inpatient or outpatient procedure requiring anesthesia services, or (b) within twenty-four (24) hours after the patient’s inpatient admission or outpatient registration, whichever occurs first. Any portion of the updated H&P performed by an Advanced Practice Professional shall be reviewed and co-signed by the admitting Physician or the Advanced Practice Professional’s supervising Physician and such co-signing Physician accepts responsibility for the content of the pre-admission H&P and the updated H&P.

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

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

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

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

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

2.15 **Pre- and Post-Procedure Documentation.**

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

i. an H&P;

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

iii. consultation reports, if required; and

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

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

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

i. The performing Practitioner must either:
   • document a full procedure report, immediately after the procedure and before the patient is transferred to the next level of care (e.g. the patient leaves the recovery room),\textsuperscript{32} or
   • document a brief operative note immediately after the procedure to include name(s) of the primary surgeon and assistants, procedure(s) performed, description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis, and document a full procedure report within twenty four (24) hours of the procedure;\textsuperscript{33} or
   • accompany the patient from the procedure room to the next unit or area of care, and document a full procedure report in the new unit or area of care.\textsuperscript{34}

ii. The full procedure report must be signed by the performing Practitioner and must include the following information:\textsuperscript{35}
   • Date and time of the procedure;
   • Pre-procedure diagnosis;
   • Type of anesthesia administered;
   • Name and description of the specific procedure performed;
   • Name(s) of performing provider and any individual(s) (e.g. surgical assistants) who performed a significant surgical or procedural task during the procedure (even when performing those tasks under supervision);
   • A description of techniques, findings, and tissues removed or altered;
   • Estimated blood loss, specimens removed, complications, prosthetic devices, grafts, tissues, transplants, or implants (tissue or devices); and
   • Post-procedure diagnosis.

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

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

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

\textsuperscript{32} Wis. Admin. Code DHS § 124.14(3)(a)10 (2009); JCS RC.02.01.03, EP 5 (Jan. 2010).
\textsuperscript{33} 33 JCS RC.02.01.03, EP 5, Note 1 (March 2011).
\textsuperscript{34} JCS RC.02.01.03, EP 5, Note 2 (Jan. 2010).
\textsuperscript{35} 42 CFR § 482.51(b)(6) (Interpretive Guidelines, effective October 17, 2008); Wis. Admin. Code DHS § 124.14(3)(a)(10) (2009); JCS RC.02.01.03, EP 6 (Jan. 2010).
iii. Any unanticipated events or complications (including blood transfusion reactions) and the management of those events.\textsuperscript{36}

(d) Discharge From Post Procedural Observation. If the patient is admitted and subsequently discharged from a post-sedation or post-anesthesia care area, the medical record must contain the name of the practitioner responsible for the discharge, and documentation that the patient was discharged from the post-sedation or post-anesthesia care area either by the responsible practitioner or by another individual in accordance with written discharge criteria.\textsuperscript{37}

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

(a) Pre-Procedure Evaluation. The medical record must contain a pre-anesthesia evaluation, including at a minimum: (1) information regarding the choice of anesthesia and the procedure anticipated, (2) the patient’s previous medication and anesthetic history, (3) potential anesthetic problems, ASA patient status classification, and orders for preoperative medications, for all inpatient and outpatient procedures. The pre-procedure assessment shall be recorded within forty-eight (48) hours prior to procedure and before any pre-procedure medication has been administered.\textsuperscript{38}

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

(c) Intraoperative Report. The anesthesia provider shall complete an intraoperative report, which shall include, at a minimum: (1) the name and profession of the practitioner who administered anesthesia, the supervising anesthesiologist (if any) and the performing practitioner; (2) name, dosage, route and time of administration of all drugs and anesthesia agents; (3) type, route and amount of IV fluids administered; (4) blood or blood products, if applicable; (5) mechanism of oxygenation, flow rate, and pulse oximetry readings; (6) continuous recordings of patient status, including blood pressure, heart and respiration rate; and (7) any complications or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient’s response to treatment.\textsuperscript{39}

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

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

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

(b) Maternal Medical Record. Each obstetric patient shall have a complete hospital record which shall include:
   i.  Prenatal history and findings;
   ii. Labor and delivery record, including anesthesia;
   iii. Physician’s progress record;
   iv.  Physician’s order sheet;
   v.  A medicine and treatment sheet, including nurses’ notes;
   vi.  Any laboratory and x-ray reports;
   vii. Any medical consultant’s notes; and
   viii. Estimated blood loss.

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

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

\textsuperscript{40} 42 CFR § 482.52(b)(3) (Interpretive Guidelines, effective October 17, 2008).
2.19 **Pathology Reports.**
The medical record must contain all pathology reports, including reports of microscopic findings (if any). If only macroscopic examination is warranted, the medical record must contain a statement that the tissue has been received and a macroscopic description of the findings provided by the laboratory.

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

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

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

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

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

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

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

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

3. Request for Clarification Forms

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

4. Medical Record Audits

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

5. Use and Disclosure of Protected Health Information

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

References:

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

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

Wisconsin Administrative Code

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

FORM(S): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013, 3/22/16, 2/7/23

BOARD OF DIRECTORS APPROVAL: 5/16/16, 2/20/23

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

POLICY STATEMENT

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

1. BYLAWS COMMITTEE

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

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

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

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

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

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

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

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

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

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

2. **PRACTITIONER WELLNESS COMMITTEE**

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

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

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

2.2.2 Develop and implement a process for identifying and assessing Staff Members who may suffer from an impairing condition, and address such conditions as necessary. Such process shall include referral to Medical Staff leadership for appropriate corrective action (including any state or federally mandated reporting requirements), if, at any time

¹ JCS MS.11.01.01, EP 1 (Jul. 2015).
during the diagnosis, treatment, or rehabilitation phase of the process, it is determined that a Staff Member is unable to safely perform his or her Clinical Privileges;²

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

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

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

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

3. Credentials Committee

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

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

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

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

² JCS MS.11.01.01, EP 8 (Jul. 2015).
3.2.3 Consulting with, and obtaining any information from, any sources which the Credentials Committee deems necessary, desirable or relevant to the matter in question;

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

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

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

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

4. MEDICAL EXECUTIVE COMMITTEE

Refer to the Medical Staff Bylaws.

5. PRACTICE EVALUATION COMMITTEE

5.1 Composition
The Practice Evaluation Committee shall be composed of (1) the Medical Staff Secretary-Treasurer who shall serve as chairperson; (2) the Chief of Staff Elect; (3) five (5) other Medical Staff Members representing different specialties, and (4) an Advanced Practice Professional Staff Member, and representatives, including without limitation, those from administration, nursing service, patient safety, risk management, and quality management, may be consulted by the Practice Evaluation Committee to provide expertise as required or desired for the Practice Evaluation Committee to perform its duties.

5.2 Duties
The duties of the Practice Evaluation Committee shall include, but are not limited to:

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

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

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

5.2.4 Perform Focused Professional Practice Evaluation when potential Practitioner and/or Advanced Practice Professional opportunities are identified;
5.2.5 Assure that the process for peer review is clearly defined, fair, defensible, timely, consistent, and useful;

5.2.6 Providing a forum to discuss quality of care issues;

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

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

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

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

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

FORM(S):

MEDICAL EXECUTIVE COMMITTEE APPROVAL: August 1, 2006; November 21, 2006; February 5, 2008 / April 1, 2008; June 1, 2010 / August 10, 2010; March 19, 2013; March 24, 2015; September 22, 2015, September 26, 2017; March 23, 2021; May 25, 2021; November 23, 2021, February 7, 2023

BOARD OF DIRECTORS APPROVAL: August 22, 2006; November 28, 2006; August 28, 2008; August 24, 2010; April 18, 2013; April 20, 2015; November 16, 2015, December 18, 2017; April 19, 2021; June 21, 2021; December 20, 2021, February 20, 2023

POLICY STEERING COMMITTEE: January 23, 2015; October 28, 2015, October 25, 2017
ON-CALL COVERAGE AND RESPONSE

POLICY STATEMENT

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

1. EMERGENCY DEPARTMENT CALL COVERAGE

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

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

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

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

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

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

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

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

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

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

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

2. GENERAL INPATIENT AND OUTPATIENT CALL COVERAGE

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

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

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

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

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

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

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

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

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

Wisconsin Administrative Code

FORM(S):
None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013, 11/25/14, 2/7/23
BOARD OF DIRECTORS APPROVAL: 4/18/2013, 12/15/14, 2/20/23
POLICY STEERING COMMITTEE: 1/23/15
ONGOING AVAILABILITY AND
DESIGNATION OF ALTERNATE PROVIDERS

POLICY STATEMENT

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

1. ONGOING AVAILABILITY

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

2. DESIGNATION OF ALTERNATE STAFF MEMBERS

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

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

2.2 Ensure the alternate Staff Member:

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

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

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

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

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

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

3. Failure to Comply

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

REFERENCES:
None

FORM(S):
None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013, 2/7/23

BOARD OF DIRECTORS APPROVAL: 4/18/2013, 2/20/23
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

POLICY STATEMENT

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

1. SCOPE

OPPE applies to all practitioners with clinical privileges at ASMMC.

2. DEFINITIONS

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

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

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

3. POLICY

3.1 Selection of Indicators for OPPE Profile Reports:

(a) Indicators and targets are approved by the Medical Staff Department, the ASMMC Credentials Committee, and the ASMMC Medical Executive Committee.

(b) Any changes, including deletions, must be approved as stated above.

3.2 Responsibility for Review of OPPE Profiles:

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

3.3 Frequency of Review:

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

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

3.4 Use of Information Resulting from OPPE:

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

4. PROCEDURES/RESPONSIBILITIES

4.1 Maintenance of OPPE Data and Evaluation Process:

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

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

4.2 Practitioner Notification:

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

4.3 Profile Reviews:

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

4.4 Practice Evaluation Committee (PEC):

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

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

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

4.6 ASMMC Credentials Committee:

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

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

REFERENCES:

Code of Federal Regulations
- None.

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

FORM(S):

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/22/16, 2/7/23

BOARD OF DIRECTORS APPROVAL: 5/16/16, 2/20/23

POLICY STEERING COMMITTEE: 4/27/16
PEER REVIEW

POLICY STATEMENT

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

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

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

1. DEFINITIONS

1.1 Peer Review.

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

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

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

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

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

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

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

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

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

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

2. **Policy**

2.1 **Peer Review.**

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

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

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

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

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

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

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

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

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

i. The specific provider;

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

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

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

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

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

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

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

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

3. **PROCEDURE**

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

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

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

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

(b) Circumstances that may benefit from EPR include:

i. Litigation - when dealing with the potential for a lawsuit.

ii. Ambiguity - when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges.

iii. Lack of internal expertise - When no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the Medical Executive Committee or governing board.

iv. Miscellaneous issues - when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the Medical Executive Committee or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

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

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

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

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

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

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

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

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

“Statement of confidentiality”

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

**REFERENCES:**

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

**FORM(S):** None

**MEDICAL EXECUTIVE COMMITTEE APPROVAL:** 11/25/14, 9/22/15, 3/22/16, 2/7/23

**BOARD OF DIRECTORS APPROVAL:** 12/15/14, 11/16/15, 5/16/16, 2/20/23

**POLICY STEERING COMMITTEE:** 1/23/15, 10/28/15, 4/27/16
Clinical Case Review Algorithm

Clinical case involving Medical Staff or Advanced Practice Professional is entered into MIDAS

Risk refers to Medical Staff/Quality for review

Case summary prepared by Quality RN

Primary review and screening is performed by Department Chairperson

Screened-out case is closed

Screened-in case is sent to involved provider for response

Department Chairperson reviews involved provider's reply and makes recommendation

Case screened for PEC Review

Screened-out case is closed

Practice Evaluation Committee reviews case and makes final determination

PEC Chair notifies Department Chair of any discrepant decision

No OFI

OFI

System OFI

Final determination may include follow-up action such as:
- Notification Letter
- Focus study
- Educational Letter
- “Cup of coffee” conversation
- Formal meeting with formal corrective action w/wo FPPE to monitor for change
- Refer repeat OFIs, patterns of OFIs or a single egregious OFI to MEC

Involved provider and Department Chair receive notification letter regarding the final determination of the case.

Enter Midas follow up to appropriate system team

Follow up actions to be communicated to PEC as appropriate

Referral Sources:
Patient/Family; Friend; Caregiver; Physician; Risk; Quality Indicators; System Quality Teams
Complaint/Grievance regarding Medical Staff or Advanced Practice Professional code of conduct is entered into MIDAS

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

Risk refers to Medical Staff/Quality for review

Case summary prepared by Quality RN

Complaint/Grievance is sent to provider for response

Department Chairperson or alternate (i.e., CMO) reviews complaint/grievance including provider’s response and makes determination

Unsubstantiated complaint/grievance

No further action/consider trending for future occurrences

Indeterminate (Trend)

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

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

Substantiated complaint/grievance

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

Chief of Staff may refer to Practitioner Wellness Committee

Medical Staff/Quality Office to keep documentation and track for rolling 12 months

CMO and Director of Quality review monthly for trends

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

PROVIDER ORDERS

POLICY STATEMENT

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

1. GENERALLY

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

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

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

1.4 Incomplete, Unclear, Illegible or Unacceptable Orders.³
An order that is incomplete, unclear, illegible, contains unacceptable symbols or abbreviations, or is otherwise unacceptable will not be implemented until the order is clarified and, if appropriate, a new order issued. The Staff Member or Clinical Assistant responsible for implementation of the order shall contact the Ordering Provider for clarification and, if appropriate, issuance of a new order. Whenever possible, the Ordering Provider will re-issue the order with the clarifying details. If the Ordering Provider is not available, the Staff Member or Clinical Assistant responsible for implementation of the order shall contact one or more of the following individuals (listed in order of priority) for clarification: (a) the Ordering Provider’s designated alternate; (b) the patient’s attending physician; (c) an associate of the Ordering Provider who practices in the same specialty; (d) the Physician on call for the Ordering Provider’s service in the Emergency Department; and (e) the appropriate Clinical Chairperson.

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

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

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

1.7 **Authentication and Co-Signature.**

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

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

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

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

2.2 **Written Orders.**

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

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

   ii. the CPOE is not functioning;

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

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

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

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

2.4 **Verbal Orders.**

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

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

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

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9 42 CFR § 482.23(c)(2); CMS Transmittal 47, June 5, 2009.
10 JCS MM.04.01.01, EP 7 (Jan. 2010).
11 42 CFR § 482.23(c)(2)(i) (Interpretive Guidelines, effective October 17, 2008); JCS MM.04.01.01, EP 6 (Jan. 2010).
iii. Verbal Orders may only be issued to an individual who is authorized to receive verbal orders. The following persons are authorized by the Medical Staff to receive verbal orders: physician assistants, registered nurses, chiropractors, respiratory therapists, pharmacists, physical therapists, occupational therapists, speech therapists, radiologic technicians, respiratory technicians, psychologists, dietitians and social workers. Such authorized individuals may receive a verbal order and enter it into the patient’s medical record, if the verbal order relates to the clinical area in which such authorized individual is trained.

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

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

vi. Only physical therapists, occupational therapists, or speech therapists may accept a telephone or verbal order from a physician related respectively to physical therapy, occupational therapy, or speech therapy, under urgent or emergent situations.

vii. Only a speech therapist may make the judgment to advance or down-grade within a patient’s dysphagia diet order. All other diet related orders must be given by a physician.

viii. Verbal orders are never acceptable for chemotherapy agents.

(b) Issuing a Verbal Order.

i. An Ordering Provider must communicate a verbal order, in person or over the telephone, only to a duly authorized individual and such verbal order must relate to the clinical area in which such authorized individual is trained.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

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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.
- All other elements required for the particular order (e.g., see Section 4.2 for minimum requirements of medication orders).

(c) **Mandatory Read Back.** The accepting individual shall write the complete order on an order sheet and shall read the entire order back to the Ordering Provider. The accepting individual must then receive confirmation from the Ordering Provider that he/she has received the correct order. Once confirmation is received, the accepting individual shall enter the verbal order into CPOE.

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

i. Verbal orders must be promptly authenticated in CPOE by the Ordering Provider (or a practitioner assuming care of the patient) as soon as possible, and in all events within forty-eight (48) hours (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.

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

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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.
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.
• 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.

3. REQUIREMENTS FOR CERTAIN TYPES OF ORDERS

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

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

3.3 Orders for Diagnostic Testing.
In addition to basic requirements for orders, all orders for diagnostic testing shall include: (a) the reason, purpose or indication (orders for outpatient diagnostic tests must include the symptoms, diagnosis or ICD-9-CM code); (b) the type of testing; (c) any specific requirements or instructions; (d) the frequency, schedule and duration of testing; and (e) if the test requires the administration of medications or other substances (e.g., contrast dye), the order must include the necessary elements for medication orders. An order for imaging studies (X-ray, CT Scan, MRI, etc.) must include a concise statement describing the reason for the imaging study.20

3.4 Medication Orders.
(a) Requirements.21 In addition to basic requirements for orders (form, timeliness, authentication), all orders for medications must include:

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20 Wis. Admin. Code DHS § 124.18(e)(2).
21 JCS MM.04.01.01, EPs 2, 3, and 9 (Jan. 2010).
POLICIES GOVERNING MEDICAL PRACTICES
Provider Orders

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;

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 medications orders are acceptable:

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

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

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

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

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

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

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

(c) High Alert and Hazardous Medications. 23 The Medical Center maintains a list of high-alert and hazardous medications and utilizes specific strategies for avoiding

22 JCS MM.04.01.01, EP 1 (Jan. 2010).
23 JCS MM.01.01.03 (Jan. 2010).
errors related to such medications. Orders must be written in accordance with the requirements set forth in such policies.

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

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

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

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

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

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

(j) **Stop Orders.** The Medical Center’s stop order policy does not prevent the Ordering Provider from ordering medication for any reasonable length of time that the Ordering Provider may choose, and is intended to cover only those situations in which drug administration orders do not state a specific length of time or duration. If the following medications are ordered without specific

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24 JCS MM.04.01.01, EP 4 (Jan. 2010).
25 NPSG.03.03.01 (Jan. 2010).
26 JCS MM.04.01.01, EP 10 (Jan. 2010).
limitations as to dosage and time, such medications shall be automatically discontinued as follows, unless specifically reordered by the attending Practitioner:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics</td>
<td>10 days</td>
</tr>
<tr>
<td>Controlled Substances</td>
<td>5 days</td>
</tr>
<tr>
<td>All pre-op and/or prenatal</td>
<td></td>
</tr>
<tr>
<td>medication</td>
<td>post-op/postpartum</td>
</tr>
<tr>
<td>Transfer medication orders</td>
<td></td>
</tr>
<tr>
<td>IV Fluids</td>
<td>3 days</td>
</tr>
</tbody>
</table>

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

3.5 Standing Orders.

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

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

3.6 Transfer Orders.

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

3.7 Discharge Orders.

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

3.8 **Blood Transfusion Orders.**
All orders for blood transfusions must be entered in accordance with the Medical Center’s policies on blood and blood components.

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

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

3.11 **Therapeutic Diet Orders.**

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

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

ii. Modification in diet textures;

iii. Oral supplements;

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

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

vi. Weight, including daily weight;

vii. Speech therapists, Nutrition education;

viii. Vitamin and mineral supplements; and

ix. Calorie counts.

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

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

Wisconsin Statutes
- None.

Wisconsin Administrative Code and Other Guidance

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

FORM(s): None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 3/19/2013, 9/26/17, 2/7/23, 4/25/23

BOARD OF DIRECTORS APPROVAL: 4/18/2013, 12/18/17, 2/20/23, 5/15/23

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

POLICY STATEMENT

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

REFERENCES:

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

FORM(S):

None

MEDICAL EXECUTIVE COMMITTEE APPROVAL: 9/26/17, 2/7/23

BOARD OF DIRECTORS APPROVAL: 12/18/17, 2/20/23

POLICY STEERING COMMITTEE APPROVAL: 10/25/17