One

Atrium Health
Medical Director Guide

A Guide to Onboarding New Physicians & ACPs

Dear Physician Leader,

On behalf of Atrium Health Medical Group, I would like to thank you for your commitment to One Team. We recognize the skills and expertise you bring to our enterprise and want you to know that we value your leadership. You are critical to our pursuit of providing excellent patient care.

Comprehensive provider onboarding is imperative to the growth and development of our System. From day one, new providers must be given the appropriate resources to ensure their success, both professionally and personally.

This Medical Director Guide was created in an effort to assist you throughout the onboarding process. Please use this tool as a roadmap to complete the following:

- Set Expectations
- Establish Clinical Guidelines
- Foster Professional Development
- Create a Support Network
- Celebrate Milestones

It is a privilege to serve as a leader within Atrium Health. With that privilege comes a responsibility to educate and engage providers regarding our culture of caring. Thank you for being a key contributor to the continued success of our providers and organization.

Sincerely,

Atrium Health Medical Group Leadership

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New Physician & ACP Site-Based Orientation Checklist

Organization
Review of Principles of Professionalism
Aware of Local/Regional/Administrative Structure
Physician Leadership Structure
Patient Satisfaction
Quality Measures
Review of Local/Site Based Orientation Manual
Review of Atrium Health Provider Related Policy & Procedure
Completion of ACE Modules
Introduction to PeopleConnect/PhysicianConnect
Submission of e-Forms (Reimbursement/Travel/etc.)
Navigation of SharePoint/One Drive, Etc.
Workflow
Staff Introduction
Introduction of other Physician Leaders
Parking
Parking Sticker
Badge/Access
Bathroom
Office
Office/Clinic Needs: Computer, Phone, Desk, VM, Supplies, Etc.
Lunch/Common Area
Directions on other areas in facility
Office Flow of Patients
Standing Orders
Familiarize with Equipment/Supplies/Medications/Etc.
Messaging & Halo
Refills (Specifically Controlled Substance)
Lab Endorsement
Coverage of Other Providers
Review Forms (Physicals, X-ray, Billing, Patient Education, etc.)
Referrals (Concept of Care Coordination, To Whom to Refer)
Utilization of Physician Connection Line
Transfers to Hospital
Triage Policy
Schedule & Schedule Modification
Emergency Care
Staff Meetings (location/frequency)
Scope of Care
Chronic Disease Management (if applicable)
Acute Care
Panel of Patients
Procedures (Create a separate checklist of approved procedures)
Call Rotation/Responsibilities
EMR
Meaningful Use EMR Requirements
Review of EMR Related Questions
Login Information and Authorization for Physician Connect/Referral Portal/ Internet/Shared Drives
Patient Experience
Curo Conversations
One Behaviors

Licensure/Certification Maintenance
BLS Certified
ACLS Certified (if applicable)
PALS Certified (if applicable)
Hospital Privileges
CME
DEA
NC/SC License
Board Certification
NC Privilege License
Review Delineation of Privileges (if applicable)
Benefits, Productivity & Compensation
Visits per Day
WRVUs per Visit
Net Revenue per Visit
Review Atrium Health Holidays
Leaves of Absence
Paycheck Distribution
LiveWELL
PTO Requests/Vacation Requests
CME Allowance
Dedicated CME Time
Incentive Opportunities
Professional Development
System Resources/Educational Opportunities (AHEC, Center for Advanced Clinical Practice, IRB, Center for Faculty Excellence, etc.)
Performance Evaluation
Goals
Mentoring Strategy
Marketing/Community Integration
Introduction of Physician Liaison (if applicable)
Marketing Plan/Strategy (if applicable)
Provider Retention Programs
Provider Spouse/Significant Other Employment Assistance Program
Security/Safety/Infection Control/Prevention/Emergencies
Department-Specific Security/Safety
Fire Safety (Procedures, Fire Pull Stations, & Extinguishers)
Hazard Communication
Concern & Incident Reporting
Hand-Hygiene
Flu Vaccine Program
Exposure Control Plans
Department-Specific Infection Control Procedures
Emergency Alert Codes (Facility, Security, Medical)
Exits
Patient Safety
Use of Patient Restraints
Severe Weather Policies
Policies
Acceptable Use Policy (IS.PHI 600.01)
Corporate Compliance/HIPAA
Minimum Work Standards

Mission

To improve Health, elevate Hope, and advance Healing – for all.

Vision

To be the first and best choice for care.

Core Values

Caring: We treat our customers with dignity, giving them the courtesy and gentleness they need. We are helpful; we listen; we communicate; we respond to patient needs.

Commitment: We are dedicated to Atrium Health, taking pride in our organization and our jobs, projecting a professional image and striving to be the best in all we do.

Integrity: We honor and uphold confidentiality, are honest and ethical, keep our commitments, accept responsibility for our actions and respect the rights of patients, families and each other.

Teamwork: Linked by our common mission, Atrium Health respects the professionalism and contributions of our coworkers, understands that physicians are an integral part of the team, values diversity in all its forms and recognizes that people are our greatest assets.

Review Atrium Health Principles of Professionalism

Principles of Professionalism: to be used as a guide to govern your interactions with patients, families and colleagues.

As an Atrium Health Provider, I am committed to:

Superior Clinical Quality, and I will
- Keep my professional knowledge and skills current and recognize the limits of my abilities
- Adopt mutually agreed upon best practices
- Embrace innovation and continuous improvement in patient care and practice operation
- Seek out information and resources needed to provide excellent care

Excellent Customer Service, and I will
- Achieve and maintain optimal patient access
- Ensure that the needs of the patients come first for all parties
- Encourage patient involvement in care and treatment decisions
- Work toward excellent patient satisfaction
- Communicate in a clear and timely fashion

Ethical Behavior, and I will
- Treat patients and staff with respect and dignity
- Demonstrate the highest levels of ethics in professional and personal conduct
- Be respectful in discussing care rendered by others in front of staff and patients
- Treat my colleagues in the way I would like to be treated
- Foster a spirit of collegiality and communication

Medical Leadership, and I will
- Be engaged in creation and support of organizational and group goals
- Accept collective responsibility for welfare of patients, peers, and coworkers
- Work to make Atrium Health the employer of choice on all levels
- Participate in and support group decisions
- Participate in group governance
- Support medical leadership by recognizing its authority
- Strive to be a role model to my patients and colleagues by maintaining a healthy lifestyle

Teamwork, and I will
- Lead a team where integrity, commitment, cooperation, and caring are of uppermost importance
- Communicate with and influence those around me in a positive manner
- Listen to others and accept feedback gracefully
- Participate in and support teaching
- Teach and lead by example
- Value the work of others at all levels
- Interact with colleagues, administration and staff in a respectful, positive, and cooperative manner

Stewardship, and I will
- Manage resources wisely
- Support career development for physicians and staff
- Arrive at work on time and give best efforts to the practice
- Strive to code appropriately and submit charges promptly
- Attend to the economic aspects of the practice

Signature: ______________________________ Date: ______________

Review Medical Group and Service Line Structure

Due to the size and complexity of Atrium Health, we have a heavily matrixed organizational and reporting structure, which is consistent with other leading integrated healthcare networks across the country. This includes Care Divisions, Service Lines, and Regional Markets.

Our leadership structure allows us to better organize ourselves, our programs and our processes around the needs of our patients and communities.

The structure fosters a healthcare delivery system that is integrated, connected, convenient, reliable and affordable. It is designed to enhance our:

Within the Medical Group, there are four Care Divisions & four Service Lines:

Care Divisions	Service Lines
Primary Care & Medical Specialties	Sanger Heart and Vascular Institute
Adult Acute	Levine Cancer Institute
Surgical Specialties	Behavioral Health
Children's Services	OB/GYN

The Medical Group is also structured around seven different markets

- Center City
- Lake Norman
- North
- NorthEast
- South
- Southeast
- West

Review Care Division Structure & Leadership

The Care Divisions, under the direction of the Atrium Health Medical Group, are divided into four specialty divisions

Adult Acute Care
Critical Care
Emergency Medicine
Gastroenterology
Hepatology
Hospitalists
Infectious Disease
Hospice & Palliative Care
Neurology (Adult)
Perspective Health & Wellness
Physical Medicine & Rehabilitation
Pulmonology
Virtual Critical Care

Women's Services
Ambulatory OB/GYN
Female Pelvic Health and Gynecologic Urology
Gynecologic Oncology
Maternal Fetal Medicine
OB/GYN Hospitalists
Reproductive Endocrinology and Infertility

Children's Services
Adolescent Medicine
Child Maltreatment
Critical Care
Development Pediatrics
Endocrinology/Diabetes
Gastroenterology
Genetics
Hematology/Oncology/ Bone Marrow Transplant
Infectious Diseases/Immunology
Neonatology
Nephrology
Neurology
Newborn Nursery
Palliative Care
Pediatric Hospitalists/ Inpatient Team (CHIPS)
Pulmonary
Rheumatology
Urology
General Pediatrics

Primary Care & Medical Specialties
Corporate Health
Family Medicine
Internal Medicine
Sports Medicine
Urgent Care
Medical Sub-Specialties:
Dermatology
Endocrinology
Rheumatology
Sleep Medicine

Surgical Services
Surgery:
Bariatric & Metabolic
General/GI
HPB
Surgical Oncology
Transplant
Trauma/SCC/ACS
Oral Medicine & Surgery
Orthopaedic Surgery
Plastic Surgery
Urology
GU Oncology
Female Urology
Pediatrics Surgery

Care Division Leadership

Each Care Division has a Clinical Leader, Administrative Leader, and Academic Leader

Care Division	Clinical Leader: Scott Rissmiller, MD Deputy Chief Physician Executive	Administrative Leader: Tom Laymon, President/Chief Operations Executive	Academic Leader: Mary Hall, MD SVP/Chief Academic Officer
Primary Care & Medical Specialties	Al Hudson, MD	Jeff Ozmon, SVP	Scott Furney, MD
Surgical Services	Brent Matthews, MD	Lauren Iannitti, VP	Brent Matthews, MD
Adult Acute	Scott Lindblom, MD	Shannon Carpenter, VP	Michael Gibbs, MD
Children's Services	H. Stacy Nicholson, MD	Jennifer Terry, VP	Suzette Caudle, MD
Women's Services	Suzanna Fox, MD	Shad Ritchie, VP	Robert Higgins, MD

Review Service Line Structure & Leadership

Service Line Leadership:

There are four Service Lines, which are independent of the care divisions. Each service line has a clinical leader and an administrative leader.

Service Line	Clinical Leader	Administrative Leader
Sanger Heart and Vascular Institute	Paul Colavita, MD President, SHVI	Scott Moroney Vice President, SHVI
Levine Cancer Institute (LCI)	Derek Raghavan, MD, PhD, FACP, FRACP President, Levine Cancer Institute	Kevin Platé Vice President, Levine Cancer Institute
Behavioral Health	Wayne Sparks, MD Senior Medical Director, Behavioral Health	Martha Whitecotton SVP, Behavioral Health Services
Musculoskeletal Institute	Claude T. Moorman III, MD President, Musculoskeletal Institute	Chan Rouse Vice President, Musculoskeletal Institute

Review Regional Market Structure & Leadership

Chief Medical Officers:

Due to the vast area covered by Atrium Health, there are also Chief Medical Officers assigned to each facility.

Facility	Chief Medical Officer
Metro Division	Gary L. Little, MD, MBA SVP & CMO, Metro Division
Carolina Medical Center	TBA
CMC Mercy	TBA
Levine Children's Hospital & Jeff Gordon Children's hospital	Andrew C. Herman, MD
CHS Pineville	Saju D. Joy, MD
CHS Union	Paul D'Amico, MD
CHS Northeast	Dan Hagler, MD
CHS University & CHS Lincoln	Vineet Goel, MD
CHS Stanly	Paul D'Amico, MD
Carolinas Rehabilitation	William Bockenek, MD
CHS Cleveland	Charles Tomlinson, MD

Review Departmental Leadership, Structure & Resources

- Departmental/practice administrative structure - organizational charts so they understand how they fit into the care divisions/service lines
- Department/practice meeting structure and frequency
- Information sharing and feedback loop
- **Local Orientation Manual -** If applicable, review your department's orientation manual.
- **Important Policies -** Review all policies & procedures pertinent to this role as well as the following:
  - **Communications Environment Acceptable Use Policy**
    Atrium Health relies on its communication resources to support its business processes and functions. This policy sets forth procedures for the appropriate use of Atrium Health Communication Resources by its employees, independent contractors, agents, and other users.

    Please review this policy with your new provider:
    http://documents.carolinas.org/CorpSafety/Administrative%20Policy%20and%20Procedure%20Manual/07%20Information%20Services/CHS-IS-600-01.pdf

  - **Corporate Compliance/HIPAA**
    During orientation, providers receive a copy of the "Code of Business Conduct – A System of Integrity" booklet and this information is briefly covered. Please take time to elaborate on these topics and share details that you deem helpful to providers joining your area.

- **ACE Modules -** Ensure that the new provider completes their assigned ACE modules.
  - To complete the Annual Compliance Education requirements, providers should log in to PeopleLink. Step-by-step instructions for completing Annual Compliance Education requirements are found in the Teammate Learning Guide, available on PeopleLink through the Resources menu, Resources tab.

- **PeopleConnect/PhysicianConnect**
  Please make sure your new provider understands how to access PeopleConnect/PhysicianConnect. It would be helpful to review the resources on PhysicianConnect in greater detail to make sure they are fully utilizing the available tools. **PeopleConnect:** http://peopleconnect.carolinas.org/
  PhysicianConnect: http://physicianconnect.carolinas.org/

- **Submission of eForms (reimbursement, travel, etc.)**
  Review the process for travel requests/reimbursement in your area. If the provider will submit their own forms, the following links should be used:
  Travel Requests/Travel Reimbursements:
  http://peopleconnectmore.carolinas.org/reference/eforms/forms/Travel/travel.cfm
  Mileage Reimbursements:
  http://peopleconnectmore.carolinas.org/reference/eforms/forms/Mileage/Mileage.cfm
  Miscellaneous Reimbursements (meals, etc.):
  http://peopleconnectmore.carolinas.org/reference/eforms/forms/Disbursement/disbursement.cfm

- **SharePoint**
  Several departments within Atrium Health house important information related to their areas on SharePoint. Make sure the new provider knows how to navigate applicable SharePoint sites:
  http://teams.carolinas.org/SitePages/Home.aspx

Review Workflow Components

Helping your new provider understand the general flow of the office is a critical step in their ability to be successful in your practice. This should be one of the first things that is covered with the new provider. The following items provide an overview of key components to address when discussing the workflow.

Review each of these items with your new provider to help acclimate them to your area.

Staffing

- Introduction of team/dedicated clinical staff
- Introduction of other physician leaders
- Assign and introduce a physician/ACP mentor (Ideas/tips on serving as mentor are available through the Center for Physician Leadership.)
- Dedicated CMA
- Other staffing needs outlined by new provider

Physical Space

Tour of office/facility

- Physician lounge, kitchen, cafeteria, conference rooms, operating rooms, bathroom locations etc.
- Directions to other areas/site locations/facilities

Parking

- Parking sticker (received during orientation)
- SMART PASS (if applicable)

Security

- Badge access

Office and physical items in office

- Phone
- Voice mail set-up
- Business Cards
- Lab Coat/Jacket
- Pager/Beeper
- Computer
- Access

Emergency procedures and codes including the location of the following

- Alarms, exits, extinguishers, fire pull stations

** If any of the above items (parking, badge access, office items, etc.) are not available or working properly please contact your Practice Manager or Integration Specialist so the issue can be resolved ASAP.*

Office flow of patients

- How patients are checked in and brought back to exam rooms
- Flagging system
- Lights system
- Nursing/medical assistants
- Standing orders
- Checkout procedure

Equipment/Supplies

- Where they are located within the office
- Ensure they know how to properly operate equipment
- Review equipment/supplies reordering process

Medications

- Standard prescriptions written
- Refill process-controlled substances/narcotic contract
- Registration for NC/SC database to review controlled substance reporting system
  - NC-Controlled Substance Reporting System (NC-CSRS)
    The forms below are registrations for a state-wide prescription drug monitoring program database. These databases are accessed by physicians, ACPs, and pharmacists to see what narcotics are already prescribed for

a patient to make sure they are not prescribing more narcotics to a person that might cause them to overdose, feed an addiction, or sell the narcotics based on their prescription history. The database also allows physicians to see if the patient has been to a doctor the day before they are in their office and received narcotics from that physician.

Currently, North Carolina and South Carolina have their own respective databases so there are two different processes to register. Most providers will not register for the SC SCRIPTS access, but we at least want to offer the option to those that practice either in or closer to South Carolina. Here are the two databases:

- NC-Controlled Substance Reporting System (NC-CSRS): They can review the instructions attached to apply online if they have their NC medical license. If for some reason they do not have their medical license in North Carolina yet, they can gain access through the paper route. (See appendix)
- SC-SCRIPTS: Here is a link to the instructions for completion: http://www.scdhec.gov/Health/FHPF/DrugControlRegisterVerify/PrescriptionMonitoring/

The SCRIPTS Database Access Request Form and Privacy Statement Form can be found in the appendix

- E-script overview
- Narcotic Contract for Patients – Please review with your new provider (See appendix)

Messaging

- Process for receiving and answering
- After hours

Lab Endorsement

- Certification and review process/frequency

Review of Forms

- Standard forms used by the office (clinical, referral forms, billing, patient education, etc.)

Referrals & Care Coordination

- Providers and resources used
- Referral process
- Utilization of Physician Connection Line
- Emergency care
- Transfers to hospital/hospitalist
- Triage policy

Scheduling

- Process
- Daily templates-should discussed prior to first day in clinic
- Modification-any modification needs to be done prior to first day in clinic
- Access
- Call rotation and where to locate call schedule(s)

Coverage for Other Providers

- Process for obtaining
- EMR Proxy
- Policies/Procedures for requesting time off
- Staff utilization

Communication

- Meetings (team, physician, operations, etc
  Share frequency and sample agendas
- Committee structures
- Leadership structure
- How feedback is addressed and followed up on

Review Practice Scope of Care

Due to the variation among different practices and specialties, please review the specific scope of care practiced within your area with your new Physician/ACP. Refer to Delineation of Privileges or other documented material that outlines this information.

Review Practice EMR Utilization

Canopy training for new providers is broken out by ambulatory, acute, and hybrid training. It consists of web-based modules, followed by a 1-day instructor-led session at the Airport Training Center. While this is a focused group session, it addresses basic information and does not cover everything your new provider will need to know.

If there is a Canopy Lead Provider in your practice please have this person spend some dedicated time with the new provider during the first few weeks so they can begin to gain an understanding of the nuances that make EMR usage more efficient. Here are some other essential items to address with your new provider as it relates to the EMR:

- Login Information
- Confirmation that Personal/Identifying Information is Correct (Spelling of Name, Accuracy of NPI/DEA, Etc.)
- Meaningful Use Requirements
  - Policy located in the appendix
- Standard Templates/Favorites Used by Others in the Practice including:
  - Pre-completed note templates
  - Review of how to create macros and auto text
  - Introduction of Power Chart Touch
- Review of Standard EMR Related Questions
- Assist with proper Dragon set-up and use
- Review Medical Group Documentation Standards (see appendix)
- Process for Documentation/Charting/Prescriptions when Canopy is "Down"
- Accessing Training Webinars/Bulletins
- Refer to My EMR (assist with creating a login)
- Consider reviewing previous Canopy Lead Provider content – this is accessible by the Canopy Lead Provider on their SharePoint site
- Resources Highlighted on Physician Connect (Clinical and Non-Clinical)
- Review of other SharePoint Sites or Shared Drives Utilized by the Practice or Specialty

Review Provider & Patient Communication Model

At Atrium Health, we use an evidence-based Provider & Patient Communication Model (Curo Conversations). We expect you to embrace this method to benefit your interaction with patients and their families. Curo is Latin for "to care for". Our expectation is that you use at least one step within each element of Curo during patient interaction.

The following are some examples of how to demonstrate Curo Conversations:

C

CONNECT
- Convey value, respect and concern
- Assess the emotional state of the patient (observation, inquiry)
- Set a shared agenda
- Reassure the patient

Connect and Convey Respect
- Knock before entering the room
- Wash hands/foam in
- Greet the patient and family
- Introduce yourself (role and title)
- Make a personal connection (how are you today?)
- Ask for permission to speak in front of family/visitors
- Ask for the patient's goals for the visit
- Observe how the patient is feeling

U

UNDERSTAND
- Elicit the patient narrative
- Use reflective listening
- Demonstrate empathy

Understand the Patient
- Ask for their story/ or patient narrative
- Use verbal continuers, "go on," "tell me more"
- Use positive non verbals (i.e. nodding of head)
- Honor the patient's privacy
- Ease anxieties or fears

R

REVEAL AND RELATE

- Share diagnosis information (identify main problem/issue)
- Use Ask Me 3™, Teach Back and Plain Language
- Discuss next steps (address what patient needs to do/share why it's important)
- Use shared decision making
- Provide closure and reassurance

Reveal and Relate

- Share possible diagnosis information
- Pause and check in regularly for understanding
- Convey to patient so they are able to articulate our ASK ME THREE Model:
  1. Identify their main problem
  2. Address patient need (what is most important that we need to accomplish today?)
  3. Address what the patient needs to do and next steps
- Reassure the patient about your partnership with them
- Ask what additional questions they have
- Provide a handshake and a personal goodbye

O

OUTCOMES

- Create One Experience between providers and patients: Include, inform and inspire

Outcomes

- Did you answer questions effectively?
- Did you allow the patient space to share?
- Did you verify Communication Board was updated and used it in the interaction?
- Were you clear and avoided medical jargon? Can they restate next steps?
- Did you include them throughout the process, inspire them and inform them?
- Curo Conversations is used to build connection with our patients.

As team members we are committed to positive relationships with our colleagues. Review Curo Conversations information with your new physician/ACP

Review One Behaviors

Atrium Health Core Value	Behavioral Expectations and Teammate Agreements
Caring	**Behavioral Expectation:** • Begin and end each interaction with words and actions that demonstrate caring for patients and teammates. • Anticipate, listen, acknowledge and respond to the spoken and unspoken needs of teammates and patients. **Agreement:** • I will connect with the individual through the use of empathy and compassion before moving to the business needs of the interaction. • I will use respectful words and tone of voice in all my interactions.
Commitment	**Behavioral Expectation:** • Promote a clean and safe environment. **Agreement:** • I will speak up for the safety of our patients, my teammates and myself. • I will wash my hands carefully to avoid the spread of infection and monitor teammates to ensure compliance.
Integrity	**Behavioral Expectation:** • Demonstrate respect for teammates and patients. **Agreement:** • I will make eye contact and acknowledge each person I encounter. • I will honor privacy, making sure that I do not discuss or display confidential information.
Teamwork	**Behavioral Expectation:** • Acknowledge and celebrate accomplishments of our teammates and patients. **Agreement:** • I will work collaboratively with all teammates and value their diversity and unique contributions. • I will recognize accomplishments – large and small – of patients and teammates.

Review Maintenance of Licensure/Credentialing

Credentialing

To ensure that we attract and retain highly qualified providers, all applicants must complete an application for credentialing and to obtain specific privileges. During the credentialing process, the medical staff services team will thoroughly investigate the applicant's previous experience which include work experience, education, criminal background check and all other pertinent information pertaining to primary source verification. Following, a provider will be granted specific privileges based on current competencies.

Due to the details that encompass the credentialing and privileging process, we recommend the submission of a completed packet at a minimum of 90-days prior to the start date. This will allow ample time to address any concerns or additional needs that may arise during the process.

To receive an application, please send a request to MedicalStaffServices@CarolinasHealthCare.org. Upon receipt, a password and email will be provided to begin the applications. Once the completed application is received, the provider will be contacted by a member of the MSS team to begin the partnership and provide any clarification needed regarding the process.

Reappointment

At Atrium Health, all providers are reappointed to the medical staff every two years. At that time, the medical staff services department and current medical staff will re-evaluate a provider's competencies. This is processed by specialty. To begin the process, the provider will receive an electronic reappointment packet at a minimum of 4 months prior to the expiration of their current appointment term. A completed reappointment application must be submitted to the Medical Staff Services Office within 30 days of receipt of the application. Failure to return a completed application within this time frame will result in the assessment of a reappointment processing fee. In addition, failure to submit an application at least 3 months prior to the expiration of the Medical Staff member's current term may result in automatic expiration of appointment and clinical privileges at the end of the current term of appointment, and the individual may not practice until an application is processed.

Request to Perform New Procedure(s)

At Atrium Health, we understand that advances in procedures and technology occur daily within the healthcare industry and it is our goal to ensure that our providers are equipped to accurately and safely perform new procedures. Therefore, it is mandatory that the Physician Champion of the new procedure makes MSS aware of any new procedures which will begin the approval process and addition to the Delineation of Privileges (DOP). Please note that this can take several months for approval and performing the procedure is strictly prohibited until approved by all appropriate parties which includes a system-wide credentials committee, local credentials committee, Medical Executive Committee, and Board of Commissioners.

Request for Proctoring

Proctoring provides an opportunity for objective evaluation of a physician's clinical competence to perform a procedure or a non-procedural skill, including the technical and cognitive skills utilized in the performance of the procedure or non-procedural skill, by a proctor knowledgeable in the procedure and who represents, and is responsible to, the medical staff. Successful completion of a proctoring program helps to ensure that physicians seeking clinical privileges within the Atrium Health enterprise practice in a safe manner, within the standard of care for their specialty and/or subspecialty.

The guidelines for a proctoring program include:

- The determination of the type of proctoring required for the procedure being proctored, i.e., intellectual (external), hands-on (internal) or proctoring by simulation should be declared on a specialty-by-specialty and/or procedure-by-procedure basis by the Chief of the Department.
- The number of cases to be proctored should be reasonable with the understanding that additional observation may be necessary in some cases.
- The time allotted to complete the proctoring process should be reasonable, allowing the proctor(s) and proctoree enough time to complete the required observations. The proctoring program should not exceed two (2) years in length.
- It is not acceptable for a proctor to be a casual or transient observer of the procedure(s) or non-procedural skill. The proctor(s) must observe enough to ensure a complete evaluation that includes all of the important aspects of the procedure or non-procedural skill.
- The proctor must complete case evaluation forms in a timely manner and the completed proctoring evaluation forms must be available to the proctoree upon request.
- Members of the medical staff within the same specialty and/or subspecialty, and/or privilege to privilege preferably with extensive experience, should act as a proctor.
- Proctoring by more than one individual is recommended whenever possible.

To receive an application for proctoring, please contact the Medical Staff Services office at (704) 355-2447 or MedicalStaffServices@CarolinasHealthCare.org

Review Benefits, Productivity & Compensation

Physicians who are just completing residency or fellowship often have the most questions with these specific topics. However, even the most experienced physician or ACP needs to have information about how these are addressed at Atrium Health.

Please take some time with your new physician or ACP and your operations leader to discuss this information with them in detail. There are additional resources that we can offer to your new physician or ACP if needed when discussing these topics. Here are some highlights to cover with them:

Benefits

- Standard Benefits (Available in Appendix)
  - › Medical, Dental, Vision (Premiums, Deductibles, Health Savings Account, etc.)
  - › 401k, Advantage Plan, Other Retirement Plans Available to them
  - › Other voluntary benefits
- CME Process and Available Money for CME
- Professional Fees (License, DEA, Etc.) and who can assist in the renewal of these
- Review of Atrium Health Holidays (Christmas Day, New Year's Day, Good Friday, Memorial Day, July 4th, Labor Day, Thanksgiving Day)
- Scheduling Vacation & CME
- LiveWell Overview & Resources - http://livewell.carolinashealthcare.org/
- Open Enrollment (Oct. – Nov.)

Compensation & Productivity

- Compensation Plan Overview
- Sample Productivity Measures & Expectations
  - › Visits Per Day
  - › WRVUs Per Visit
- Additional Compensation Opportunities
- Paycheck Distribution & Viewing Capabilities

For additional information regarding specific questions about physician benefits, please contact: ExecutivePhysician.Benefits@carolinashealthcare.org or (704) 631-0120

For ACP benefits contact HR Benefits at HRbenefits@carolinashealthcare.org or (704) 631-0263

Review Professional Development Resources

Center for Physician Leadership & Development

Atrium Health physicians are being charged to lead the transformation of care delivery in this continuously-evolving healthcare environment. In 2008, an innovative initiative was launched to advance the leadership development of System physicians. In 2013, that work led to the formation of the Center for Physician Leadership & Development

There are four main factors driving the importance of establishing strong physician leaders:

1. Increasing complexity of Atrium Health and the national healthcare landscape
2. Many Physicians' desire to lead, yet lack of formal training to do so successfully
3. Need for physician leadership competencies, which are aligned to the System's strategic priorities
4. Opportunity to differentiate the System in collaborative, aligned approach to leadership development

The mission of the Center for Physician Leadership & Development is to strategically identify, develop and support physicians and their clinical partners in their expanding roles at Atrium Health through the provision of multiple, varied and innovative programs and resources. We tailor offerings to the unique needs and developmental phase of the physicians we serve. This team can also be a valuable resource to physicians who are serving as mentors.

The CPL team resides within the Division of Medical Education and consists of diverse and uniquely talented professionals with a combined 100+ years of experience designing, delivering, and researching physician leadership and educational programs.

- **Leadership Development:**
  Please contact the Center for Physician Leadership & Development for all questions regarding courses, programs and services, at: CPL@atriumhealth.org
  Learn more at: http://peopleconnect.carolinas.org/cpl

- **New Physician & ACP Mentoring and Coaching**
  The Center for Physician Leadership and Development offers unique opportunities for mentoring and coaching. These programs are tailored to newly-hired Physicians and ACPs. For more information, please e-mail cpl@atriumhealth.org
  - **Mentoring** - Mentors help new providers explore strengths, blind spots, and focus on personal and professional goals. Mentors and mentees agree to at least a 6 month commitment and meet a minimum of once per month
  - **Coaching** - Professional coaches work one-on-one with providers to assess current challenges and opportunities, and will review a variety of validated self-assessment tools.

- **Academic Development:**
  Please contact the Center for Faculty Excellence for all questions regarding academic leadership, teaching and research: CFE@atriumhealth.org
  Learn more at: www.CarolinasHealthCare.org/CFE

Center for Advanced Practice

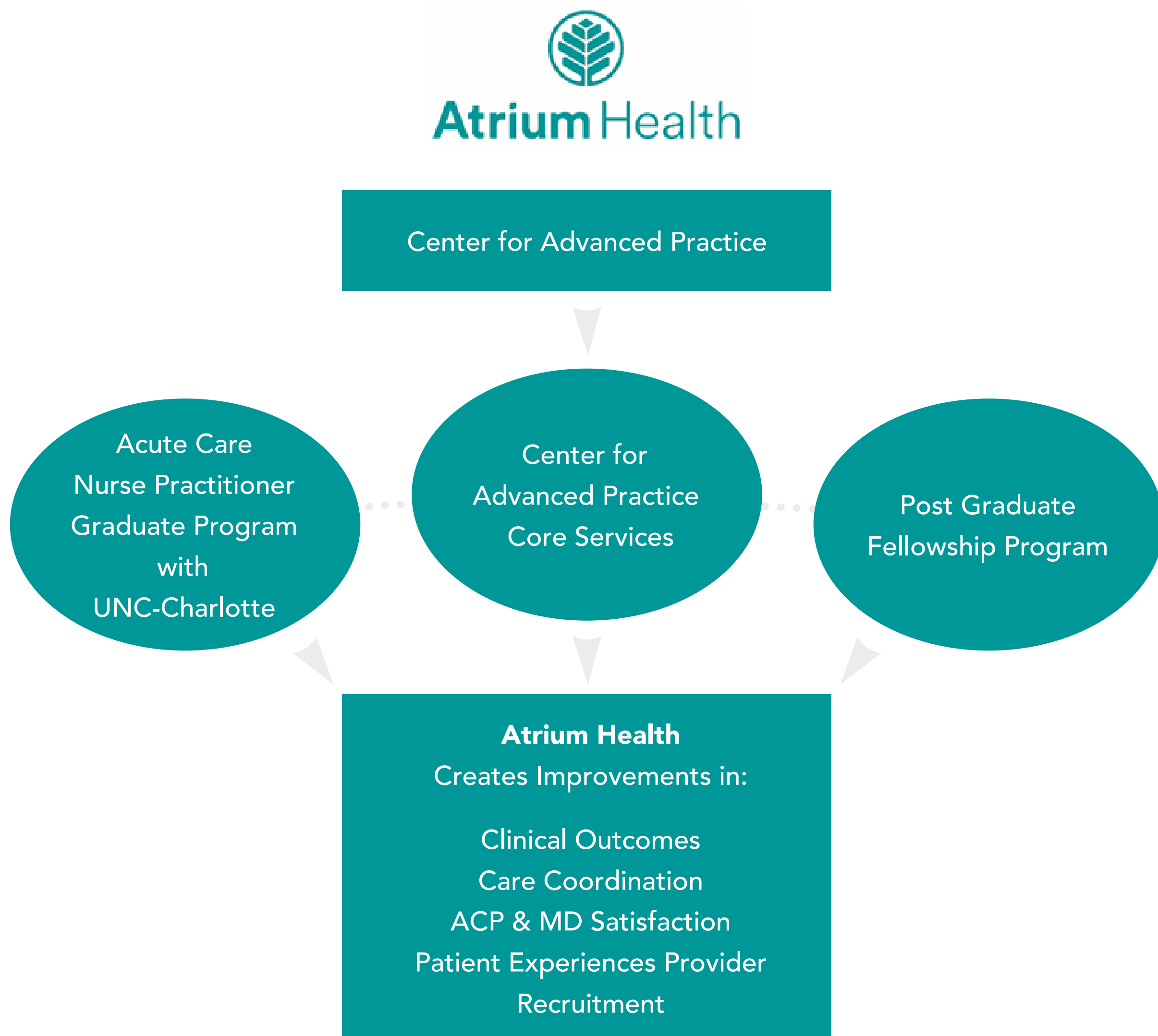
The Center for Advanced Practice was started in 2013 by Atrium Health as a way to train and support advanced clinical practitioners. Atrium Health is one of the first in the nation to create a comprehensive, three-tiered approach for optimizing the role of advanced clinical practitioners.

Mission

To innovate on the care delivery model by defining and optimizing the role of Advanced Clinical Practitioners across Atrium Health.

Vision

To be chosen by Advanced Clinical Practitioners as the best place to work and deliver cost effective, superior patient care.



For more information on the Center for Advanced Practice visit:
http://www.carolinashealthcare.org/center-for-advanced-practice

Charlotte AHEC

The Charlotte Area Health Education Center, a part of the NC AHEC Program, strives to fulfill its mission of providing quality educational opportunities for all healthcare professionals by building partnerships, promoting recruitment and retention of healthcare professionals, and advancing healthcare in the communities we serve. We provide our services to healthcare professionals of the following counties: Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Stanly, and Union.

The Charlotte AHEC office of Continuing Education offers workshops in the following areas:

- AHEC Library & Research
- Aging Education
- Allied Health Education
- Care Management Education
- Continuing Medical Education
- Dental Education
- Diversity
- Leadership Education
- Mental Health Education
- Nursing Education
- Pharmacy Education
- Public Health Education
- Quality Initiatives
- Interdisciplinary

For more information, please visit www.charlotteahec.org

Center for Faculty Excellence

Mission

The **Center for Faculty Excellence (CFE)** supports and enhances the expertise and skills of Atrium Health faculty in the areas of teaching, research, and leadership.

The CFE serves as a clearinghouse for offerings, resources, and expertise across departments throughout Atrium Health. The Center provides resources, continuing education offerings and personal consultations to foster leadership, enhance instructional effectiveness, and improve the academic environment.

Priorities

- To meet the expanding needs of faculty as educators, leaders and scholars
- To share resources and expertise across the departments and throughout the system
- To realize and foster significant untapped talent and expertise throughout the system
- To coordinate and centrally manage faculty development for increased interdisciplinary networking

For more information, please visit: http://www.carolinashealthcare.org/cfe-center-for-faculty-excellence

Review Marketing Resources

Corporate Communication, Marketing & Outreach (CCM&O) will provide every newly employed Atrium Health physician with a standard marketing package. This will include physician bio cards as well as being added to the "Find a Doctor" search feature on the Atrium Health website. Marketing will also be responsible for adding your new provider to the appropriate department specific website.

More robust marketing campaigns will be determined on a case-by-case basis. A marketing representative will work with your department to develop a practice growth plan which will highlight further marketing needs which can include, but are not limited to, lobby posters, advertisements, media, etc.

Additionally, a physician liaison will work with your department and new physician to determine whether a networking campaign and community tours are necessary. Should a campaign be needed, your liaison will assist in marketing the services your physician provides in the community, will conduct needs assessments, and will work with administrators to determine proper steps, expansion of services, etc. The liaison will also assist in scheduling networking events on your physician's behalf. Please note, the department should also take ownership in the development of new physicians. The practice should market and network new providers as needed. Generating referrals and building a patient panel is a team effort.

For more information, please visit the CCM&O Website:
http://peopleconnect.carolinas.org/body.cfm?id=222&fr=true
Or call (704) 631-0930

Review Provider Spouse/Significant Other Employment Assistance Program

Provider Spouse/Significant Other Employment Assistance Program
This program is designed to help your spouse/significant other begin networking for their job search. We have developed contacts within Atrium Health Human Resources to help with internal opportunities, as well as contacts at other companies across a variety of industries within the Charlotte area.

For more information, contact Provider Retention at ProviderRetention@atriumhealth.org

Review Safety & Security Policies

Please review the following policies and make sure to review your local safety & security policies and procedures if they aren't located within the included links below:

- Safety Policies/Manuals http://peopleconnect.carolinas.org/safety-policies
- Hazard Communication http://peopleconnect.carolinas.org/hazard-communication
- Incident Reporting http://peopleconnect.carolinas.org/reporting-tools
- Hand Hygiene http://peopleconnect.carolinas.org/hand-hygiene
- Flu Vaccine program http://peopleconnect.carolinas.org/flu
- Exposure Control http://peopleconnect.carolinas.org/ee-health-page
- Atrium Health Medical Group Communicable Disease Reporting
  Reminder for all Providers concerning Communicable Diseases and Conditions Reporting
  - Due to the significant impact communicable diseases and conditions can have on the health and well- being of our patients, teammates, and general public, it is imperative that providers familiarize and follow your states rules and regulations for all requirements. Reporting is required by law for certain diagnosed or suspected communicable diseases and conditions are to be reported to designated Health Authorities in the time frame and manner specified by your state. Confirmation of disease is not required prior to reporting.

  Resources for reporting are outlined by state as follows:
  - NC DHHS- North Carolina Department of Health and Human Services:
    http://epi.publichealth.nc.gov/cd/providers.html

    What reporting systems and processes are used in North Carolina?
    For most reportable communicable diseases, cases are reported to the local health department through a number of mechanisms, including direct communication like phone calls, mail, electronic reporting, and via a standardized DHHS disease questionnaire and reporting form (DHHS 2124), which is available from local health departments and DPH.

  - SC DHEC- South Carolina Department of Health and Environmental Control:
    http://www.scdhec.gov/Health/FHPF/ReportDiseasesAdverseEvents/ReportableConditionsInSC/

    What reporting systems and processes are used in South Carolina?
    In South Carolina, these diseases and conditions are specified in the List of Reportable Conditions (pdf), published annually. The list also includes outbreaks of disease or unusual clusters of illness, events such as animal (mammal) bites and pesticide poisoning, and findings suggestive of disease (e.g., hemolytic uremic syndrome).

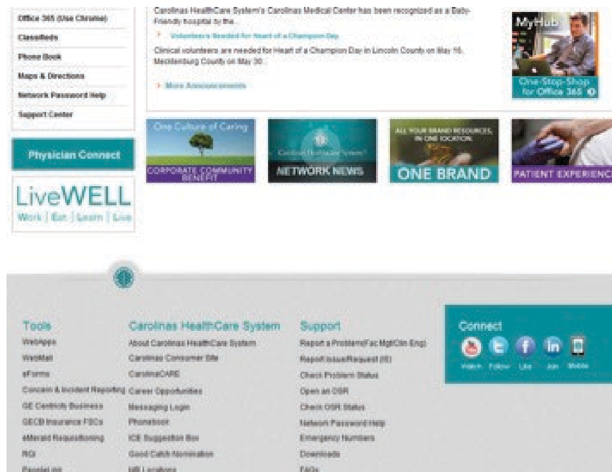
  - DPH Georgia- Georgia Department of Public Health:
    https://dph.georgia.gov/disease-reporting

    What reporting systems and processes are used in Georgia?
    All Georgia physicians, laboratories, and other health care providers are required by law (OCGA 31-12-2) to report patients with the conditions listed under Notifiable Disease Reporting Requirements.

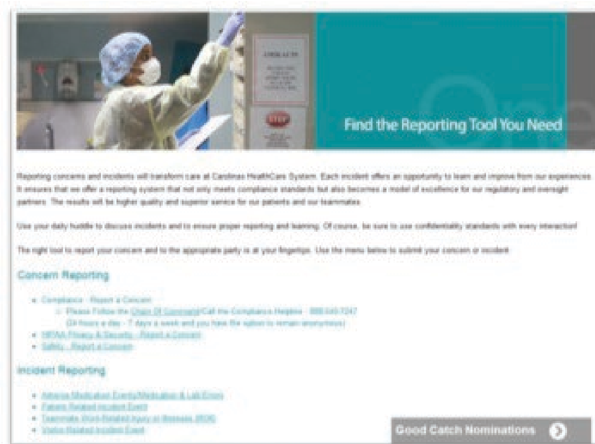
Please remember to consult your local states websites and health departments for more detailed information for requirements related to reporting of communicable diseases and conditions as required by your state. Thank you for your time and attention to this matter!

Review Concern & Incident Reporting

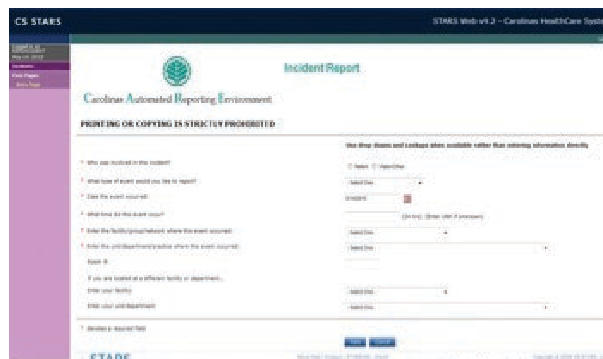
- Review how to report near misses, unsafe conditions, and/or medical errors
  - › Step 1: Open People Connect (http://peopleconnect.carolinas.org/)
  - › Step 2: Scroll to the bottom of the page and look under Tools and click on Concern and Incident Reporting



  - › Select the correct tool for your concern from the links provided



  - › Wait for the computer to log into the reporting system, then fill out all spaces on the form. Incident Reports are anonymous



Risk Managers, Patient Safety Coordinators, CNEs, CMOs, Managers and AVPs review all the clinical events reported. The most serious are investigated and deemed Sentinel Events and/or Serious Safety Events or near misses and analysis is done in the form of either a Compact Cause Analysis team (precursor and near miss events) or a Root Cause Analysis team (RCA)

Review Additional Atrium Health Policies

Please follow the link below to view Atrium Health policies on PeopleConnect. While all policies should be reviewed, please take a moment to address Acceptable Use and Corporate Compliance/ HIPAA with your new provider.

http://peopleconnect.carolinas.org/policies

Several of the Atrium Health Medical Group Policies are currently in development. As these policies are updated they will be housed here PeopleConnect > Policies > Atrium Health Medical Group. Please make sure your new provider reviews all these policies.

Organization
Volunteer Medical Services
Medical Emergency Care
Care of the Patient Having a Precipitous Delivery
Suicide Precautions
Patient Identification
Voluntary Admission and Involuntary Commitment
Follow-Up on Labs, Diagnostic/Screening Tests and Procedures
Inspection of Protective Lead Shielding
Refusal for Consent of Pediatric Immunizations
Medication Reconciliation
Depart Summary - Discharge Instructions
Standing Order Format and Procedure
Security
Utilization of Outside Medications
Management of Controlled Substances
After Hours Care
Prescription Medication and DME Refills
Orientation of Clinical Staff
Physicians, Substitute/Locum Tenens: Billing For
Continuity Provider
Duplicate Unit Numbers
Managed Care Panel Status Changes
Medicare - Limited Coverage Guidelines
Policy Review and Approval Process
Closing Practice Locations Temporarily due to Severe Weather or Disaster
Scope of Care/Service
No show and patients arriving late
Patient Assessment
Referral Policy
Use of therapeutic Heating Device- Electrical Heating Pad
HealthCheck Registration & Charge Entry
Triage - Patients in the Practice
TSI
Termination of the Patient - Physician Relationship
STAR and IDX Computer Downtime Procedures- Archive
Specimen Collection and Handling
Fee Schedule, CPT Codes, and ICDA Codes - Review & Approval
Disposal of Expired Medications and Vaccines

This guide was developed by the Atrium Health Medical Group Physician & ACP Engagement & Well-Being Committee with feedback from you and your colleagues. The Physician & ACP Engagement & Well-Being Committee welcomes your feedback and suggestions about additions or changes to this guide. Please email your comments to provideronboarding@atriumhealth.org.

Please remember to provide shadowing opportunities for your new provider. Onboarding continues past the first few weeks and extends into the provider's first year. Please take time to meet with your provider regularly during this first year to ensure they are having a smooth transition and positive experience.

Thank you for taking the time to onboard your new provider. Once the items have been reviewed, please have your new provider complete the electronic attestation within 30 days of the start date.

Thank you,
Atrium Health Medical Group
Physician & ACP Engagement & Well-Being Committee

Meaningful Use Requirements

- Meaningful Use SharePoint Site:
  https://carolinashealthcare.sharepoint.com/sites/PSG/MU/_layouts/15/start.aspx#/SitePages/Home.aspx
- Details on the current MU measures:
  https://carolinashealthcare.sharepoint.com/sites/PSG/MU/2015%20%202017%20MU%20Measures/Forms/AllItems.aspx

Pain Management Agreement

I understand that ____is prescribing opioid medication to help me to manage my chronic pain. The goal of this medication is to help lessen my pain, so that my physical, emotional and social function will improve. If my activity level or general function gets worse, the medication may be changed or stopped. The risks, side effects and benefits have been explained to me and I agree to the following conditions and opioid treatment. I understand that use of these medications is a big responsibility. Failure to adhere to these conditions may result in stopping the medication, discharge from the practice and even federal prosecution.

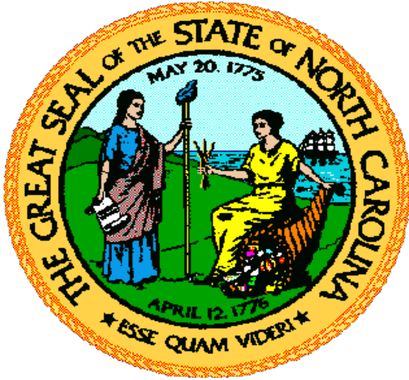
1. I will participate in **other treatments** that are recommended and will be ready to wean off or stop the opioid medication as other effective treatments become available.
2. I will take my medications exactly **as prescribed** and will not change the medication dosage or schedule without approval. If changing meds I will bring unused pills to my provider for proper disposal
3. I will keep **regular appointments** at the clinic. This includes Behavioral Health appointments.
4. All opioid and other controlled drugs for pain must be prescribed only by ____.
5. If I have another condition that requires the prescription of a controlled drug (like narcotics, tranquilizers, barbiturates, or stimulants); or if I am **hospitalized** for any reason, I will inform the clinic within **one business day.**
6. I will designate one pharmacy where all my prescriptions will be filled. It is my responsibility to notify my provider if I change pharmacies.
   Pharmacy Name: ____
   Address: ____Phone: ______________________Patient Initials: ______
7. I understand that lost or stolen prescriptions will **not be replaced**, and I will not request early refills.
8. I understand that the use of any **illegal and recreational drugs or excessive alcohol use may lead to cancellation of this agreement.**
9. I am responsible for keeping track of the medication left and plan ahead for arranging office visit appointments in a timely manner so that I will not run out of medication.
   - Refills will only be given during a face to face office visit with my primary care provider or another physician in the practice if he/she is unavailable
   - Refills will be made only during regular office hours. Refills will not be made at night, on weekends or during holidays.
10. I will not give/sell my medications to anyone else.
   I authorize this practice's providers and /or staff to discuss my care and treatment while undergoing opioid therapy with my pharmacy and any other medical facilities involved in my care.
   Patient Name (print):_________________________________Patient Signature:___________________________________
   Date:_____________
   Provider Signature:__________________________________Date:______________________________Time:___________

Source: Adapted from ICSI Assessment and Management of Chronic Pain, Second Edition, March 2007; Institute for Clinical Systems Improvement

Carolinas HealthCare System
Pain Management Agreement

Patient Information or Sticker
Patient Name:
Date of Birth
Medical Record #:
Updated Date:

DRAFT



North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and
Substance Abuse Services

Controlled Substances Reporting System
Mail Service Center 3008
Raleigh, NC 27699-3008
Phone: (919) 733-1765
Fax: (919) 508-0983

Prescriber / Dispenser Database Access

☐ New ☐ Update ☐ Terminate

Name (First, MI, Last, Suffix (Jr., Sr., III))	
Professional Title	State Board License Number
Facility Name	DEA Number (Resident MD's add DEA suffix #). Pharmacists use store DEA #.
Facility Address	City, State, Zip Code
Area Code & Telephone Number	Area Code & Fax Number
Email Address *Note: Please add nccsrs-info@hidinc.com to your email contacts or acceptance list to prevent your notification emails from being rejected or sent to your spam folder.	Proposed Password (Symbols are NOT accepted)
Signature	Date

Subscribed and sworn to me, a notary public in and for the State of North Carolina, on this ________ day of ________________, ________. My commission expires on the ________ day of ________________, ________.

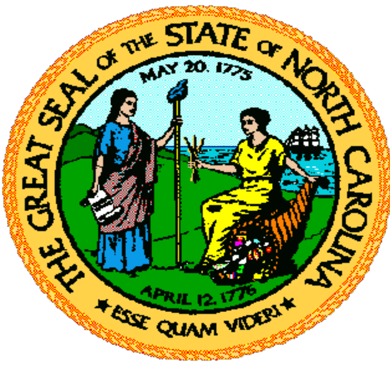
____
Notary Signature

Pursuant to N.C.G.S. 90-113.75 a person who intentionally, knowingly, or negligently releases, obtains, or attempts to obtain information from the system in violation of a provision of this section or a rule adopted pursuant to this section shall be assessed a civil penalty not to exceed ten thousand dollars ($10,000) per violation.

Mail the following items to the Controlled Substances Reporting System: (Incomplete/Deficient applications will not be accepted)

1. **Notarized Database Access Form**
2. **Signed Copy of Privacy Statement**
3. **Copy of Current Driver's License**

DEPARTMENT USE ONLY			
Date received	☐ Approved ☐ Disapproved	Signature	Date of Action



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Fax: (919) 508-0983

Privacy Statement

Statutory Authority:
Article 5E, 90-113.70 the North Carolina Controlled Substances Reporting System Act, requires the Department of Health and Human Services to establish and maintain a controlled substances prescription reporting system of dispensed prescriptions for all Schedule II-V controlled substances. The purpose of this legislation is to improve the State's ability to identify controlled substances abusers or misusers and refer them for treatment, and to identify and stop diversion of prescription drugs in an efficient and cost effective manner that will not impede the appropriate medical utilization of licit controlled substances.

Access to Information:
NCGS 90-113.74. (c) (1) authorizes DHHS to release data from the Controlled Substances Reporting System to persons authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for their patients.

NCGS 90-113.74. (c) (3) authorizes DHHS to release data from the Controlled Substances Reporting System to Special agents of the North Carolina State Bureau of Investigation who are assigned to the Diversion & Environmental Crimes Unit and whose primary duties involve the investigation of diversion and illegal use of prescription medication and who are engaged in a bona fide specific investigation related to enforcement of laws governing licit drugs. The SBI shall notify the Office of the Attorney General of North Carolina of each request for inspection of records.

Unlawful Disclosure:
Prescription information in the Controlled Substances Reporting System is privileged and confidential, is not a public record pursuant to G.S. 132-1, is not subject to subpoena or discovery or any other use in civil proceedings, and except as otherwise provided in Article 5E, may only be used for investigative or evidentiary purposes related to violations of State or federal law and regulatory activities. Except as otherwise provided in Article 5E, prescription information shall not be disclosed or disseminated to any person or entity by any person or entity authorized to review prescription information.

As per 90-113.75., a person who intentionally, knowingly, or negligently releases, obtains, or attempts to obtain information from the system in violation of a provision of this section or a rule adopted pursuant to this section shall be assessed a civil penalty not to exceed ten thousand dollars ($10,000) per violation. The clear proceeds of penalties assessed under this section shall be deposited to the Civil Penalty and Forfeiture Fund in accordance with Article 31A of Chapter 115C of the General Statutes.

Account Agreement:
By signing this agreement I understand that inappropriate access or disclosure of this information is a violation of North Carolina law. I hereby agree to follow the security and password policies of the NC Controlled Substances Reporting System. I agree that user account additions, deletions, and changes will be submitted in writing. I agree that I will not share my account information, login name, or password with anyone, even if they are authorized users of the program.

Signature: ______________________________________ Date: ____________________

Print Name: _____________________________________

Revised June 30, 2017

Bill summary

The Strengthen Opioid Misuse Prevention (STOP) Act of 2017 (Session Law 2017-74/H243)

The Strengthen Opioid Misuse Prevention (STOP) Act of 2017 was recently signed into law in order to combat the opioid epidemic that has had a severe impact in North Carolina. Several provisions apply to North Carolina Medical Board licensees prescribing targeted controlled substances (defined below) and are listed below in order of their effective dates.

Targeted Controlled Substances

The STOP Act only applies to "targeted controlled substances." These are Schedule II and III opioids and narcotics per the North Carolina Controlled Substances Act, specifically those listed in N.C. Gen. Stat. § 90-90(1), (2) or 90-91(d).

Effective July 1, 2017

Opioid Prescribing Consultations with Supervising Physician

Physician Assistants and Nurse Practitioners prescribing targeted controlled substances are required to personally consult with the supervising physician if (1) the patient is being treated at a facility that primarily engages in the treatment of pain by prescribing narcotic medications or advertises for any type of pain management services, and (2) the therapeutic use of the prescription will, or is expected to, exceed 30 days.

Furthermore, when prescribing to the same patient continuously, Physician Assistants and Nurse Practitioners are required to consult with a supervising physician at least once every 90 days to verify that the prescription remains medically appropriate.

Note: The Board has not yet determined how it will define the term "consult." The most important consideration is whether a meaningful consultation about the patient and the recommended treatment occurs and is documented in the patient record. The Board might ultimately leave it to the discretion of PAs, NPs and their supervising physicians to determine how consultations occur (e.g. in person, via telephone or other electronic means).

Providing Information on Disposal of Targeted Controlled Substances

Hospice and palliative care providers prescribing targeted controlled substances to be administered to a patient in his or her home for the treatment of pain as part of in-home

hospice or palliative care shall provide oral and written information upon commencement of treatment to the patient and his or her family regarding the proper disposal of such targeted controlled substances.

This information shall include availability of permanent drop boxes or periodic "drug take-back" events that allow for the safe disposal of controlled substances.

Streamlined Set Up of Delegate Accounts

This provision streamlines the process of creating delegate accounts for prescribers in emergency departments in the North Carolina Controlled Substances Reporting System (NC CSRS).

Distribution of Naloxone

This provision allows community distribution of naloxone by organizations that have a standing order to do so. Parties are required to include "basic instruction and information" on how to administer naloxone.

Effective September 1, 2017

Timely and Accurate Prescription Reporting by Pharmacies

Pharmacies are required to report prescriptions to NC CSRS by the close of business the day after a prescription is delivered (previously the law required pharmacies to report the prescription within three days of the date it was delivered).

In addition, the STOP Act authorizes NC CSRS to assess monetary penalties against pharmacies that do not supply correct data to NC CSRS after being informed that information is missing or incomplete.

Effective January 1, 2018

Limitations on Prescriptions for Acute Pain

Acute pain is defined as pain, whether resulting from disease, accident, intentional trauma, or other cause, that the practitioner reasonably expects to last for three months or less. It does not include chronic pain or pain being treated as part of cancer care, hospice care, palliative care, or medication-assisted treatment for substance use disorder.

Practitioners cannot prescribe more than a **five-day supply** of any Schedule II or Schedule III opioid or narcotic **upon the initial consultation** and treatment of a patient for acute pain *unless* the prescription is for post-operative acute pain relief for

1203 Front Street, Raleigh, NC 27609 | P.O. BOX 20007, Raleigh, NC 27619
Tel: (919) 326-1100 | Fax: (919) 326-1131 | Email: info@ncmedboard.org | www.ncmedboard.org

immediate use following a surgical procedure, in which case the prescription cannot exceed a **seven-day supply**.

Upon subsequent consultation for the same pain, practitioners may issue any appropriate renewal, refill, or new prescription for a targeted controlled substance.

This provision **does not apply** to prescriptions issued by practitioners ordering targeted controlled substances to be wholly administered in a hospital, nursing home, hospice facility, or residential care facility.

Practitioners acting in accordance with these limitations are immune from civil liability and disciplinary action from this Board.

Effective January 1, 2020

Electronic Prescribing

Practitioners must electronically prescribe for all targeted controlled substances. This provision does not apply to:

- Practitioners, other than a pharmacist, dispensing directly to an ultimate user.
- Practitioners ordering for administration in a hospital, nursing home, hospice facility, outpatient dialysis facility or residential care facility.
- Practitioners experiencing temporary technological or electrical failure or other extenuating circumstances that prevent the prescription from being transmitted electronically. Practitioners must document the reason for this exception within a patient's medical record.
- Practitioners writing a prescription to be dispensed by a pharmacy located on federal property. Practitioners must document the reason for this exception in the patient's medical record.
- Persons licensed to practice veterinary medicine.

Effective upon completion of NC CSRS technical upgrades* (date TBD)

Mandatory Review of NC CSRS

*DHHS will work on various technical upgrades to NC CSRS in order to make the system more user-friendly, improve reporting capabilities, provide inter-state connectivity with other Prescription Drug Monitoring Systems, and connect to the statewide health information exchange. Mandatory CSRS registration and use provisions become effective once the State Chief Information Officer confirms the required upgrades to NC CSRS are fully operational within the Department of Information Technology and the system is connected to the statewide health information exchange.

Prior to prescribing a Schedule II and Schedule III opioid or narcotic, practitioners are required to review a patient's 12-month prescription history in the NC CSRS.

For every subsequent three-month period that the Schedule II or Schedule III opioid or narcotic remains part of the patient's medical care, practitioners are required to review the patient's 12-month history in the NC CSRS.

Reviews should be documented within the patient's medical record along with any electrical or technological failure that prevents such review. Practitioners are required to review the history and document the review once the electrical or technological failure has resolved.

Certain practitioners may, but **are not required** to, review the NC CSRS prior to prescribing a targeted controlled substance to a patient in any of the following circumstances:

- Controlled substances administered in a health care setting, hospital, nursing home, outpatient dialysis facility or residential care facility.
- Controlled substances prescribed for the treatment of cancer or another condition associated with cancer.
- Controlled substances prescribed to patients in hospice care or palliative care.

The STOP Act authorizes NC CSRS to conduct periodic audits to determine prescriber compliance with review requirements. NC CSRS shall report to the Board any licensee found to be in violation of the requirement to check NC CSRS; violations may result in regulatory action by the Board.

1203 Front Street, Raleigh, NC 27609 | P.O. BOX 20007, Raleigh, NC 27619
Tel: (919) 326-1100 | Fax: (919) 326-1131 | Email: info@ncmedboard.org | www.ncmedboard.org

Carolinas HealthCare System

South Carolina H3824:
Prescription Monitoring Program for Controlled Substance Schedule II-IV

Intent

SC H3824 requires health care practitioners to review South Carolina patients' controlled substance prescription history as maintained in the Prescription Monitoring Program (PMP)/SCRIPTS program database before prescribing a Schedule II – IV controlled substance. The law seeks to:

- Improve prescribing and dispensing practices
- Assist in early intervention for patients who may be abusing or addicted to prescription drugs
- Identify & implement prescription drug diversion efforts

Rationale

- 46 people die each day form prescription opioid overdoses
- 4x as many deaths from 1999-2013
- Increased risk of heroin use resulting from prescription drug abuse

Who is Responsible?

- Practitioner/Pharmacist and Practitioner's authorized delegate:
    - Authorized delegate: PA, NP, RN or Resident
    - Can delegate authority to no more than 3 accounts
    - Must reconfirm every 180 days
    - Responsible for deactivating delegate account upon termination or if no longer needed
    - PMP Delegate Policy: http://www.dhec.sc.gov/Health/FHPF/DrugControlRegisterVerify/PrescriptionMonitoring/DelegatePolicy/

Exceptions

The review requirements do not apply in the following instances:

- Prescribing a Schedule II controlled substance to treat a hospice patient
- Issuing a prescription for a Schedule II controlled substance for no more than a 5-day supply
- Prescribing a Schedule II controlled substance for an established patient with chronic condition
    - Practitioner must review controlled substance history every 3 months
- Prescribing a Schedule II controlled substance for a patient in a skilled nursing facility, nursing home, residential care center, or assisted living facility where the patient's medications are administered and monitored by staff.
- Practitioner is unable to access due to exigent circumstance
    - Circumstance and potential adverse impact to patient from not receiving the prescription must be documented in the EMR.
- Practitioner utilizes technology (EMR) to automatically display the patient's controlled substance prescription history from the prescription monition program

Penalties

- Fines from $2000 - $10,000 and/or 2 -10 years of imprisonment pus reporting to respective board for disciplinary action. Punishable activities include:
    - Knowingly failing to submit information
    - Knowingly disclosing protected health information
    - Knowingly using the information in a manner or for a purpose in violation of the article
    - Knowingly failing to review history or failure to consult authorized delegate before issuing a prescription
- Pursuant to section 44-53-1680(F), a practitioner must not incur any civil or criminal liability for "injury, death, or loss to person or property on the basis that the pharmacist or practitioner did or did not seek or obtain information from the prescription monitoring program."

Continuing Education Requirements

- Dentist/Optometrist/Podiatrist: All are required to have 2 hours CEU every 2 years of prescribing and monitoring
- PA's: 4 CEU's every 2 years of prescribing and monitoring
- APRN: 1 hour of opioid CEU training per year

Cost

There is no cost to sign up for or use the SCRIPTS prescription monitoring system

Recommendation

All practitioners should sign up for and utilize the SCRIPTS prescription monitoring system as outlined and document appropriately in the electronic medical record, unless they meet one of the exceptions above. Practitioners should document exceptions in the EMR. Atrium Health Office of General Counsel can advise final rule on this matter. North Carolina and 49 other states/territories have already implemented a prescription monitoring program.

How to Register for the SCRIPTS system:

- Go to https://southcarolina.pmpaware.net/login and click the "Create an Account" link.
- A registration tutorial is available at: http://www.appriss.com/product-documentation/PMPA_Tut_Registration_Process_V1.pdf

Helpful Links

- South Carolina H3824 Bill http://www.scstatehouse.gov/sess122_2017-2018/bills/3824.htm

- SCRIPTS Program Information http://www.dhec.sc.gov/Health/FHPF/DrugControlRegisterVerify/PrescriptionMonitoring/

- South Carolina Department of Health and Environmental Control http://www.scdhec.gov/

Prescription Monitoring Program
2600 Bull St.
Columbia, S.C. 29201-1708
Phone: (803) 896-0688

PRACTITIONER / PHARMACIST DATABASE ACCESS REQUEST

☐ **New** ☐ **Update** ☐ **Terminate**

Pursuant to S.C. Code Ann. § 44-53-1680(B) and (C), a person who knowingly discloses, or uses this information in a manner or for a purpose in violation of this article is guilty of a felony and, upon conviction, must be fined not more than ten thousand dollars or imprisoned not more than ten years, or both.

REQUESTOR INFORMATION **PRINT OR TYPE**

______________________________ Practitioner/Pharmacist Name

☐ **MD** ☐ **RPh** ☐ **DO**
☐ **DMD/DDS** ☐ **PA-C** ☐ **APRN**

______________________________ State Board License #

DEA # (Practitioner) ______________________________ DEA # (Pharmacy) ______________

Primary Practice Location Name ______________________________

Practice Location Street Address ______________________________

Practice Location Mailing Address ______________________________

City ______________ County ______________ State ________ Zip ________

Area Code & Telephone # ______________ Fax # ______________ E-mail Address ______________

Proposed Password ______________________________
(Must be at least 8 characters, (1) upper case, (1) lower case and (1) number, no dictionary words or names.)

I certify that the information I request will be kept confidential, and I understand that I will be held libel for any breach of that confidentiality.

______________________________ Signature of Affiant

______________ Date

****

STATE OF SOUTH CAROLINA)
COUNTY OF ______________) **AFFIDAVIT**

Before me, the undersigned authority in and for the State of South Carolina, personally appeared:
____,
who is known to me and who after being first duty sworn deposes and says that the above and foregoing document is true and correct to the best of his/her knowledge, information, and belief formed after reasonable inquiry.

Subscribed and sworn to before me this __________ day of ____________________, 20____.

Notary Public Seal
Notary Signature______________________________

FOR DEPARTMENT USE ONLY			
Date Received	☐ Approved ☐ Disapproved	Signature	Date of Action

 SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

Prescription Monitoring Program
2600 Bull St.
Columbia, S.C. 29201-1708
Phone: (803) 896-0688

PRACTITIONER / PHARMACIST PRIVACY STATEMENT

Statutory Authority:
The South Carolina Department of Health and Environmental Control (DHEC) is granted authority under S.C. Code Ann. § 44-53-1640(A) to establish and maintain a program to monitor the prescribing and dispensing of all Schedule II, III, and IV controlled substances by professionals licensed to dispense these substances in this State. This program is intended to improve the state's ability to identify and stop diversion of prescription drugs in an efficient and cost effective manner that will not impede the appropriate medical utilization of licit controlled substances.

Access to Information:
S.C. Code Ann. § 44-53-1650(D) provides that Drug Control may provide data in the prescription-monitoring program to the following persons:

(1) A practitioner or pharmacist who requests information and certifies that the requested information is for the purpose of providing medical or pharmaceutical treatment to a bona fide patient;

(2) An individual who requests the individual's own prescription monitoring information in accordance with procedures established pursuant to state law;

(3) A designated representative of the South Carolina Department of Labor, Licensing and Regulation responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other persons authorized to prescribe, administer, or dispense controlled substances and who is involved in a bona fide specific investigation involving a designated person;

(4) A local, state or federal law enforcement or prosecutorial official engaged in the administration, investigation, or enforcement of laws governing licit drugs and who is involved in a bona fide specific drug related investigation involving a designated individual;

(5) The South Carolina Department of Health and Human Services regarding Medicaid program recipients;

(6) A properly convened grand jury pursuant to a subpoena properly issued for the records;

(7) Personnel of Drug Control for purposes of administration and enforcement of this article.

User Account and Password:
User account login and passwords will be assigned by the Prescription Monitoring Program (PMP) Management. User login and password accounts are never to be shared. All user account deletions, additions, access, permissions, and changes must be submitted in writing.

Unlawful Disclosure:
S.C. Code Ann. § 44-53-1650(A) provides that prescription information submitted to Drug Control is confidential and not subject to public disclosure under the Freedom of Information Act or any other provision of law.

S.C. Code Ann. § 44-53-1680(B) provides that a person or persons authorized to have prescription monitoring information pursuant to this article who knowingly discloses this information in violation of this article is guilty of a felony and, upon conviction, must be fined not more than ten thousand dollars or imprisoned not more than ten years, or both.

S.C. Code Ann. § 44-53-1680(C) provides that a person or persons authorized to have prescription monitoring information pursuant to this article who uses this information in a manner or for a purpose in violation of this article is guilty of a felony and, upon conviction, must be fined not more than ten thousand dollars or imprisoned not more than ten years, or both.

I understand that inappropriate access or disclosure of this information is a violation of South Carolina law and may result in disciplinary action by my licensing board and/or revocation of database access privileges.

Account Agreement:
By signing this agreement I hereby agree to follow the security and password policies of the PMP. I agree to not disclose nor misrepresent any data or protected health information to any unauthorized person or party. I agree that I will not share my account information, login name, or password with anyone, even if they are authorized users of the program.

Signature: ___________________________________ Date: ______________________

Print Name: _________________________________

Instructions for completing the Prescriber / Dispenser Database Access Request:

1. Information on the form must be legible
2. Fill in **ALL** fields
3. Propose a password:
   - Passwords must be at least 8 characters in length
   - Passwords must contain at least one (1) capital letter and one (1) lowercase letter and one (1) number
   - Passwords **CANNOT** contain symbols
4. After completing the access request form, have it notarized and mail **ALL of the following documents** to the address listed on the application:
   1. access request
   2. signed privacy statement
   3. copy of your current driver's license

*Health Information Designs, Inc. will notify you by e-mail with your confirmation login information. Please be sure to add nccsrs-info@hidinc.com to your email contacts or acceptance list to prevent your notification emails from being rejected or sent to your spam folder.

Carolinas HealthCare System

Carolinas HealthCare System Medical Group Division

Medical Records Standards

June 2016

Publication: January 2015, Revised June 2016

Applies To: Carolinas Healthcare System Medical Group Division

Policy:

RE: Medical Records Standards

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Appendix 11

Carolinas HealthCare System

Background

Electronic medical record systems (EMR-S) are a key to the transformation of health care. "The widespread use of electronic health record systems has the potential to improve the quality of care, increase patient safety, reduce medical errors, and control health care costs."[1]

The EMR is an ongoing narrative of the patient's health record that is updated with each visit and can lead to improved patient outcomes and enhanced safety. It therefore is everyone's responsibility to keep the data in the EMR accurate and updated within an appropriate timeframe.

Purpose

To provide EMR users with standards that will help to the ensure notes are coherent, substantive and billing-compliant, and completed within an acceptable time frame. Because the EMR is a dynamic tool compared to the static paper documents of a previous era, there are elements other than the physician note that are essential to be addressed at each patient encounter. This document outlines the Medical Group Division standards for medical documentation integrity, timeliness of documentation and result review completion, and defines the responsibilities for EMR use beyond the provider's note for a given encounter.

Applicability

This practice standard applies to all Medical Group Division medical record entries. In this document, the terms EMR and Canopy are used interchangeably.

Timeliness of Record Completion

It is essential that our documentation of care for our patients not only be accurate, but also be completed and available for clinical and financial use by others in the organization within a reasonable timeframe. In the worst case, deficient documentation may become a rate-limiting step in patient management or a cause of error, delay, duplication, patient harm, or the basis for accusation of billing fraud. Table 1 lists both goals for best practice and minimum work standards for documentation and billing.

Power Note/Dictation
Completion of documentation for all patient encounters the same day as the visit is ideal, and should be the goal of every provider. Provider notes must be authenticated (signed, not just saved) in order to be visible to others. Formatting documentation in a manner (e.g., Dynamic Documentation or APSO format) which allows a provider to rapidly locate an assessment and plan without scrolling through multiple pages of imported data is strongly encouraged. It is understood that some practices may impose a more rigid standard based on their specialty and/or operational needs.

[1] Recommended Requirements of Enhancing Data Quality in Electronic Health Record Systems June 2007 the Office of the national Coordinator for HIT and US DHHS

Table 1. **Documentation, Billing, and Result Review Completion Standards**

Item	Best Practice	Minimum Standard
Inpatient / ED / Urgent Care		
H&P	Same shift	24 hours
DC Summary	Same shift	24 hours
Progress Notes	Same shift	24 hours
ED Notes	Same shift	24 hours
Virtual Visit	Same shift	24 hours
Urgent Care	Same shift	24 hours
Consult Note	Same shift	24 hours
Procedure Note	At completion	At completion
Brief Op Note	At completion	At completion
Operative Dictation	At completion	Same shift
Attending co-signature (medical student, resident, ACP student)	Same shift	48 hours
Utilization / Coding Queries	Same shift	72 hours
Outpatient - Office		
All encounters	Same day	3 business days
Clinical Messaging		
Critical	Direct / Immediate	Direct / Immediate
Routine clinical questions	Same day	1 business day
Lab / Diagnostic Studies - Review, generate report / action		
Critical - Written process for same day management		
Routine*	3 business days	4 business days
Billing	Same shift / day	72 hours

*Appropriate to clinical urgency and patient need. 4 business days for routine preventive health visit results is likely reasonable, 4 business days for outpatient MRI brain results for sudden vertigo is unlikely to be acceptable to patients, even if negative.

Proxy: Each division / service line to develop written protocol for management of clinical messages and urgent results and clinical requests during scheduled and unscheduled absences, with goal to manage patient needs without delay.

Clinical Messages
Emergent or critical clinical messages should be managed immediately by direct personal communication between providers and staff. Documentation in the EMR should occur at an appropriate time, but it is understood that the EMR is not an emergency management tool.

Other messages (e.g., patient calls, questions, medication and refill requests) will be managed with appropriate attention to clinical urgency, and will be reviewed and action taken within one business day. These standards apply to providers and all practice staff.

Laboratory/Diagnostic Results
Each practice should implement a mechanism to identify and address critical results the same day. Upon receipt of non-critical laboratory and diagnostic reports the provider will review and generate a response to the patient in accordance with Table 1. It is strongly recommended that these results be addressed within 72 hours to correspond with their release in My Carolinas. It is understood that at times providers may delay reporting until other pending studies are resulted. This is not to be construed as a deviation from standard practice.

Provider Absence
All practices will have a written protocol for management (proxy) of each provider's practice during scheduled or unscheduled absence. Management of clinical questions, medication requests, most refill requests, and critical results should not be delayed due to provider absence. Whether to include reporting and management of normal or mildly abnormal laboratory or radiographic results should be determined at the practice level.

CHS Medical Group Division Standards for Documentation Integrity

General Principles:

- Maintenance of the information in Canopy is all of our responsibility.
- Providers should make every effort to place all and only clinically appropriate and relevant information in the record.
- Having good provider documentation (notes) is only part of the expectation. These are static documents reflecting the work done at a particular encounter. Providers are also responsible for the dynamic parts of the EMR that exist apart from the H&P, progress note, or office visit note, etc.
- While team members may support the provider in some aspects of charting, the provider remains ultimately responsible for the information in the record. It is our responsibility to oversee and direct the maintenance of our patient's medical records.
- Any team member may record positive family history information obtained from the patient (e.g., Father had Type II diabetes at age 50). However, only providers should document all or part of a patient's Family History as "negative."
- Avoid copying and pasting text from another provider's note without attribution to the author.
- Unless essential to support medical decision making, avoid wholesale inclusion in the note pieces of information readily available elsewhere in the EMR (e.g., Family History, Social History, lab and

diagnostic reports). To support coding and compliance, these data can be referenced in the note as having been reviewed.

- Always review dictated notes to verify that they have been accurately transcribed, especially when using voice recognition programs such as Dragon.
- Provider notes will be viewable by the patient, who are ultimately the ones most concerned about and impacted by our documentation of their health issues.
- Encourage a culture of mutual responsibility for integrity of our documentation. All who view documentation should be responsible to identify and report examples of poor or inappropriate medical record entries. If possible, feedback about concerns should be directed to the initial author of the entry in question. If not feasible, these concerns can be directed to HIM.

Pre-created documentation via form or template, copy forward or copy/paste procedures, and voice recognition are legitimate elements of an EMR and can be extremely helpful if used correctly. While these capabilities can assist the provider in efficiently creating organized and meaningful documents, when misused this same technology can result in confusing, disjointed and overloaded notes. A way to overcome this problem is for providers to consider how important each part of the record is to the actual care of the patient.

> "Physician documentation is not a compilation of data: It is an explanation of the data. If we simply adopt electronic templates and – through policy or neglect – allow physician documentation to become an efficient way to obtain mineable data, we are not optimizing patient care; we are undercutting it."
>
> *Recommended Requirements of Enhancing Data Quality in Electronic Health Record Systems June 2007 the Office of the national Coordinator for HIT and US DHHS

<u>Specific Issues:</u>

Template Use

Templates are an effective mechanism for documenting quantitative data such as a patient's ROS (Review of Systems). However failure to update a template that is pre-populated with for example, negative responses, when the patient has a contradictory positive response to a question as recorded in the HPI (History of Present Illness) section, <u>or</u> failure to remove a negative response when the question was never asked creates an erroneous record entry and can potentially lead to improper patient care or payment.

When using a pre-completed note template or macro, the provider *must* remember to:

- Update any item when the response differs from the pre-loaded response (e.g., from negative to positive or normal to abnormal);
- Remove any item when not performed.

Scribe Policy

Carolinas HealthCare System

Copy Forward and Copy/Paste

Only information that is pertinent to the decision making for this visit/encounter should be copied forward. If the copy forward or copy/paste function is used inappropriately it can r Common Abbreviations pplicable information as well as propagating inaccurate information. For example, a note copied over multiple inpatient days that repeatedly states "*Hospital Day 2. . .Coronary angiography and stenting tomorrow*" is inappropriate.

Unapproved Abbreviations

Copying information into a note when that information is already available elsewhere in the medical record makes the information even less useful because it may obscure the important thought process for the patient encounter on that specific date of service. Rather than importing an x-ray report it is far more useful to state: "*I've reviewed the CXR images for the last 3 days and there is a new left lower lobe infiltrate developing*." This shows what a provider did (data collection, image viewing, interpretation, and the impact of their thought process), and it is one clear line in the note instead of an extra page of imported detailed text which is already present elsewhere in the integrated EMR.

Note entries should be individualized and representative of the current visit/encounter (i.e., patient-specific and visit-specific). For example, a brief recheck visit that will be billed as a 99212 should probably not include a 10-system ROS or detailed Family History.

Proofreading

We are all responsible for the contents of our documentation, including errors. To the extent possible, proofreading typed, templated, or electronically transcribed material is strongly encouraged. Some providers may elect to include notations that portions of the documentation were completed with voice recognition software. The result of such notation might encourage a reader to alert the preparer of the document to errors which need corrections or request explanation of what was intended. It should be understood that such notations provide no protection from consequences of documentation errors.

Keeping the Record Current

Collected history data can be shared across encounters and care settings using the EMR. *"A Review of Systems (ROS) and Past, Family and Social History (PFSH) obtained during an earlier encounter does not need to be rerecorded if there is evidence that the physician reviewed and updated the previous information."*[2] However, the physician must document that they have reviewed the information, confirming (or supplementing as needed) the data recorded by others. When there have been no changes in the previously recorded information the provider can document their review by:

- Stating "*I have reviewed the PFSH and ROS and find nothing changed*" or by
- Clicking the "Mark all as reviewed" bar on the Past, Family, and Social History tabs.

Medical record information must be regularly reviewed and updated to avoid contradictory documentation. For example, a HPI stating that the "*Patient smokes 2-4 cigarettes daily"* while the Social History states "*Smoking Status: Never Smoker*" is contradictory and confusing.

[2] CMS Documentation Guidelines

Reporting Past, Family and/or Social History

Currently the Canopy (Cerner EMR) options used to describe a patient's past, family and/or social history include terms such as: noncontributory, negative, not significant, etc. Medicare does not recognize the use of these terms.

> *Per Palmetto GBA (Medicare Part B) "the statement 'noncontributory, unremarkable or negative' does not indicate what was addressed." Medicare wants to know whether the nurse or physician asked about specific conditions, for example, does the patient have any family history of coronary artery disease.*

According to the AMA/CMS Documentation Guidelines, review of the patient's history consists of one or more of the following:

- Past history includes experiences with illnesses, operations, injuries and treatments. In Canopy, this history is addressed primarily on the Consolidated Problem List.
- Family history includes a review of medical events, diseases, and hereditary conditions that may place the patient at risk
- Social history includes an age appropriate review of past and current activities

Therefore, by using any of the following terms to document a review of the patient's history, whether it is past, family or social history, it means that you either did not actually address these elements of the history or do not consider them pertinent to the reason for which you are seeing the patient.

- Noncontributory
- Negative
- Not significant
- Unremarkable

Instead of using these terms, we recommend calling out specific aspects of the history that are relevant to your decision making or indicate that you evaluated these elements by "marking as reviewed" in the EMR or stating in your note that they were reviewed.

In addition, entries such as "denies" Past History or Family History "none reported" are not acceptable and need to be further defined. If for some reason the family history cannot be obtained, the documentation must support the reason why (e.g., patient adopted). In situations where the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history (e.g., change in mental status, patient uncooperative or combative).

Inappropriate Use of the Message Center

On occasions, an issue with a particular patient that surfaces within the EMR points out the need for structural or process change within the organization. While this can be very instructive, it is inappropriate to "have this conversation" with our colleagues using the Message Center function within the patient's chart. Complaints about office practices, criticisms of our colleagues, references to other patients, or discussion of practice policies or politics have no place in a patient record. All messages created using Message Center are permanent parts of the patient record.

Medical Scribes

Entries into the EMR made by a "medical scribe" should be made from dictation by the provider (physician or ACP) and should document details of the encounter and only reflect the level of service provided. The individual acting as the medical scribe may not inject their own opinions or observations regardless of their background or clinical training. The billing provider is ultimately responsible for all documentation and must verify that the scribe's entry accurately reflects the service provided. Refer to the Scribe Policy approved by Carolinas Healthcare System IT Advisory Committee (PITAC)

Teaching Physician/Resident Linkage Statement

Medicare makes it clear that for E/M (Evaluation and Management) services, teaching physicians do not need to repeat documentation already provided by the resident. However the teaching physician must:

- Document that they saw and examined the patient, personally performed the critical or key portion(s) of the service, and participated in the management of the patient and
- Reference the resident's note if both notes are being used to support the service billed by the teaching physician.

An example of an acceptable linkage statement is: Agree with Dr. Resident's (Name of Resident) above findings as written. The patient presented to me, and I saw and examined the patient independently. Please see my key portion of the encounter as documented.

A statement of "Agree with above." or "Discussed with resident. Agree." are unacceptable because the documentation does not make it clear that the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

Amendments, Corrections, and Deletions

Occasionally a provider may discover an entry made at the time of service was not properly documented and needs to be amended or corrected after rendering the service. This is an acceptable practice in the EMR as there is a mechanism for flagging the correction and accessing the original entry.

It is not appropriate to overwrite entries made by other users, with the intent of making it appear as if the physician performed portions of the visit that they did not perform. For example when a physician and an ACP each personally perform a face-to-face portion of an E/M visit with the same patient on the same date, the physician should document a separate note or append an amendment to the ACP's note when documenting their portion of the service. It is not appropriate to copy the ACP's note, adopting it as one's own.

Abbreviations

Abbreviations should always be clear to the reader as to their meaning, based upon the context of the conversation. A list of frequently used abbreviations can be found at: Common Abbreviations

For patient safety reasons, there is a list of abbreviations that should NEVER be used, found at: Unapproved Abbreviations

EMR Minimal Use Expectations for CHS Provider

Our Electronic Medical Record (EMR) system, Canopy, provides the capability to capture, document, and display essential health information about our patients, enabling us to care for them across our enterprise. However, the information in Canopy is only as up to date and accurate as the inputs we make as a care team. As Canopy has become the definitive repository for our patient's medical records, it is imperative that all CHS providers use the electronic tools available to maintain the accuracy of these records. This section establishes the *minimum* expectations for provider's use of the EMR based on their role in the care of the patient.

For Primary Care Providers:

At every appropriate encounter[1] with a primary care provider, the following elements of the patient's chart should be reviewed / updated:

- Allergies
- Appropriate Vital Signs
- Medications (medication reconciliation)
- Immunizations[1]
- Family and Social Histories[1]
- Problem List
- Clinical Summary (previously called Depart Summary)
- Documentation of care at visit

[1] All items should be addressed at a wellness exam, or if the patient has not been seen in the office for an extended time. For simple or problem focused visits, review / documentation of these items may not be needed.

For Specialty, ED and Urgent Care Providers:

While specialty providers, ED and urgent care providers ***may*** address the above comprehensive aspects of the medical record, the primary responsibility for this remains with the primary care provider. The specialist or emergency provider is responsible to clarify problems under their management (e.g. changing a problem of "joint pain" to a more specific "rheumatoid arthritis" based on specialty expertise). Also, medication changes, new allergies identified, new problems identified must be documented (e.g. patient presents to the ED with acute anaphylaxis to insect envenomation – this should be added to the problem list by the ED provider).

When the patient you are caring for is new to CHS, it is imperative, regardless of the limited extent of your clinical interventions, that the problem list, medication list, and allergies be entered into the EMR. Many

patients are referred to our specialists or acute facilities from outside our system, and quality care for these patients requires that these aspects of their medical record be accurately entered into the EMR.

For Surgical and Procedural Specialists:

As for other specialists, surgeons and providers who routinely perform procedures should assume primary responsibility for maintaining accurate records around the problem(s) that they are managing. Maintenance of the Procedure Profile is especially within the purview of the surgeon. If you remove someone's spleen, perform a mastectomy, or replace their hip joint it is your team's burden to ensure that this is accurately recorded on the Procedure Profile. In addition to updating the procedure profile, many surgical conditions also need to be noted on the Problem List (e.g. the patient s/p splenectomy has an immune compromise that needs to be noted on the Problem List). Medication reconciliation (to the extent that you discontinue, change or prescribe meds for your patient), and new allergies identified in your care of the patient are also your responsibility. Dictating this information into your note **is not** an adequate way to update the EMR.

When the patient you are caring for is new to CHS, it is imperative, regardless of the limited extent of your clinical interventions, that the problem list, medication list, and allergies be entered into the EMR. Many patients are referred to our specialists or acute facilities from outside our system, and quality care for these patients requires that these aspects of their medical record be accurately entered into the EMR.

Acute and Post-Acute Care Providers:

Many times admission to the hospital involves major medication changes, identification of new problems or changes to the management of these problems. It is the responsibility of the teams managing the care in the hospital or post-acute care facility to perform careful medication reconciliation, document the care delivered, and update Allergies, Problem Lists, etc… It is also imperative to communicate with the primary care providers a summary of care during the acute or post-acute stay to provide an appropriate hand-off to ensure excellent ongoing care. This means that discharge summaries must be completed in a timely manner, and the PCP notified that the patient has been discharged.

When the patient you are caring for is new to CHS, it is imperative, regardless of the limited extent of your clinical interventions, that the problem list, medication list, and allergies be entered into the EMR. Many patients are referred to our specialists or acute facilities from outside our system, and quality care for these patients requires that these aspects of their medical record be accurately entered into the EMR.

Appendix

Physician Not Available to Complete Record.

In the rare event where a provider is not available to sign off on his/her medical record entries, in order to close the electronic note the following statements may be used.

> At the top of the note under the Final Report heading, insert the following statement:
>
> > The patient encounter has been signed by Dr. *Available* for Dr. *Unavailable* who is no longer employed by Practice *XXX* and unavailable to sign/close this record.
>
> At the bottom of the note above the Signature Line, insert the following statement:
>
> > Dr. *Unavailable's* signature below was generated as part of the Cerner signature proxy process. Dr. *Unavailable* performed/authored the original note and no portion of this note has been altered as a result of the signature proxy process.

Corporate Compliance should be contacted anytime this entry is used in order to determine whether documentation adequately supports the service(s) billed.

YOUR CARE – YOUR CHOICE RESOURCE

Advance Care Planning and Goals of Care Discussion

The Your Care – Your Choice team wants you to succeed in having discussions with patients surrounding Advance Care Planning and their future wishes.

How do we do this? The conversation can be hard, but it doesn't have to be. Keep it simple and understandable.

1. What is your understanding of your illness?
2. What are your future lifetime goals?
3. What is your biggest fear? (pain, burden to family, loss of function, financial)
4. What are you willing to sacrifice to prolong your life? (testing, pain, functional cross)

Did you know that you can bill for this? Please see our resource guide provided at the bottom of the page.
This is an ***ONGOING*** conversation. The ***PROCESS*** would ideally begin in a community/family setting, move to the ambulatory setting and continue throughout the patient's acute experiences along the continuum of care. The ***GOAL*** is to align a patient's care wishes with what they actually experience throughout their healthcare journey. We know too often this does not happen.

The Your Care – Your Choice SharePoint site offers multiple resources for the conversation, billing and external resources. You can access the site using the link below.

https://carolinashealthcare.sharepoint.com/sites/PallCare/YourCareYourChoice

We are here to help you succeed and want you to feel comfortable with this difficult conversation! Additionally, we are happy to schedule time with your team to educate your providers.

Please do not hesitate to call or email the Your Care – Your Choice team for any help that you may need!

Thank you,

The Your Care – Your Choice Team

Beata Skudlarska, MD
Executive Medical Director

Jessica Kaiser Mendelsohn, MD
Medical Director

Michelle Kirby, MHA/MBA, BSN, RN
Program Manager / NM

Carol McLaughlin
Administrative Assistant

Carolyn Collins, BSN, RN
Catherine Hall, MSW, LCSW
Carol Hovey, MSN, RN, HNB-BC
Kim Shellenberger, LCSW, ACHP-SW
Educators

Kate McCullough
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