



FACULTY PHYSICIANS' RESPONSIBILITIES STATEMENT

Patient First Philosophy

The Faculty Group Practice was founded to provide comprehensive and quality care for patients. The role of the faculty physicians and staff is to provide compassionate care for the maximum benefit of the patient. Every patient will receive all needed services in an environment where there is genuine concern for the patient.

The faculty physicians of UAMS Medical Center demonstrate professional, respectful behavior to patients at all times, consistent with the group's philosophy to put the welfare of patients first.

- As faculty physicians, we provide a positive, supportive atmosphere to patients and their families. We speak positively about the staff, facilities, other patients, and other physicians in the presence of our patients.
- We introduce ourselves to each patient and explain our role as the faculty physicians. Understanding the educational setting in which we provide patient care, we also explain the role of residents, medical students, and other team members who are present.
- Before entering a patient's room, or an exam room, we review the patient's chart and familiarize ourselves with the patient's name and medical condition. We refer to each patient by name after introduction.

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PRINCIPLES & RULES OF OPERATION

Revised 3/7/07

This document sets forth the principles of operation of the University of Arkansas for Medical Sciences Faculty Group Practice (UAMS FGP). This document replaces the University of Arkansas Medical College Physicians Group Bylaws.

The final authority of the UAMS FGP (FGP) rests with the Dean of the College of Medicine of the University of Arkansas for Medical Sciences, following the recommendations of the FGP Executive Committee.

ARTICLE I COMPOSITION AND ORGANIZATIONAL STRUCTURE

Section I. Composition and Membership

The full-time physicians, dentists and Ph.D. clinical psychologists who are UAMS College of Medicine faculty and who provide patient services are voting members of the UAMS FGP. Others may be included as non-voting members at the discretion of the Dean acting on behalf of the Executive Committee. All FGP members are eligible for FGP fringe benefits pursuant to the College of Medicine Faculty Group Practice Fringe Benefit Program.

Section II. Termination of Membership

A member's standing in the UAMS FGP shall be terminated whenever he or she:

1. Is terminated from the University;
2. Does not meet the rules and standards established by the UAMS FGP, as determined by the Executive Committee, after consultation with the appropriate department chair.

Section III. Organizational Structure

UAMS FGP is an un-incorporated division of the College of Medicine. Its activities and operations are subject to review and approval by the Dean of the College of Medicine.

ARTICLE II PURPOSES AND RESPONSIBILITIES

Section I. Mission and Responsibilities

The principal mission of the FGP is to provide support, assistance, oversight and management of medical practice within UAMS College of Medicine. Its other responsibilities include:

1. Promotion of professional practice at UAMS in order to further the mission of the College of Medicine.
2. Approving, billing and collecting patient care fees generated by members and ensuring effective and efficient operation of the billing and collecting system.
3. Providing a mechanism for receiving and distributing professional earnings and other revenue, in accordance with the policies of the College of Medicine, the approval of the Dean, the policies of the Board of Trustees, and in accordance with state laws and regulations.
4. Addressing faculty concerns related to clinical practice.
5. Making decisions concerning contracting with managed care plans and other insurance plans on behalf of the faculty.
6. Establishing and enforcing professional standards, policies and procedures related to practice management and patient care, including access, availability and effective communication with referral sources.
7. Conducting a comprehensive risk management program for its members.
8. Evaluating and determining the appropriate size and specialty mix of the FGP.
9. Evaluating the quality of faculty patient care.

10. Serving as the principal liaison and representative of the clinical faculty in its relationships with hospitals, clinics, and other health care entities with which the faculty are associated.
11. Setting and allocating the appropriate assessments to be deducted from clinical revenue. This shall include negotiating an appropriate contribution to the Dean to support College of Medicine functions.
12. Receiving and acting on reports and data from its committees and subcommittees.
13. Authorizing the budget for the operation of the group practice.
14. Administration and assessment of the clinical practice development fund.

ARTICLE III MEMBERSHIP MEETINGS

Meetings of the FGP membership shall be called by the Dean of the College of Medicine, who serves as Chair of the Executive Committee. Meetings may be called by the UAMS FGP Chair, whenever necessary or appropriate. The agenda for the meetings is prepared by the Dean and Executive Associate Dean for Clinical Affairs, after receiving input from the Executive Committee.

ARTICLE IV FGP EXECUTIVE COMMITTEE

Section I. Executive Committee Composition

Membership on the committee will be for a three year term. The membership of the committee shall consist of:

- a. Dean, College of Medicine, and Chair of the Executive Committee and Board
- b. The Executive Associate Dean for Finance and Administration, ex officio.
- c. The Executive Associate Dean for Clinical Affairs, who also serves as the Executive Director of the FGP, ex officio.
- d. At least four chairs of clinical departments, one from ACH and three from UH.
- e. Four non-chairs, 2 from University Hospital and 2 from Arkansas Children's Hospital.

Executive committee members act as representatives of all group practice physicians and practitioners.

Attendance by surrogates is not allowed. Failure to attend at least 75% of the meetings annually will be a sufficient reason for replacement.

Section II. Election of New Members

The Dean shall appoint a nominating committee to compile a slate of candidates for open positions on the committee. Current positions will expire on the last day of the month of June in the year of the expiration of the term on the committee. Prior to July 1 of that year, the nominating committee, after receiving input from appropriate sources, shall present a slate of candidates to the FGP Executive Committee.

Section III. Duties and Responsibilities of the Executive Committee

The role of the UAMS FGP Executive Committee is to act on behalf of the membership in order to insure that the mission and responsibilities are carried out. The UAMS FGP Executive Committee shall function within the rules and regulations, shall be responsive to the membership, and shall be accountable for meeting institutional objectives. Actions of the Executive Committee will be referred to the Board for information and discussion.

Section IV. Chair

The Chair shall be the only officer of the FGP Executive Committee. The Dean of the College of Medicine shall serve as the chair of the UAMS FGP. The chair shall prepare the agenda for the Executive Committee meetings. The Chair may designate someone to serve as interim chair in his/her absence, for the purpose of conducting FGP Executive Committee meetings.

Section V. Executive Committee Meetings

The UAMS FGP Executive Committee shall meet at regular intervals, as determined by a majority of the committee. A quorum shall consist of a simple majority of the voting members. Robert's Rules of Order shall be followed during executive committee meetings. Minutes of meetings shall be filed in the office of the Chair, with copies distributed to all members of the Committee.

Section VI. Board

The Board of the UAMS FGP shall consist of the clinical chairs of the College of Medicine, in addition to the non-chair members and ex-officio members of the Executive Committee. Meetings of the Board shall be held regularly, at an interval to be determined by the Chair.

Section VII. Other Committees

The Executive Committee may establish other standing and ad hoc committees without amendment to the Bylaws as deemed necessary to carry out the mission of the Group Practice.

ARTICLE V

FINANCIAL RESPONSIBILITY

Section I. Collection and Transfer of Funds

UAMS FGP is responsible for the efficient billing, collection and transfer of funds in accordance with FGP policies, University policies and procedures and State laws and regulations.

Section II. Custodian of Funds

By direction of the University of Arkansas Board of Trustees, UAMS FGP is responsible, as custodian, for the maintenance of a separate auxiliary professional fee fund. This fund may be subdivided, on approval of the UAMS FGP Executive Committee, into separate, specific subsidiary accounts for each service contributing to the fund.

Section III. Sources of UAMS FGP Funds

All sources of generated income related to professional care of patients belong to the UAMS FGP including, but not limited to, the following:

1. Patient care fees from all sources, regardless of where and when they are earned by the faculty member.
2. Professional consultation.
3. Professional income from procedures and services provided from the delivery of patient care.

Section IV. Income going directly to faculty

Subject to University policies and state law limitations, other sources of income not related to professional practice may be retained by the faculty member including, but not limited to, the following:

1. Honoraria. All Honoraria are subject to review by the FGP for evaluation of conflict of commitment.
2. Prizes and awards.
3. Faculty members' interests in: a. Royalties b. Copyrights c. Patent Rights
4. Non-professional income.
5. Compensation received as a result of military leave.
6. Others, including consultation and testimony in legal matters, only upon the approval of the department chair and the Dean.

GUIDELINES & STANDARDS

Mission Statement - UAMS Medical Center Outpatient

1. Recognizing that accessibility is a key component of excellent patient care, we, as faculty physicians will participate in the development of a reasonable and accessible scheduling mechanism for clinics, preferably through a centralized scheduling system.
2. Our goal is to make new patient appointments available with a health care provider in every clinic within 14 days or within a reasonable period of time which meets the medical needs of the patient and is acceptable to both the patient and the referring physician.
3. Patient appointments are made during the initial contact telephone call from the patient or referring physician.
4. Provisions for “overbooks” are developed for each clinic, so that arrangements can be made for seeing “urgent” patients promptly.
5. Our goal is to avoid the cancellation of clinics. When missing a clinic is unavoidable, we try to arrange for coverage by an appropriate colleague. We plan our attendance at medical meetings, conferences, lectures, etc., as much as possible around clinic schedules and block scheduling for these clinics when a conflict is unavoidable, rather than canceling clinics after patients have been scheduled.
6. As the faculty physician, we are in the clinic on time for the first scheduled patient. When tardiness is unavoidable, we offer an apology to the patients who have been waiting. We have responsibility for the clinic schedule.
7. As faculty physicians, we are involved in all aspects of our patient’s care. We use CMS guidelines regarding the presence of faculty physicians. We inform each patient that we are responsible for each visit.
8. Before we leave the exam room, we ask each patient if there are any further questions concerning their condition or plan of treatment.
9. As faculty physicians, we communicate with appropriate physicians and services involved in our patient’s ongoing care.
10. We work with the Medical Director of the clinic, clinic management, and our fellow physicians to utilize clinic resources effectively and efficiently.

Practice Statement - UAMS Medical Center Inpatient

1. When on service for inpatients, we see each of our patients daily, and document our care in the patient’s record. We inform each patient which faculty physician is responsible for his or her care.
2. Each service will ensure that a qualified faculty physician is available at all times.
3. Each service ensures that an attending faculty physician is accessible by telephone promptly to referring physicians, patients, colleagues, the Emergency Room, and nursing units.

4. As faculty physicians, we respond quickly to non-emergent calls from referring physicians, and we help to establish a mechanism to notify us promptly of such calls.
5. As members of the Faculty Group Practice, we collaborate in the development of a campus-wide Medical Exchange Service. We will participate in the development of a clearly designed on-call schedule that includes accurate pager and phone numbers, which is available to provide 24-hour access.
6. Inpatient consults are seen as soon as possible. Our goal is to provide consultations according to the following guidelines:

Routine:	Within 24 hours
Urgent:	Within 4 hours
Emergency:	Immediately (less than 1 hour)

When patients are seen by a resident or fellow on a consulting service, documentation of his/her discussion of the case with the attending physician will be placed in the medical record promptly. Except for unusual situations, consult attending will see the patient within a reasonable time period after the resident or fellow's initial visit and will provide his/her own written consult documentation in the medical record. Each service will develop its own specific standards for consultation, which must be consistent with these parameters, but which may be more stringent as medically indicated. Each service's standards will be reviewed and approved by GPEC.

7. Pre-operative consultations for elective surgery are coordinated between the surgical and consulting services. When possible, consultations occur prior to hospitalization to avoid unnecessary delays in surgery or additional days in the hospital for the patient.
8. Upon completion of an operation or a procedure, we notify the family of the outcome prior to the delivery of a patient to the recovery room. We also notify the family of the location of the recovery room and tell them when they will be able to visit the patient.
9. After an operation or a procedure, we provide the family with all information pertinent to the patient's welfare, in accordance with HIPAA policies, including answering questions.
10. As faculty physicians, we ensure that the discharge treatment plan, home health, and follow-up care are well planned and implemented. Each patient is given clear instructions as to who should be contacted to discuss problems and how to make this contact. We ensure that all home health orders clearly delineate the responsible faculty or community physician.
11. As faculty physicians, we communicate with appropriate physicians and services involved in our patient's ongoing care.
12. Compliance with these standards will be evaluated periodically by chart audit. In addition, faculty who has concerns regarding any service's performance or compliance with these standards should communicate those concerns to the Medical Director's office for follow-up and investigation.

This document expresses the intent of the Faculty Group Practice to provide timely, accurate, and pertinent information to referring physicians regarding the care of their patients in both the inpatient and outpatient settings. We recognize our responsibility to provide information to referring physicians as an integral part of the patient's overall care, and present these guidelines as our recognition of the value of patient referrals in enhancing the mission of UAMS, and the relationships between FGP physicians and referring physicians. We are committed to the successful implementation of the standards of communication and reporting included in this document.

Arkansas Children’s Hospital (ACH)

Practice Statement

In order to enhance, sustain, and restore health and development of children, Arkansas Children’s Hospital provides excellent clinical services, teaching and research. ACH is committed to working with others to achieve high-quality, cost-effective, fully accessible services for Arkansas’ most precious resource—our children, without regard to race, religion, or inability to pay.

Central Arkansas Veterans Healthcare System (CAVHS)

Practice Statement

Mission Honor America’s veterans by providing exceptional health care that improves their health and well-being.

Vision To be a patient-centered, integrated healthcare organization for veterans providing excellent health care, research, and education; an organization where people choose to work; an active community partner; and a back-up for national emergencies.

Values Desirable qualities, characteristics and behaviors of importance and value are: Trust, Respect, Commitment, Compassion, and Excellence.

Organizational Description

The Central Arkansas Veterans Healthcare System (CAVHS) is a six-facility health service organization within the Department of Veterans Affairs (VA), serving a primary area comprised of 155,552 veterans. CAVHS has two main campuses and four Community Based Outpatient Clinics (CBOCs). The two main campuses are the John L. McClellan Memorial Veterans Hospital and the Eugene J. Towbin Healthcare Center, which are located in Little Rock and North Little Rock, Arkansas, respectively. The McClellan Hospital provides acute medical and surgical services and utilizes 178 beds. The Towbin Center delivers long-term psychiatric care, mental health services, and nursing home care, and has 356 beds. Throughout its rich 83-year history, CAVHS has been widely recognized for its tradition of high quality, compassionate health care for Arkansas veterans, and for excellence in education, research, and emergency preparedness.

Health Care Services

CAVHS is a tertiary care facility classified by the VA at the highest level, Complexity Level 1A. We offer a broad spectrum of inpatient and outpatient services, ranging from primary care and disease prevention to complex surgical procedures and extended rehabilitative care. We have an active research program that was funded with over \$25 million in grants last year. Our CBOCs are contract clinics located in areas with the highest concentration of veterans. CBOC locations include Mountain Home, Mena, Hot Springs, and El Dorado. In addition, we deliver care to veterans using a mobile unit in Monticello, a home health care service center in Hot Springs, and a VA drop-in day treatment center for homeless veterans in downtown Little Rock. In 2005, CAVHS served 57,739 veterans, including veterans returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) - a growing patient population. CAVHS also serves as a teaching facility, with more than 1,500 students and residents enrolled annually in more than 65 educational programs. Our principal teaching affiliate is the University of Arkansas for Medical Sciences (UAMS), which is the state’s only medical school.

Organizational Culture

CAVHS is one of 138 health service organizations operated by the VA through the Veterans Health Administration (VHA), which consists of 21 Veterans Integrated Service Networks (VISNs). CAVHS is part of the South Central VA Healthcare Network (SCVAHCN), also called VISN 16, which includes facilities in Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Florida, and Texas. The culture of CAVHS is built on the foundation of the Mission, Vision, and Values.

REPORTING AND COMMUNICATION STANDARDS

The following standards apply to all UAMS Medical Center, Arkansas Children's Hospital clinics, and all other off-site clinics staffed by FGP physicians. These standards are intended to provide all pertinent patient information, including clinic visit notes, diagnostic testing, and treatment plans, to the patient's referring physician, including both FGP referring physicians and non-FGP referring physicians.

Outpatient Clinic Visits

All FGP consulting physicians will provide a legible (preferably typewritten) communication to the referring physician within 14 days of the clinic visit. Ideally, the report should be done in 48 hours. In addition, we will strive to provide more immediate communication to referring physicians via the following channels:

1. If the consulting physician identifies a condition with a patient that is urgent, or one that requires immediate treatment, a phone call should be made to the referring physician immediately.
2. For other non-urgent clinic visits, several options are available for immediate communication with referring physicians:
 - A phone call to the referring physician
 - A secure e-mail to the referring physician (particularly useful for on-campus referring physicians)
 - Facsimile

In addition to these standards regarding communication of clinic visits to the referring physician, a department or clinic specific protocol will be developed to communicate the results of diagnostic and/or therapeutic services to the referring physician, provided the information was not included in other communications.

Inpatient Care Reporting and Communication Standards

1. The attending physician or consulting physician or his/her designee will communicate with the referring physician and/or primary care provider at least once per admission, or for extended stays, once per week.
2. Unusual, unexpected, or urgent clinical issues will be communicated to the referring physician and/or primary care provider before the end of the following business day via a phone call.
3. Discharge Summaries will be dictated within 24 hours of discharge and mailed to the referring physician and/or primary care provider within 48 hours of completed transcription, either signed or unsigned by the physician
4. Operative Notes will be dictated within 24 hours of the procedure. Physicians may choose to communicate these results in one of the following ways:
 - The operative note may be mailed--signed or unsigned--to the referring physician and/or primary care provider within 48 hours of completed transcription.
 - A summary of the operative note may be included in a letter to be mailed to the referring physician and/or primary care provider within 48 hours of completed transcription.
5. Consulting attendings will provide written consult documentation in the medical record as per the Inpatient Practice Statement Guidelines.

CAVHS Inpatient and Outpatient Reporting and Communications Standards

CAVHS Medical Center Bylaws is available for referencing.

<http://vaww.little-rock.med.va.gov/cos/docs/BylawsMedicalStaff.pdf>

SYSTEMS OF REPORTING AND COMMUNICATION

Recognizing that many of these standards require cooperation from the various hospitals, the Faculty Group Practice will work together with UAMS Medical Center and Arkansas Children's Hospital to ensure that effective systems are in place to accurately implement these standards, and to identify, track, and maintain information on referring physicians and progress toward guidelines stated in this document.

On-Call Messaging Standards UAMS Medical Center

1. As clinical systems are activated, all UAMS Medical Center-based Faculty Group Practice physicians and house staff will utilize the centralized, on line messaging system.
2. Department/division office staff or physicians will be responsible for inputting and updating schedules and contact information, including the name and contact information for the attending physician on call. All call schedules will be entered/revised/maintained in the electronic AmTelCo database.
3. All physicians will be responsible for responding to pages according to the following guidelines and indicators:

*8	indicates a call from a physician	pages will be returned within 5 minutes
*1	indicates an emergency call	pages will be returned within 5 minutes

If not returned within the allotted time frame, the next physician on call will be paged. All other pages will be returned within 15 minutes.

4. External referring physicians calling into the Access Center will be asked if they would like to speak to a UAMS attending physician. If they would, they will be immediately routed to the attending on call for the particular service, via phone or pager. If the referring physician has no preference he/she will be directed to the physician (either resident or faculty) currently taking first call.

Arkansas Children's Hospital

1. All Arkansas Children's Hospital-based Faculty Group Practice physicians and house staff will utilize the centralized, on line paging system.
2. Department/division office staff or physicians will be responsible for inputting and updating schedules and contact information, including the name and contact information for the attending physician on call.
3. All physicians will be responsible for responding to pages according to the following guidelines and indicators: Calls from other physicians or emergency calls will be returned within 5 minutes. If not returned within the allotted time frame, the next physician on call will be paged. All other pages will be returned within 15 minutes
4. External referring physicians calling the ACH Operator will be asked if they would like to speak to a UAMS attending physician. If they would, they will be immediately routed to the attending on call for the particular service, via phone or pager. If the referring physician has no preference he/she will be directed to the physician (either resident or faculty) currently taking first call.

APPOINTMENT SYSTEM GUIDELINES

Having identified the Faculty Group Practice's primary objective to put the Patient First, we affirm the following guidelines related to outpatient appointment scheduling in order to ensure patient and family centered care. These guidelines are intended to assure patient satisfaction, access, and convenience with all aspects of outpatient visit(s). In order to ensure our commitment to providing excellent medical care to all patients, these guidelines address our clinical purpose to ensure efficient clinic operations, gathering accurate patient information, and verifying payer status at or before the time of service.

UAMS Medical Center Appointment Scheduling

1. Patients will be given an appointment to the appropriate clinic at a time consistent with that clinic's approved policy.
 - 1a. Faculty will work with their respective clinics and with the appointment center to insure a response to referring physicians' request for a patient appointment or consult within 24 hrs. A response is defined as a date and time for the patient appointment.
2. Provisions for "overbooks" are developed for each clinic, so that arrangements can be made for seeing "urgent" patients promptly.
3. Arrangements will be made for emergent patients to be seen in the clinic or in the Emergency Department immediately.
4. All pertinent patient information will be gathered to include insurance coverage at the time the appointment is scheduled, verified before the actual clinic visit, and re-verified at the time of the visit.
5. Patients may schedule appointments at least six months in advance.
6. Each clinic will develop and publish criteria, following a standard format, for handling work-ins, walk-ins, and overbooks, including a scheduling contact person, and the number, type, and distribution of these appointments. Each clinic's criteria will be approved by the Clinic Medical Director and copies distributed to all persons scheduling appointments.
7. All patients, including those participating in clinical trials who need clinic appointments as a part of their protocols, which require a visit, will be scheduled using the standard appointment system (e.g., Meditech, SMS, etc.).
8. All patients will be scheduled using the standard appointment scheduling system (e.g., Meditech, SMS, etc.). Appointments may be scheduled by appropriately trained clinic/department staff members or by the appointment center.
9. An attempt will be made to schedule outpatient visits for a single patient (lab, x-ray, and other clinics) in a manner that is convenient for the patient
10. A referral source and the primary care physician will be printed on each physician's and clinic's daily appointment list. Note: This is not a part of SMS' standard format. It will require custom programming.

UAMS Medical Center Templates

1. No “block scheduling” will be allowed on the system; all appointments will be time-specific according to the type of appointment.
2. Each provider’s template will be developed with the individual provider’s input to reflect specific practice requirements and needs. Each physician, or his/her designee, will describe the appointment types to be included in the specific definition of their clinic templates and appointment schedule.
3. Each provider’s individual template will be approved in writing by each provider and his/her Clinic Medical Director upon completion (form will be developed and attached).
4. Providers will submit their clinic schedule templates for no less than (3) months in advance.
5. Clinic time will be blocked for non-clinical time slots, i.e., conferences, vacations, meetings, rounds, etc.
6. Once established, templates will not be changed for at least thirty days.
7. The same provider will not be scheduled simultaneously in different locations.

UAMS Medical Center Clinic Cancellations

1. Clinic cancellations by physicians and/or house staff officers must be approved, in writing, by the Clinic Medical Director at least thirty days in advance of the scheduled clinic session (form will be developed and attached).
2. Reasonably understood emergencies, e.g. illness of physician or family, death in the family, or professional emergency, etc., will be exempt from the thirty day time frame. Notification of personal emergencies requiring clinic cancellation will be made as soon as possible to the Clinic Medical Director and Clinic Manager.
3. The Departmental Chair has the overall responsibility to ensure that all of their clinics operate as scheduled and to ensure that during major national and local meetings faculty coverage is immediately available. To avoid cancellation of a clinic when a provider must be absent as per (2) above, the provider and/or the Clinic Medical Director may choose to assign another appropriate provider to cover the absent provider’s clinic schedule.
4. If cancellation is necessary, the canceling physician needs to review the list of patients with clinic staff in order to determine urgency level for re-scheduling patients. Adding a make-up clinic or adding extra appointments to future clinics should be considered in order to see the re-scheduled patients in a timely fashion.
5. A report of blocked and cancelled clinics will be made available to Clinic Medical Directors and Department Chairs on a regular basis.
6. Faculty will be expected to offer least 85% of their allotted appointment times.

Arkansas Children's Hospital Appointment System Guidelines

Appointment Scheduling

Majority of appointments scheduled through Appointment Center

Templates

Templates are numerous and specialty-specific

Clinic Modification Policy

A "Clinic Modification Form" will be completed each time a physician wishes to cancel, block, limit or add the number of patients to be seen in a scheduled clinic and outlines the procedure to be followed for scheduled or unscheduled modifications of clinics.

Definitions

Blocked clinics

Clinics that are cancelled at least three months out. These are clinic times that will not have a physician in attendance because of predictable conflicts, such as meetings, service conflicts, and vacation. These times are predicted well in advance so that patients hopefully are not scheduled for that clinic time and so staff and space may be used for other purposes. (Definition changed at 11/13/03 Outpatient Care Committee).

Cancelled clinics

Clinics that are closed in less than 3 months after patients are assigned to that clinic. These are clinic times that will not have a physician in attendance because of unpredictable conflicts such as illness and other emergencies. Cancellation of clinics requires moving already scheduled patients. If not related to an emergency or illness and less than 6 weeks notice, the clerical support for the physician may be required to assist with contacting patients and families. The clinic staff can make the schedule changes in Meditech but letters are not expected to be sufficient notice in this timeframe. Telephone contact must be made to these patients and families.

Limiting a clinic

Canceling a portion of the scheduled patients for a clinic.

Adding a clinic

Adding patients for clinic visits during a time that clinic is not routinely scheduled.

1. Blocked Clinics

- a. Clinics should be blocked as far in advance as possible (at least three months prior to clinic).
- b. The physician wishing to block a clinic will notify the Clinic Director and Clinic Medical Director of the need to block a clinic time. The physician wishing to block the clinic will make every attempt to have another physician see patients during that clinic time to maximize appointment availability for patients and referring physicians

2. Cancelled or Limited Clinics

- a. No clinics should be cancelled or limited for non-emergent reasons less than 30 days of a scheduled clinic.
- b. If a clinic is cancelled or limited and an alternative physician is not available to see PREVIOUSLY scheduled patients, the canceling or limiting physician should work with the Clinic Director to open a NEW clinic within 2 weeks of the cancellation or limitation to allow reappointment of the non-urgent patient and to assist with rescheduling of patients as required by the clinic director.
- c. The physician who is canceling or limiting the clinic is expected to make arrangements to see the emergent or urgent requests in a timely manner.

3. Number of Clinics Cancelled and Blocked:
 - a. If a physician cancels (not blocks) >3 clinics in a six month period, the Section Chief and Chairman will be notified.
 - b. The number of blocked and cancelled clinics should not exceed 20% of the clinics during a twelve month period unless previously negotiated with the Chairman and with the approval of the Section Chief.

4. Process of Adding, Blocking, Canceling, or Reducing a Clinic:
 - a. The physician who is adding, blocking, canceling or reducing a clinic will complete a “Clinic Modification Form” and send it to:
Clinic Medical Director, Clinic Director, Patient Information Coordinator
 - b. All “Clinic Modification Forms” must be sent electronically via e-mail. The form is in the following locations: K:\General\ACS\Clinic Modification Form; My ACH Vault: Forms, Forms, Forms.
 - c. If the Clinic Medical Director chooses to deny the physician the ability to cancel the clinic, he/she will notify the Clinic Director as well as the physician.
 - d. The Patient Information Coordinator (PIC) of the clinic, unless instructed otherwise by the Clinic Director, will modify the clinic and scheduled patients according to the “Clinic Modification Form”. After completing the PIC portion of the “Clinic Modification Form”, the PIC will return the COMPLETED form electronically to the following: Requesting Physician, Clinic Medical Director, Clinic Director, and Ambulatory Care Services.
 - e. Ambulatory Care Services will enter the data into the Clinic Modification Database.

CAVHS Scheduling

First Step

Act as soon as possible
 No more than 7 days, on all applications and appointment requests
 “Today” is day 1 not 0 – weekends count

Actions that count: Assign patient in PCMM to a provider/team and/or schedule an appointment
 Completing the service

Second Step

Schedule patients within 30 days of desired date based on the following to comply with performance measures:

NEW PATIENT:

Seen in specialty are last 24 months last 24 months
 Desired date: is date the consult request or patient request is made.
 Typically today’s date.
 Service connected* - 30 days
 Non-service connected** - 30 days

ESTABLISHED PATIENT:

Not seen in specialty area
 Desired date: is date requested by provider or patient to be seen.
 Typically “in the future”
 Service connected* - 30 days
 Non-service connected** - 30 days

* VHA policy distinguishes between >50% and <50%, performance measure does not

** VHA policy is 120 days but performance measure requires 30 days.

CAVHS Third Step

Only if appropriate appointment cannot be made based upon the above:

1. Service connected (new or established) must be seen within 30 days of desired date. If cannot schedule then notify supervisor or EWL contact. Alternative arrangements need to be made to have patient seen within 30 days of desired date.
2. Non-service connected (new or established) schedule within 30 days if possible to comply with performance measure. But VA policy allows for scheduling beyond 30 days and up to 120 days for NSC, if necessary, even though this will count against us for the performance measure. If over 120 days, must put on wait list so contact your supervisor or EWL contact.
3. Inform them:
 - a. Patient name and last four SSN
 - b. SC/NSC Status
 - c. New Patient/Established patient
 - d. Desired date
 - e. No Appropriate appointment slot available
 - f. Document your communication with supervisor or EWL contact according to service procedure (e.g. consult, progress note, email, etc)

Questions: Ask your supervisor or send e-mail to VHALIT Scheduling Help.

UAMS E-MAIL ACCESS AND USAGE

Scope UAMS faculty, employees, students, contract personnel, vendors, volunteers, and official visitors.

Definitions

Confidential Information includes information concerning UAMS research projects, confidential employee information, information concerning the UAMS research programs, proprietary information of UAMS, and sign-on and password codes for access to UAMS computer systems. Confidential information shall include Protected Health Information.

Protected Health Information (PHI) means information that is part of an individual's health information that identifies the individual or there is a reasonable basis to believe the information could be used to identify the individual, including demographic information, and that (i) relates to the past, present or future physical or mental health or condition of the individual; (ii) relates to the provision of health care services to the individual; or (iii) relates to the past, present, or future payment for the provision of health care services to an individual. This includes PHI which is recorded or transmitted in any form or medium (verbally, or in writing, or electronically). PHI excludes health information maintained in educational records covered by the federal Family Educational Rights Privacy Act and health information about UAMS employees maintained by UAMS in its role as an employer.

Policy

The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the procedure to be followed while accessing and using e-mail. This policy applies to all usage of electronic mail systems within UAMS where the mail either originated from or is forwarded into a UAMS computer network. It applies to all e-mail users including, but not limited to, faculty, staff, students, and volunteers if UAMS information is involved regardless of whether UAMS computer resources are used or not.

Procedures

Privacy, Confidentiality and Public Records Considerations

The UAMS electronic mail (e-mail) system is available to authorized users for the expressed purpose of conducting UAMS business. Reasonable efforts will be made to maintain the integrity and effective operation of its electronic mail systems (e-mail), but users are advised that those systems should not be regarded as a secure medium for the communication of sensitive or confidential information. Any e-mails sent outside of the UAMS network containing confidential information, including ePHI, must be encrypted. Refer to Section D below.

Permissible Uses of Electronic Mail

1. Authorized Users: Only UAMS faculty, staff, and students and other persons who have received permission under the appropriate UAMS authority are authorized users of UAMS electronic mail systems and resources.
2. Purpose of Use: The express purpose of UAMS electronic mail resources is for UAMS business, including academic, clinical and research pursuits.

Prohibited Uses

E-mail is the property of UAMS. Prohibited uses of electronic mail include, but are not limited to:

1. Using for personal monetary gain or for commercial purposes that are not directly related to UAMS business.
2. Sending copies of documents in violation of copyright laws.
3. Including the work of others in electronic mail communications in violation of copyright laws.

4. Unapproved capturing or opening of another individual's electronic mail except as required as part of assigned job duties for authorized employees to diagnose and correct delivery problems.
5. Using electronic mail to harass or intimidate others or to interfere with the ability of others to conduct University business (this includes inappropriate or offensive content, chain-letters and/or "spamming" - sending non-approved / non-solicited advertisements to other individuals on campus.)
6. Using electronic mail systems for any purpose restricted or prohibited by state and federal laws and regulations or by UAMS Policy.
7. "Spoofing" - constructing an electronic mail communication so it appears to be from someone else.
8. Attempting unauthorized access to electronic mail or attempting to breach any security measures on any electronic mail system, or attempting to intercept any electronic mail transmissions without proper authorization.
9. Broadcasting messages to "Everyone" within UAMS without prior permission from the UAMS e-mail administrator (see Section H below).
10. Using custom backgrounds, special formats, or colors within your email. Refrain from this practice and use plain, white backgrounds and professional formats. The only exceptions to this are special emails crafted to be official UAMS business invitations, announcements, advertisements, or pamphlets.
11. Use of quotations or sayings within your message or signature block. This practice has great potential to offend so quotations must not be used and any that exist must be removed. Again, the exceptions would be special official UAMS business emails crafted for specific purpose.

Confidential Information & ePHI in E-Mails/Electronic Communications

1. E-mail is encrypted automatically inside the UAMS network. Any e-mails sent outside of the UAMS network containing Confidential Information, including ePHI, must be encrypted.
 - a. The UAMS workforce may utilize encryption methods of their own choosing.
 - b. It is recommended that the UAMS workforce utilize the enterprise secure e-mail gateway solution.
 - (1) This is easily accomplished by clicking on the "mark secure" button provided on the standard toolbar in Outlook, or
 - (2) The word [secure] typed with the brackets into the subject line will also encrypt the message
 - (3) Communication with other organizations in many cases will be set up for automatic encryption and a list of these organizations will be provided.
2. The patient's e-mail address is part of the patient's Protected Health Information and must be protected as any other PHI in accordance with all applicable laws, regulations and UAMS policies.
3. For Protected Health Information (PHI) that is subject to the minimum necessary requirements of the HIPAA regulations, reasonable efforts must be made to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. [Policy 3.1.25 Minimum Necessary](#)
4. UAMS takes the steps necessary to make sure that your e-mail and other computer messages are secure, but no one can guarantee the security and privacy of e-mail messages. Therefore, it is best not to use e-mail to send highly sensitive information.
5. Confirm the e-mail address before sending any e-mail containing Confidential Information or ePHI, to ensure there are no typographical errors.
6. Caution should be taken when using distribution lists or forwarding e-mails that contain Confidential Information and ePHI.
7. E-mail containing PHI may not be auto-forwarded to any non-uams.edu account, including but not limited to personal and commercial e-mail accounts such as AOL, Yahoo, or MSN.

Provider Communications with Patients via E-mail

1. The decision to correspond with patients via e-mail is left to the discretion of the physician or clinic. It is the responsibility of the clinic to determine additional e-mail communication guidelines, such as (a) how often e-mail will be checked; (b) instructions for when and how to escalate to phone calls and office visits; and (c) the types of transactions that are appropriate for e-mail.
2. Any ePHI originated by UAMS must be encrypted when being sent via e-mail.
3. UAMS takes the steps necessary to secure e-mail and other computer messages, but no one can guarantee the security and privacy of e-mail messages. Use caution when sending highly sensitive information.
4. E-mail communication is a convenience for the patients and should not be used for emergencies or time-sensitive situations.
5. Keep in mind that the patient's e-mail address is part of the patient's Protected Health Information and must be protected as any other PHI in accordance with all applicable laws, regulations and UAMS policies.
6. Before sending the e-mail containing Confidential Information or ePHI, confirm the e-mail address to ensure it does not contain any typographical errors.
7. E-mail messages must include (a) information in the subject line, such as prescription refill, appointment request or other information generally describing the purpose of the e-mail; and (b) patient name, telephone number and patient identification number in the body of the message.
8. Clinically relevant messages and responses will be documented in the patient's medical record.
9. Upon a patient's receipt of e-mail, patients will be provided guidelines of using e-mail for communicating with their provider.

UAMS Access and Disclosure of Communications

To the extent permitted by law, UAMS reserves the right to access and disclose the contents of faculty, staff, students, and other users electronic mail without the consent of the user. UAMS will do so when it believes it has a legitimate business need including, but not limited to, those listed below only after explicit authorization is obtained from the appropriate UAMS authority.

1. Faculty, staff, and other non-student users are advised that UAMS' electronic mail systems should be treated like a shared filing system, i.e., with the expectation that communications sent or received on UAMS business or with the use of UAMS resources may be made available for review by any authorized UAMS official for purposes related to UAMS business.
2. Electronic mail of students may constitute "education records" subject to the provisions of the federal statute known as the Family Educational Rights and Privacy Act of 1974 (FERPA). UAMS may access, inspect, and disclose such records under conditions that are set forth in the statute.
3. Any user of UAMS electronic mail resources who makes use of an encryption device to restrict or inhibit access to his or her electronic mail must provide access to such encrypted communications when requested to do so under appropriate UAMS authority.
4. UAMS will not monitor electronic mail as a routine matter but it may do so to the extent permitted by law as UAMS deems necessary for purposes of maintaining the integrity and effective operation of UAMS electronic mail systems.
5. Limitations on Disclosure and Use of Information Obtained by Means of Access or Monitoring: To the extent permitted by law, the contents of electronic mail communications, properly obtained for UAMS purposes, may be disclosed without permission of the user. UAMS will attempt to limit disclosure of particular communications if disclosure appears likely to create personal embarrassment, unless such disclosure is required to serve a business purpose or satisfy a legal obligation. Special Procedures to Approve Access to, Disclosure of, or Use of Electronic Mail Communications: Individuals needing to access the electronic mail communications of others, to use information gained from such access, and/or to disclose information from such access and who do not have the prior consent of the user must obtain approval in advance of such activity from the appropriate UAMS authority. The request for approval shall take into consideration ways to minimize the time and effort required to submit and respond to requests,

the need to minimize interference with UAMS business, and protection of the rights of individuals. The request for granting access to electronic communications is provided in Section F below.

6. UAMS will inspect and disclose the contents of electronic mail in accordance with the established approval process. Such action will be taken as necessary; to include:
 - a. To respond to legal processes or fulfill UAMS obligations to third parties,
 - b. in the course of an investigation triggered by indications of misconduct or misuse,
 - c. as needed to protect health and safety,
 - d. as needed to prevent interference with the academic, clinical or research missions of the organization,
 - e. as needed to locate substantive information required for UAMS business, or
 - f. as required under the Arkansas Freedom of Information Act.

Procedure for Granting Approval to Access Electronic Communications of Others

1. The following information will be required prior to approval of access to electronic communications addressed to others:
 - a. Name and title of the person whose communications will be accessed;
 - b. Name and title of the person who is requesting access;
 - c. Name and title of the person who will do the accessing;
 - d. Detailed description of why the access is needed;
 - e. Required duration of the access or dates within which access is desired;
 - f. What will be done with the accessed messages? With whom will they be shared?
2. Anyone may request access of messages through the UAMS Technical Support center. The following approvals are required.
 - a. Department Chairpersons and Unit Directors are the first level of approval;
 - b. Deans or Vice Chancellors are the final level of approval.
3. The IT Security Office will obtain appropriate approval and will maintain copies of all requests.
4. The person requesting the access will be given the following advice and reminders:
 - a. A reminder that concerns about fiscal misconduct or criminal activity should not be investigated by individuals or departments but should be referred to University Police, Hospital Compliance, or Internal Audit staff.
5. A reminder that to the extent permitted by law, the contents of electronic communications obtained after appropriate authorization may be disclosed without the permission of the employee. At the same time, UAMS will attempt to refrain from disclosure of particular messages if disclosure could create personal embarrassment, unless such disclosure is required to serve a business purpose or satisfy a legal obligation.

Retention & Storage of E-mail

E-mail servers are backed up completely on a daily basis. Two (2) full backups are retained in secure storage in the event of a complete network server failure. The e-mail backup and recovery system is intended to provide a means of recovery from failure of an entire e-mail server or e-mail storage device. Routine recovery capabilities and procedures do not include a capacity to recover e-mail of a specific user. E-mail recovery procedures will not be used to recover specific e-mail messages.

E-mail Site Messages

Site messaging is a tool used for campus e-mail alerts and notifications that are directed to the entire campus or a select group (i.e., Department Heads, Business Managers). These notifications are restricted and may ONLY be sent by the e-mail administrator. Messages must also have prior approval before delivery of the site message is transmitted by the e-mail system.

To request sending of a site message:

1. The party requesting an e-mail site message should contact the UAMS IT Technical Support Center (TSC) by calling 686-8555 or sending an e-mail message to 'Tech Support Center' utilizing the "Campus-Wide Email Request" web site <http://intranet.uams.edu/it/helpdesk/siteadmin.htm>
2. Except in emergency situations, the requested Site Message text must be received by the UAMS Technical Support Center no later than two days prior to the requested send event.
3. Technical Support Center logs the call and assigns call to Communications and Marketing.
4. Communications and Marketing will contact requesting party for verification of message and targeted individuals or group.
5. Communications and Marketing formats messages and forwards to the IT Server Support group.
6. Non-UAMS function announcements will not be approved.
7. Emergency site messages are processed by the Server Support group.

Disciplinary Action

Appropriate disciplinary action will be taken against individuals found to have engaged in prohibited use of UAMS electronic mail resources.

E-mail Etiquette

When you send e-mail, remember these points:

1. Don't say anything in an e-mail that you wouldn't say in a letter on your office letterhead. E-mail should contain appropriate language and be rational, reasonable and respectful.
2. E-mails may be admissible in court. Communication should be done within a framework that does not constitute negligence or willful disregard of harmful consequences that might ensue to the institution and its employees. Be aware of the difference between reply and reply-all. Assure that your communication is sent to the proper individual(s) - not inadvertently sent to someone that has no need for the information, or is adversely affected by the communication. Deleting a message is not a guarantee that the message cannot be retrieved.
3. E-mail is not a forum to discuss significant events, opinions affecting health care in the institution, lengthy debates or arguments.
4. Employee disciplinary actions are not appropriately sent through e-mail.
5. Chain letters are junk mail, and are not appropriate for business e-mail. Do not forward or reply to chain letters.
6. Use common sense when writing e-mail. Ask yourself if this is appropriate to send before you hit the SEND button.

Request to Access Electronic Communications of Others

Our department requests authority to access electronic communications sent to an individual as described below:

Name, Title, and Department of person whose communications would be accessed:

Name & Title Department

Name, Title, and Department of person requesting access:

Name & Title Department

Name, Title, and Department of person who will do the accessing (if different than above):

Name & Title Department

Reason for access request: _____

How long should the special access last? _____

What will be done with the accessed messages? With whom will they be shared?

Signature of Requesting Person Date

Signature of Department Head Date

Signature of Approving Dean or Vice Chancellor Date

Upon approval, this form is to be delivered to the following person as authorization for them to implement the requested special access:

Steve Cochran, Information Technology Security Manager.

“ON-TIME PERFORMANCE” STANDARD

Arkansas Children’s Hospital

In order to provide the best service and quality care to patients at ACH, all ACH staff and physicians will arrive in clinic within the standards outlined and all patients are expected to be on-time for appointments.

On-Time Standards for ACH Staff:

1. ACH staff will follow ACH Human Resources Policy 430 “Attendance/ Tardiness”.

On-Time Standards for Physicians:

1. All physicians are expected to be in clinic no later than 15 minutes after patient’s scheduled appointment.
2. If the physician is not in clinic at that time, the clinic nurse will page the physician. (This will occur 15 minutes after the scheduled appointment.)
3. If the physician does not arrive within 10 minutes of being paged, the Clinic Director will page the Clinic Medical Director for assistance in getting physician coverage. (This will occur 25 minutes after the scheduled appointment.)
4. If physician coverage has not arrived in clinic within an additional 10 minutes, the Clinic Director will page the Section Chief for assistance. (This will occur 35 minutes after the scheduled appointment.)
5. If there is no resolution after the Section Chief is contacted then the following will be notified:
Department of Pediatric MDs – Dept of Pediatrics Chairman
All other MDs – Outpatient Medical Director/ACH Medical Director

On-Time Standards for Patients:

1. The Medical Director by subspecialty shall define “late” within the range of 15-30 minutes.
2. When the patient arrives late for their scheduled appointment, the following will occur:
 - a. If there are openings in the clinic’s schedule that day: The PIA will communicate to the patient that because they are late, they will be worked into an open appointment slot later that same day.
 - b. If there are no appointments available in the clinic’s schedule that day: The PIA will communicate to the physician or his/her designee that the patient is late and there are no open appointments. The MD or his/her designee will decide if the patient will be an “overbook” that day or be reappointed to another day. If the patient is to be reappointed another day, an RN or MD does a quick medical assessment to ensure the patient can leave ACH.
 - c. If the patient elects to leave for an appointment: The PIA will notify the physician or his/her designee that the patient refuses to stay for an appointment later that day. The RN or MD will do a quick medical assessment to ensure the patient can leave ACH. If the patient leaves prior to medical assessment the AMA guidelines will be followed.
3. The Clinic Reminder Letter mailed to the patient will refer to these guidelines in order to set the expectations of our families.

CAVHS Waiting Times Standards – Clinic

Executive Abstract: The performance measures to improve waiting times for new and established patient clinic appointments continue in FY06 with the retention of the patient satisfaction measures. Patients seen in primary care clinics will be asked if they obtained an appointment as soon as they wanted. Responses will be grouped by those patients who have not had a primary care visit in the prior 24 months (new patient) and those previously seen in primary care (established patient).

Primary care and specialty care “new” patient measures for appointments seen within 30 days of creation date will, again, be calculated from the scheduling package as in previous years. For new patients, the measures “start” when the patients are SEEN then look backward to when the appointment was made. Calculations for “new” patients are made based on patients not having been seen in the clinic at that facility in the previous 24 months. There is then an assumption that all “new” appointments are a request for a “next available appointment”.

Rationale: Eligibility Reform changes and the new enrollment process have increased the demand for patient care services in the Veterans Health Administration (VHA). New patients represent a subset of patients who experience the longest wait times. Many organizations measure specialty care wait times from the date the consult was initiated until the date the patient was seen. This new patient wait time closely approximates this approach. While new patient access is a key leverage point, VHA must also maintain the low wait times for the established patient. Waiting time to receive an appointment is a primary dis-satisfier among stakeholders.

Resources & References:

- VHA Advanced Clinic Access <http://aca.vssc.med.va.gov/default.aspx>*
- IHI (Institute for Healthcare Improvement) sites for improving primary care and specialty care access <http://www.ihl.org/IHI/Topics/OfficePractices/Access/> and <http://www.ihl.org/IHI/Topics/OfficePractices/SpecialtyCareAccess/>
- KLF reports in general <http://klfmenu.med.va.gov/>*
- New & est. patient wait times http://klfmenu.med.va.gov/waittime/new_patient.asp*

*(note: some VA websites are accessed **internally**)

CAVHS Waiting Times – Provider

Executive Abstract: Data is collected from a survey of outpatients asking how long they waited to be seen after their appointment was scheduled to begin.

Rationale: Waits and delays past appointed time causes dissatisfaction of stakeholders

Resources & References: Institute for Healthcare Improvement (IHI), “Trimming Health Care’s Excess Waits and Delays” <http://www.ihl.org/IHI/Topics/OfficePractices/> and IHI home page www.ihl.org

Contact: John Elter, DMD, PhD (Durham) john.elter@va.gov

Indicator: Percent of outpatients who report waiting for a provider 20 minutes or less in the Survey of Healthcare Experiences of Patients (SHEP)

Methodology

- Data Origin: Mail out Survey of Healthcare Experiences of Patients (SHEP) for Ambulatory Care patients. In FY07 there will be monthly sampling with quarterly roll-up for ambulatory care. Once a patient has been selected for survey, he/she will not be eligible again for 12 months.

- **Sample Selection and Size:** A fixed number of patients are selected from the pool of all eligible New Primary Care, Established Primary Care, and Specialty Care patients at each site in order to ensure a sufficient representation from each of the three groups. Calculations indicated that 15 patients per group per site per month (45 total patients per site of care per month) would be sufficient in order to report stable results quarterly (135 total patients per site of care per quarter).

Scoring: Weighted Average Scoring - The purpose of this measure is to provide a population estimate of the proportion of Outpatients that waited no more than 20 minutes after their appointments were scheduled to begin. For this measure we use a weighted average. A weighted average is an average that takes into account the proportional relevance of each component, rather than treating each component equally. For the Wait Time measure, all patient sub-groups are combined using weights that reflect their varying selection probabilities at the clinic. The clinics scores are then rolled up with weighting that reflect the patient loads at each clinic.

MEDICAL RECORDS

Privacy and Confidentiality of Medical Records

We are required by law to maintain the confidentiality of patients' Protected Health Information (PHI) and such information may not be released, verbally or in writing, without a signed patient authorization except for the purpose of Treatment, Payment or Health Care Operations or when required or permitted by law. Refer to Use and Disclosure of PHI and Medical Records Policy 3.1.28 and Minimum Necessary Policy 3.1.25 in the UAMS Administrative Guide for details regarding the use and disclosure of patient information. If questions arise regarding the sharing of a patient's information, contact the UAMS Medical Center Health Information Management Department or the UAMS HIPAA Office for assistance. Also visit the UAMS HIPAA website at <http://hipaa.uams.edu>.

Delinquent Chart Fining Process

The new "Delinquent Medical Record Penalty" Policy #A 21 became effective on July 1, 2005. On this date, Health Information Management will regularly generate a list of attending physicians and/or their designee, residents, and APNs with delinquent records greater than or equal to 30 days (manual and e-signatures, dictations, etc.). Clinicians will be contacted by e-mail, phone, or both to advise them of their chart count. Delinquent medical records are fined at \$100 per medical record.

HIM is committed to work with you to verify all deficiencies. Please do the following to help them fulfill this commitment:

- If your delinquent list contains a chart that should not be assigned to you notify HIM within 1 week of receiving the list so they can take it off of your list.
- If you come to HIM to complete charts and cannot find a chart on your list, notify HIM so they can find the chart or denote that the chart was not available so you will not be fined that month.

You will not be able to change your chart deficiencies after the fines have been levied.

Please note that any modification by HIM to an e-signed report (ex. note was dictated under wrong account number and HIM changed to correct account number) will require a new e-signature to satisfy a legal audit trail.

Medical Records Documentation Policy

History and Physical Report

A. The history and physical examination (H & P) report must be completed within the first 24 hours of admission to inpatient services and must contain the following:

1. Chief Complaint
2. Present illness with dates or approximate dates of onset
3. Past medical history/surgical history
4. Medications
5. Allergies
6. Relevant family and social history
7. Review of systems
8. Physical examination
9. Provisional diagnosis(es) or a statement of the conclusions or impressions drawn from the H & P. Except in emergencies as determined by a physician appointee to the Medical Staff. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.
10. Plan for evaluation and treatment.

- B. When a complete H & P has been obtained within thirty days prior to an admission by a physician staff member, a legible copy may be used in the hospital's medical record. To be accepted, an interval note or history and physical update form must be completed and in the hospital's medical record that includes the reason for admission, additions to the history and subsequent changes to the physical findings.
- C. When a patient is readmitted within 30 days for the same or related problem, an interval note or the history and physical update form may be used. The interval note or form should include changes that have occurred since the previous stay and the present reason for the patient's admission.
- D. An H & P report must be on the record prior to surgery for inpatient and outpatient surgeries. If an H&P is being used that was not created on the day of surgery (can not be older than 30 days) an update must be written to the prior H&P. In cases of emergency surgery, an abbreviated physical examination and a brief description of the reason for the surgery is to be written by the physician.
- E. Dentists are responsible for the part of the patient's H & P related to specific services provided.
- F. Obstetrical records must include all prenatal information and be updated to reflect the patient's condition upon admission. For UAMS patients a copy of the Hollister prenatal form will be included in the records. For non-UAMS patients, a copy of a prenatal form from other facilities or physicians will be included in the records.
- G. For ambulatory procedures when general anesthesia is not required, an abbreviated history and physical related to the specifics of the procedure is acceptable.

Admission Documentation

- A. A provisional diagnosis or valid reason for admission must be recorded prior to treatment of patient, except in emergency cases for which the diagnosis must be recorded as soon as possible.
- B. A statement of the course of action planned for the patient while in the hospital must be recorded.
- C. There must be documentation in orders the type of admission (inpatient or observation).

Physician Orders

- A. Orders by physician must be signed and dated. First initial and last name are acceptable.
- B. The responsible physicians must authenticate all verbal orders within 48 hours.
(See hosp. Policy MS-4.01).
- C. Patients can be discharged only on the written order of the attending physician.
(See hosp. Policy MS-2). A patient who leaves against medical advice shall be discharged when it is determined in the patient's medical record that the risks and consequences of the decisions were carefully related to the patient. The patient who desires to leave the Hospital against the advice of his physician shall be encouraged to sign the statement entitled MR-31, DISCHARGE AGAINST MEDICAL ADVICE. If the patient refuses to sign the form, the refusal should be noted on the form, witnessed and placed on the patient's medical record. (Policy PS-15, *Leaving Hospital Against Medical Advice, shall be followed*).
- D. Standing orders may be formulated and specifically approved for each clinical service by the

medical staff and hospital administration. Standing orders are those affecting all patients treated in a specific medical service or all patients with a particular diagnosis or planned surgery. Standing procedures may be instituted by the nursing staff unless otherwise ordered by the physician. All standing orders shall be reviewed when initiated or revised by the Chief of Service. Standing orders approved by the hospital medical board upon initiation and yearly thereafter.

Progress Notes

- A. Progress notes should give a pertinent chronological report of the patient's course in the hospital and reflect any changes in condition and the results of treatment. Notes must be recorded, dated, and signed by the physician.

Consent

- A. A consent for operation or procedure must be completed prior to the operation except in cases where surgery is needed immediately and delay in obtaining consent would jeopardize the life, health or safety of the person affected or would result in disfigurement or impaired faculties. (*See hosp. policy L-2*).
- B. A consent must be signed by the patient, or patient representative, physician, and witness and must include the date and time of the signatures. (*See hosp. policy L-2*).
- C. A signed authorization for autopsy must be obtained from the next-of-kin and documented in the medical record before the autopsy is performed.

Surgeries/Procedure Notes

- A. Operative report must be individualized and should contain the following:
 - 1. Pre-op diagnosis
 - 2. Post-op diagnosis
 - 3. Name of operation
 - 4. Date of operation
 - 5. Names of primary surgeon and assistants
 - 6. Description of findings
 - 7. Technical procedures used
 - 8. Specimens removed
 - 9. Estimated Blood Loss
- B. An immediate handwritten post-op note must be written following surgery before physician leaves patient. Form MR7T has been developed for this purpose. The operative report is the responsibility of the surgeon and must be dictated immediately after surgery and signed by the faculty member.
- C. A procedure note for a newborn's circumcision describing technique, blood loss, complications, and anesthesia, if used, must be documented by the physician prior to the newborn's discharge.
- D. A procedure note should be written even if a procedure could not be completed.

Pre-Anesthesia Evaluation

- A. A pre-anesthesia evaluation by a physician must be documented prior to the patient's transfer to the operating area and before pre-op medication has been administered, except in extreme emergency cases. It should include the following:
 - 1. Type of anesthesia
 - 2. Patient's previous drug history
 - 3. Other anesthetic experiences
 - 4. Potential anesthetic problems
- B. The signature of the individual conducting the evaluation, and the date and time of the evaluation, must be included.

Anesthesia Report

- A. The anesthesia report should represent the recording of all events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration for all anesthetic agents, other drugs, intravenous fluids and blood or blood fractions.
- B. The anesthesia report must be co-signed by a physician if completed by a CRNA.

Post-Anesthesia Evaluations

- A post-anesthesia note should be recorded by a physician and should include at least the following:
 - 1. Presence or absence of anesthesia-related complications
 - 2. Date and time of the visit
 - 3. Signature

Consultation

Each consultation report should contain evidence of a review of the medical record, the consultant's opinion, and recommendation. This report should be signed by the consultant.

Discharge Summary

- A. A discharge summary must be completed on each patient hospitalized. It should recapitulate the significant findings and events of the patient's hospitalization and should include the following:
 - 1. Reason for admission
 - 2. Principal diagnosis
 - 3. Additional diagnosis
 - 4. Significant findings (pertinent x-ray, lab, physical findings)
 - 5. Operations and/or procedures performed, including dates
 - 6. Treatment rendered
 - 7. Condition of the patient on discharge
 - 8. Instructions to the patient and/or family where pertinent, wound care, including reference to physical activity, diet, and follow-up.
 - 9. Discharge medications.
- B. The final diagnosis in the discharge summary must contain no abbreviations or symbols.
- C. In the event of death, the date, time and cause of death should be stated in the discharge summary and death note.
- D. A dictated discharge summary is required in obstetrical cases which involve the following:

1. Patients with complications (endometriosis, fever, pre-eclampsia and stillborn)
 2. Patients delivering by cesarean section
 3. Patients not delivered with length of stay over two days
 4. Patients delivered with length of stay over four days
- E. If a discharge summary is completed prior to patient discharge, an addendum is necessary to document any significant events or treatment associated with the patient during the remainder of the stay.
- F. May be handwritten if patient is admitted less than 48 hours. Dictated summaries are required on all admissions more than 48 hours (excluding uncomplicated OB & Newborn) and all deaths.

Autopsy Report

- A. When an autopsy report is performed, provisional diagnoses must be recorded in the medical record within 72 hours.
- B. The complete protocol must be a part of the record within 60 days.

Completion of Records

- A. A medical record cannot be permanently archived until it is completed by the responsible physician(s) or is ordered filed by the Patient Care Issues Committee.
- B. A medical record is considered complete when the required contents are assembled and authenticated, all final diagnoses and complications are recorded, the discharge summary is incorporated into the record and all dictated reports have been transcribed and inserted into the record.
- C. While appointees to the Medical Staff share the responsibility for ongoing preparation of medical records, the final obligation for completion of the record rests with the responsible physician. "Responsible physician" is defined as a member of the Active or Courtesy Medical Staff and does not include any resident or intern of UAMS Medical Center regardless of any other title by which he is designated. The patient's medical record should be complete at the time of discharge including the signed, completed code sheet, outpatient day surgery, history and physical, progress notes and orders. The first physician order or initial progress note must be signed with first initial, last name, and title. All other physician orders may be initialed.
- D. Records of discharged patients must be completed within 30 days following discharge, to include the signature of the attending physician on the following:
1. Discharge Summary
 2. Operative Note (if indicated)

Outpatient medical records must also be completed within 30 days following visit or treatment. The operative report is considered delinquent if it is not completed within 24 hours.

Any medical record incomplete after 30 days shall be considered delinquent.

Medical Records Department (Health Information Management) shall notify departments weekly of the medical records that are incomplete.

The Director of Medical Records shall have the authority to resolve minor issues that may arise in the administration of record completion system. Any issues not resolved to a physician's satisfaction by the Medical Records Department shall be reviewed by the Hospital Medical Board in consultation with respective medical department chairman.

- E. The original medical record may not be removed from the Hospital except in the custody of the Director of Medical Records or his/her designee upon a court order or subpoena. The location of a medical record must be known by the Medical Records Department at all times. The medical record shall not be removed from an inpatient unit until after discharge except by Medical Records personnel.

Outpatient/Emergency Records

- A. A medical record must be maintained for every patient receiving outpatient or emergency services. These records must be completed under the same guidelines as those for inpatients, but no discharge summary is required. Discharge instructions should be addressed.
- B. Outpatient surgery records must contain an H & P with the same timeframe requirements as an inpatient record. Outpatient records for diagnostic services or outpatient therapy do not require H & P information.
- C. Records from Short Stay Unit must be completed under the same guidelines as those for outpatient records. If the patient is admitted, the record is incorporated into the inpatient record, and the inpatient record guidelines must be followed.

General Requirements

- A. The format and contents of the medical record must be standard for hospital-wide use. The design of the form used in the medical record must be standardized and approved by the Patient Care Issues.
- B. Information obtained by request from outside sources shall not be scanned as part of the patient's medical record.
- C. In the interest of maintaining legibility after microfilming of medical records, black ink should be used for documentation whenever possible.
- D. Errors should be corrected by drawing a single line through the incorrect data, labeling it as error and noting the date corrected and author's initials beside the entry.
- E. Written authorization by the patient or patient's legal representative is required to release medical information to persons not otherwise authorized to receive this information. Medical information can be used within accepted release of information standards for automated data processing, activities concerned with the monitoring and evaluation of the quality and appropriateness of patient care, for departmental review of work performance, for official surveys for hospital compliance with accreditation, regulatory, and licensing standards, and for educational purposes and research programs. (See UAMS *Administrative Guide 3.1.28 Use and Disclosure of PHI and Medical Records Policy*. Refer to UAMS *Administrative Guide Policy 3.1.27 HIPAA Research Policy* for specific requirements regarding the use and disclosure of Protected Health Information for research purposes).
- F. Medical records are the property of the hospital and cannot be removed from the hospital except in accordance with a court order, subpoena, or statute.
- G. In case of readmission of a patient, all previous records will be available for the use of the attending staff member upon request.

- H. The legend of unapproved abbreviations is available for review on the UAMS intranet website.
- I. All dictated reports include the date of dictation and the date of transcription.
- J. If an attending physician is permanently unavailable for completion of medical records, the medical record can be forwarded to an attending physician only in cases where another attending physician/faculty member was directly involved in the care of the patient. If another attending is not directly involved, then the record should be forwarded to the Department Chair.

If a resident physician is permanently unavailable to complete medical records, the record will be forwarded to the responsible Attending Physician for completion, if he/she was actively involved in the incomplete portion of the record; i.e., operative report or discharge summary, or verbal orders.

In case of an incomplete medical record where the physician is permanently unavailable and there is not appropriate physician to complete the documentation, the medical record will be forwarded to the Patient Care Issues Committee for administrative closure of the record. Documentation on the Face Sheet will indicate that the record was administratively closed and filed incomplete as approved by the Patient Care Issues.

Permanently unavailable is defined as: 1) In case of physician relocation, two attempts by the Medical Record Information Department by certified letter requesting documentation, 2) in case of physician death.

Health Information Management, Director 686-6263
Doctors' Dictation 686-6038

COMPLIANCE

UAMS Compliance Office

The mission of the faculty of the University of Arkansas for Medical Sciences is to provide high quality patient care, to optimize medical education and to develop new information through research which contributes to this high quality care. In addition, the UAMS Faculty Group Practice (FGP) is committed to ensuring that all of its affairs are conducted in accordance with all applicable laws.

As part of the FGP's commitment to integrity, we have adopted a compliance plan to ensure that all faculty and staff are aware of their responsibilities to the FGP and to obey the law. To administer this plan, the FGP has established the position of UAMS FGP Compliance Officer and appointed Deanna Brown to fill that position. Please speak directly with Ms. Brown if you have any questions or suggestions regarding compliance matters.

A major part of our compliance program involves education and training. From time to time, the FGP Coding and Documentation Unit will invite some of you to attend specialized compliance, billing and/or coding programs. We expect you to attend these sessions.

All physicians, administrators and managers should assume the responsibility to see that they and any employees they supervise understand the importance of our compliance program. All FGP members and staff should also be aware of the provisions of our compliance plan and of the procedures for reporting suspected improper activity. All reported incidents will be handled in a strictly confidential manner.

Reporting

FGP members and staff should conduct themselves in accordance with the laws and regulations that apply to our FGP operations. You should alert Ms. Brown and your department compliance leaders of any information you have or discover of possible wrongdoings, errors or violations of law. It is the policy of the FGP to take all reports of wrongdoing seriously. Reports of wrongdoing may be made orally, through the FGP Reporting Line, or in writing. If you are more comfortable reporting to the head of your department or anyone else in a position of responsibility, please feel free to do so. What is important is that you make the report. Violation of this policy, including failure to report observed or known instances of wrongful activity, may be grounds for sanctions ranging from disciplinary action to termination. (See UAMS *Administrative Guide 15.1.2 UAMS Reporting Policy, included in appendix A*).

The FGP Compliance Office has established a telephone number to which reports can be made. While reports in person help to avoid misunderstandings, anyone who feels he or she is unable to make a specific report in person may call the UAMS Compliance reporting line. The **compliance reporting telephone number is 1-888-511-3969**. Any questions or comments regarding compliance may be directed to Ms. Brown at 501-614-2182 or UAMS Mail Slot #829.

Preamble

The mission of the faculty of the University of Arkansas for Medical Sciences is to provide high quality patient care, to optimize medical education, and to develop new information through research which contributes to this high quality care. In addition, the UAMS College of Medicine (COM) Faculty Group Practice (FGP) is committed to ensuring that all of its affairs are conducted in accordance with all applicable laws. To enhance its efforts to better assist all UAMS employees and physicians in achieving this goal, the UAMS COM Faculty Group Practice Compliance Plan has been developed. The Plan shall include the provisions listed and summarized on the following pages.

Policy Statement

It is the policy of the UAMS COM Faculty Group Practice that only eligible professional services shall be billed to third party payers and patients; that all billings to patients and third party payers shall accurately reflect the services provided; and that all professional service provided for patient shall be properly documented.

To guide physicians, other health professionals and designated billing personnel, the UAMS FGP Compliance Officer shall, with the assistance of legal counsel, annually review existing billing policies and procedures, revise those policies and procedures necessary, and develop any additional procedures and policies that are deemed advisable to maintain compliance with applicable laws and regulations. All UAMS COM FGP policies concerning billing and documentation shall be considered an integral part of this plan. (See UAMS *Administrative Guide 15.1.3 UAMS Federal False Claim Act, included in appendix B*).

Administrative Responsibility

Primary responsibility for implementing and managing the FGP compliance effort shall be assigned to the UAMS FGP Compliance Officer. The FGP Compliance Officer will report to the UAMS Vice Chancellor for Institutional Compliance. The FGP Compliance Officer will, with the oversight of the Dean and the assistance of University counsel where appropriate, perform the following activities:

1. Assist in the review, revision, and formulation of appropriate policies to guide billing of professional fees by organizations that bill for services provided by UAMS medical faculty;
2. Work with departments and faculty to develop plans for implementing UAMS policies on billing;
3. Assist in developing and delivering educational and training programs;
4. Work with departments and faculty to develop and enhance billing expertise and to facilitate department-based training programs;
5. Coordinate reviews of medical records and associated billings; and
6. Provide other assistance as directed by the Dean or the Dean's designee.

To foster and enhance compliance with all regulatory requirements applicable to the COM FGP, the FGP Compliance Officer will work with and provide regular updates to the Dean of the College of Medicine and the Executive Associate Dean for Clinical Affairs.

Compliance Oversight

The FGP Compliance Oversight Committee shall consist of members from the Dean's office and faculty and staff from the clinical departments and service offices of the FGP. Ex-officio members shall include a representative from the Office of the General Counsel.

The UAMS FGP Compliance Officer will chair the FGP Compliance Oversight Committee meetings. The FGP Compliance Oversight Committee shall support and assist the FGP Compliance Officer with the following duties:

1. Ensure FGP billing affairs are conducted in accordance with applicable law;
2. Develop standards and policies that will guide the FGP in professional fee billing;
3. Review, revise, and approve clinical departmental compliance plans;
4. Review, revise, and approve training and educational programs for physicians and staff;

5. Develop a confidential disclosure program and review inquiry responses provided by the FGP Compliance Officer;
6. Oversee the internal chart audit process to assess compliance and identify deficient areas;
7. Develop standardized corrective action plans; and
8. Review, revise, and approve an annual report prepared by the FGP Compliance Officer that describes the general compliance efforts and offers specific actions to improve compliance.

The FGP Compliance Oversight Committee shall provide direction and oversight to the FGP Compliance Office and shall represent the Faculty Group Practice in addressing policies and procedures related to FGP Compliance, including any necessary corrective action plans and procedures.

The FGP Compliance Oversight Committee shall meet at least quarterly.

Policy Guidelines

The policy of the UAMS COM FGP is to bill only for professional services actually provided. UAMS recognizes that special billing requirements may apply to certain government-sponsored programs or to other providers and that any such requirement must be followed. In selecting codes to describe service rendered, UAMS physicians, other health care professionals, and billing personnel are to select codes that they believe, in good faith, correspond to services actually provided as documented in the medical record. UAMS physicians, other health professionals, and billing personnel have a collective responsibility to be knowledgeable about the meaning of the codes applicable to their areas of practice including relevant directives from billing authorities.

UAMS physicians, other health care professionals, and billing personnel shall ensure that all charges submitted contain accurate information concerning the service provided, the charge code, the identity of the provider, the date of service, and the identity of the patient.

When in doubt about how to bill a particular service, including the proper code to use, no charge shall be submitted until appropriate guidance is obtained from the departmental compliance leaders and/or from the FGP Compliance Officer. The resolution of any such billing questions shall be documented in writing.

It is the responsibility of the billing physician or other health professional to ensure that appropriate documentation supports the charge being submitted.

To guide physicians, other health professionals, and billing personnel in meeting these objectives, the FGP Compliance Officer shall, with the assistance of legal counsel, review existing policy statements, revise those statements as necessary, and develop any additional statements that seem advisable. UAMS COM FGP policies concerning billing and any periodic changes to those policies shall be considered an integral part of this Plan.

In accordance with UAMS COM FGP policy, the teaching physician ***must be physically present and personally involved***, as outlined in the Medicare Final Rule for Teaching Physicians, in the delivery of patient care services billed under his/her name. Patient care and related treatment services must be clearly documented in the medical record by the teaching physician. If the teaching physician cannot meet the physical presence and personal involvement requirements as outlined in the Medicare Final Rule for Teaching Physicians, no bill should be submitted.

The signing of Final Rule Attestation statements will be required of all UAMS physicians, other health professionals, and all other UAMS employees involved in coding, charge submission, billing, or collection processes.

Departmental Implementation Plan

Each clinical department chair shall appoint a faculty member and an administrator to serve as the compliance leaders for the departmental billing activities. The department compliance leaders will coordinate departmental compliance activities with the FGP Compliance Officer. There shall be regular contact with the compliance leaders about matters of common interest.

Each clinical department must prepare a plan to address compliance efforts on a departmental basis. Larger departments may also choose to develop plans for specific divisions. Before becoming effective, such plans shall be reviewed by the FGP Compliance Officer to ensure consistency with overall policies. If there are concerns about the content of any departmental plan, the FGP Compliance Officer shall consult with the Department Chair to explore whether the plan can be modified through mutual agreement. If such consultations fail to resolve the concerns, the FGP Compliance Officer may recommend that the Dean modify the department's implementation plan.

The departmental (or divisional) implementation plans shall, at a minimum, include the following features:

1. Written policies and procedures for billing activities undertaken with personnel by departmental compliance;
2. Educational and training programs to address billing issues of particular importance to the department;
3. A program for ensuring and documenting that all new department personnel, including faculty and house staff, receive training with regard to proper billing;
4. A program for routine "spot checks" of departmental billing to review the results of such reviews being reported to the department's compliance leaders and to the FGP Compliance Officer;
5. A system that tracks billing or compliance issues that have been raised within the department and the resolution of those issues; and
6. An annual review of the existing compliance plan in order to identify the need for changes and to identify specific compliance objectives during the succeeding year.

Departments or divisions shall advise the FGP Compliance Officer prior to engaging any outside billing consultants and shall provide the FGP Compliance Officer a copy of any reports prepared by such consultants.

Departments or divisions shall also immediately advise the FGP Compliance Officer if notified of a subpoena, carrier review audit, or inquiry by an outside agency on any issue relating to compliance.

Internal Review Process for Compliance Assessment

The Chart Audit and Documentation unit of the FGP Compliance Office is responsible for reviewing and auditing selected charges of all physicians and other health care professionals who submit charges through the FGP Billing Offices to ensure compliance with all federal and state regulations.

All preliminary findings shall be summarized and reported to the clinical department chair and department compliance leaders. After a thorough review and with concurrence from the department chair, the preliminary report will be finalized. The final report shall be submitted to the Dean of the College of Medicine and the FGP Compliance Oversight Committee. After appropriate parties review the findings, penalties may be assessed against a specific department and/or billing provider for deficiencies with compliance.

Any discovery of insufficient documentation shall result in the charges being reversed and any paid monies refunded to the appropriate payer.

Education and Training

The FGP Compliance Officer shall be responsible for developing and conducting systematic and on-going training and educational programs to enhance and maintain awareness of coding, billing, and documentation compliance requirements.

Educational forums shall be scheduled and conducted throughout the year. Attendance by physicians, residents and fellows, and other health professionals involved with documentation, coding, or charge submission, will be mandatory for a minimum of one FGP Compliance Office sponsored educational training session per year.

In July of each year, the attendance records for previous fiscal year's mandatory education sessions will be reviewed. The FGP Compliance Office shall report all incidents of non-attendance to the Dean of the College of Medicine and the FGP Executive Committee. Completion of an FGP Compliance Office on-line coding and documentation program will be required for all individuals not meeting the mandatory requirement of attending an FGP Compliance Office sponsored educational session for the previous fiscal year. A fine of one hundred dollars (\$100.00) per month shall be levied against the individual until the on-line training requirement is met.

Other education sessions on coding, billing, and reimbursement will also be conducted throughout the year. Attendance by COM and FGP employees involved with coding, billing, or the collection of professional charges will be mandatory for a minimum of one FGP Compliance sponsored educational training session per year. Incidents of non-attendance may be subject to disciplinary action and shall be reported to the appropriate department chair, business administrator, and the FGP Compliance Oversight Committee.

Investigating Compliance Issues and Corrective Action Plans

Whenever the FGP Compliance Officer determines that there is reasonable cause to believe that a compliance issue may exist, an inquiry into the matter will be undertaken, with assistance from the UAMS Vice Chancellor for Institutional Compliance when appropriate. The results of the inquiry will be furnished to the UAMS Vice Chancellor for Institutional Compliance. UAMS employees shall cooperate fully with any inquiries undertaken pursuant to this section of the Plan. To the extent practical and appropriate, efforts should be made to maintain the confidentiality of such inquiries and of the information gathered.

Whenever a compliance issue has been identified through monitoring, reporting, investigations or otherwise, the FGP Compliance Officer, in consultation with the UAMS Vice Chancellor for Institutional Compliance and the Dean of the College of Medicine, shall take or direct appropriate action to address that issue. The corrective action will be set forth in writing. There shall also be consultation, when appropriate, with the Dean of the College of Medicine and relevant clinical and billing personnel.

Corrective action plans shall be designed to ensure not only that the specific issue is addressed, but also that similar problems do not occur in other areas or departments. Corrective action plans may require that billing be handled in a designated way, that billing responsibility be reassigned, that certain training take place, that restrictions be imposed on billing by particular departments, divisions, physicians, or other health professionals, that repayment be made, that penalties be assessed, or that the matter be disclosed externally.

If it appears that certain departments, divisions, or individuals have exhibited a propensity to engage in practices that raise compliance concerns, the corrective action plan shall identify actions that will be taken to prevent such departments, divisions, or individuals from exercising substantial discretion with regard to billing.

A corrective action plan may recommend that the Dean of the College of Medicine impose a sanction or disciplinary action. Moreover, if the FGP Compliance Officer determines that any non-compliance has been willful, the Dean of the College of Medicine shall be informed of the finding. UAMS employees who have engaged in willful misconduct will be subject to disciplinary action in accordance with UAMS process, including termination.

Confidential Disclosure Program

Any UAMS employee may report to the UAMS Compliance Reporting Line, 1-888-511-3969, any activity that may be believed to be inconsistent with University policies or legal requirements regarding any aspect of physician billing practices. If it is deemed by the FGP Compliance Officer that sufficient information has been provided, the FGP Compliance Officer shall notify the UAMS Vice Chancellor for Institutional Compliance of the reported incident. The FGP Compliance Officer shall then investigate the incident and report the findings to the UAMS Vice Chancellor for Institutional Compliance, the Dean of the College of Medicine, and the Office of General Counsel. The FGP Compliance Officer shall then prepare a written report of the findings and identify any corrective action or recommendations that must be undertaken. UAMS employees who report possible compliance issues in good faith shall not be subjected to retaliation or harassment as a result of their report.

Reporting and Evaluation Process

This Plan is intended to be flexible and readily adaptable to changes with regulatory requirements. The Plan may be changed, as recommended by the Compliance Oversight Committee and approved by the FGP Executive Committee, as experience indicates a certain approach is ineffective or a better alternative is recommended. The FGP Compliance Officer shall prepare an annual report for the FGP Executive Committee describing the compliance efforts that have been undertaken during the preceding year along with any changes that may be needed to improve compliance. A FGP Assembly presentation shall be made at least annually to physician members of the UAMS COM Faculty Group Practice.

RISK MANAGEMENT

Medical Professional Liability Insurance

Medical Professional Liability Insurance (malpractice insurance) is provided to all FGP faculty members and house staff who are involved in the clinical care of patients. In addition, a department may elect to provide coverage for other health care providers who are part of the COM, who are involved in the clinical care of patients, and who bill independently for the care provided.

Coverage Information

At the beginning of each policy period (July of each year), the FGP Risk Management Department sends each department a Certificate of Insurance on each insured faculty member of the department. At the same time, a Certificate of Insurance on each resident is sent to the House staff Office.

Coverage is provided to the insured on a 24-hour per day, 365 days per year, worldwide basis for UAMS activities only. If a question arises as to whether or not a particular activity is covered, inquiry should be directed to the FGP Risk Management Department at 614-2082.

Moonlighting activities are not covered under the policy. Any physician engaged in moonlighting activities should obtain their own individual insurance policy to cover the moonlighting activities. There are several companies that write malpractice insurance coverage in the State of Arkansas. The FGP Risk Management Department will be happy to help you contact one or more of these insurers if you so desire.

While the coverage is written on a “claims-made” basis, the protection afforded to the individual insureds under the program allows them to leave employment and yet enjoy protection for the period of time for which they were UAMS employed.

Claims or suits may be settled out-of-court but only with the insured’s consent or, upon rare occasion, as directed by the FGP Malpractice and Claims Committee.

Reporting Procedures:

Insured’s are encouraged to communicate concerns about troublesome incidents to the FGP Risk Manager. If an incident occurs and you have a question about whether or not a malpractice claim may result, please report the incident to the FGP Risk Manager.

Information you should have available include the patient name, medical record number, date of birth, name of health care providers involved, and a summary of the event in question.

If an incident occurs, even if you are not directly involved but feel it may give rise to a malpractice claim or suit, REPORT IT. In the event you receive a subpoena or a Summons and Complaint, you must contact the FGP Risk Manager immediately.

FGP Risk Management Department 614-2082

Consent Issues

There are four elements of an informed consent to a medical treatment or intervention. These four elements are: competence, disclosure of information, comprehension, and voluntariness.

Competence requires the ability for an individual to make decisions intelligently and reasonably. The proposed treatment, the risks and benefits involved, the alternatives to the proposed treatment, and any explanations required need to be understood by the patient. A legally authorized representative of the patient may act on the patient's behalf if the individual patient is incapable of making reasonable decisions. Examples of incapable patients include patients who are minors, the mentally disabled, patients who are comatose, patients under the influence of drugs or alcohol, and patients who are disoriented as to time, place, or person.

Disclosure of information concerns the knowledge an individual needs to make an intelligent, reasonable decision. This includes not only the risks and benefits of the recommended treatment, but also alternative treatments and the risks of these alternative treatments. While no one can provide an exhaustive list of risks, effort should be made to be as inclusive as possible. In addition to the risks and benefits of the treatment, the patient should be provided with information regarding who will be performing the procedure or surgery. This information should include the name of the responsible faculty member as well as the name of any resident who will be performing any key portion of the procedure.

Comprehension is the ability of the patient to understand the explanations so that he or she can make an intelligent decision. Different from competency, comprehension focuses on the understanding of the knowledge received as information. Patients often cannot understand scientific and medical terminology so consent discussions and documentation should be in a language patients can understand.

Voluntariness means without any coercion or force from others. If the patient has received sufficient information and has comprehended the information, he or she should be comfortable in making the decision. Remember that patient's families, religious beliefs, moral standards, and economic and environmental constraints influence their decisions. The choice the patient makes should be his or her own and respected by the medical staff without regard to personal feeling of the medical staff.

General Considerations:

As a general rule, physicians understand the necessity of obtaining written consent from the patient prior to performing certain treatments or procedures. There are some key points that should be remembered:

- Many health professionals will admit that hospitals are intimidating institutions. Individuals (patients) are taken out of their daily routines and placed in an alien environment. After some diagnostic or surgical procedure, they are left dependent upon others for even the simplest functions. Rather than appear ungrateful and incur the wrath of the overworked nurse, intern, resident, or physician, the patient may remain silent and withhold questions or expressions of fear. For this reason, the voluntary nature of the consent they give may be compromised and effort should be taken to obtain the most informed consent possible.
- Consent given by the patient or one authorized to act on behalf of the patient is a privilege granted by the patient or one authorized to act on behalf of the patient. If the privilege granted includes limitations, and if the physician agrees to the limitations, then the limitations should be honored and the privilege granted by the patient should not be exceeded except in rare and emergent situations.
- If consent obtained while the patient is lucid is valid, then the withdrawal of consent or the refusal of consent from a lucid patient should also be regarded as valid and respected.

- Once the patient objects, the treatment or procedure becomes an assault or trespass upon the body of the patient. A physician has no more right to unnecessarily or rudely touch a patient than does a layman. If the treatment or procedure has been initiated before the patient objects and withdraws consent, said treatment or procedure should be terminated at the earliest possible time and in such a manner as to prevent harm or injury to the patient. (For example, if an invasive procedure has been initiated, the procedure should be aborted and the incision side closed, appropriate post-op treatment and instructions given, etc. If the treatment includes medications that should not be discontinued precipitously, then such information should be provided to the patient and instructions given for safe discontinuation of the medications.) In each instance, the physician should provide the patient with information concerning the risks, potential complications, and other necessary information about the refusal of the recommended treatment.
- Whether a physician or nurse regrets a patient's decision to decline treatment or withdraw consent to further care, the patient retains the prerogative. A health care provider cannot substitute personal judgment for that of a competent patient nor justifiably twist the criteria for capacity to consent in order to declare a patient incapable.

Any questions or concerns regarding risk management issues should be directed to the FGP Risk Management Department by calling 614-2082.

Patient Discount Policy

Purpose: To comply with the Health Insurance Portability and Accountability Act, the Anti-Kickback Statute and all applicable federal statutes and regulations.

Policy: All patients shall be charged for services provided by the physicians in the Medical College Physicians Group and the UAMS Medical Center.

Discounting takes many forms. These include, discount to insurance, waiver of co-payments, reduced charges, professional courtesy and no charge. Professional courtesy normally refers to a discount for a physician and the physician's dependents but takes the form of either a discount to insurance, waiver of co-pay, a reduced charge, or a no charge.

Courtesy discounts, regardless of the method, are prohibited.

Reduced charges, discount to insurance, waiver of co-payment and/or deductible are authorized only under the following circumstances:

- a) demonstrated financial hardship approved by using MCPG and PBS established guidelines,
- b) where MCPG and PBS cost analysis indicates collection is not cost effective, or
- c) risk management considerations after consultation with MCPG and Hospital Risk Managers, Hospital Administration and the Executive Associate Dean for Clinical Affairs.

No charge discount is where no charge is made to both the insurer and the patient for services or items rendered, in essence, the rendering of free care. A no charge discount is authorized only upon the following circumstances:

- a) demonstrated financial hardship approved by using MCPG and PBS established guidelines,
- b) where MCPG and PBS cost analysis indicates collection is not cost effective,
- c) risk management considerations as stated above, or
- d) for substantial donors to the University and its programs but only after requesting physician has consulted and received approval from the Department Chair, the Dean of the College of Medicine, the Chief Executive Officer for UAMS Medical Center and the office of the General Counsel.

Financial Hardship Guidelines

To be eligible for financial hardship a patient must have established a bona fide domicile in Arkansas and must have resided continuously in this state in that bona fide domiciliary status for at least six consecutive months. A bona fide domicile is a home of apparent true, fixed, and permanent nature, a place of actual residing for all purposes of living that may be distinguished from a temporary sojourn in this state. The person claiming domicile in Arkansas must provide evidence of permanent connection with the State of Arkansas and demonstrate the expectation of remaining in this state.

In addition to proof of Arkansas residency, all patients must:

- a) submit insurance information, pay for services or apply for the financial hardship exception,
- b) submit standard financial information,
- c) submit proof that an application for Arkansas Medicaid must be made, and
- d) complete the application for financial hardship within 30 days of first statement.

Other Financial Hardship Guidelines

- a) the financial hardship exception will only apply to PBS & MCPG bills at time of approval,
- b) individuals who present adequate proof of currently owed guarantor responsibility medical debt from any source in excess of 25% of their gross annual income will be evaluated under the UAMS Medically Indigent Discount Scale,
- c) individuals who owe less than 25% of their gross annual income in guarantor responsibility medical debt from any source will be evaluated under the UAMS Financially Indigent Discount Scale,
- d) payment of the facility fees and inpatient co-pays are required of ALL patients,
- e) only those services determined as medically necessary by the physician and properly processed through appropriate UAMS review protocols will be considered under the financial hardship exception, and
- f) dental care, cosmetic surgery, eyeglasses, prescriptions (patients may qualify for the Medication Assistance Program) or other elective surgeries/procedures are not considered as part of the financial hardship exception.

Volunteer Activities

The FGP recognizes that faculty members are obligated to devote their working time and effort to University activities but also recognizes that a limited amount of “outside activities” may be advantageous to both the individual employee and the University. “Outside activities” are defined as any services performed at facilities or sites other than UAMS owned facilities, Arkansas Children’s hospital, or the Veteran’s hospital. “UAMS Approved Activities” are defined as any activity not directly related to the individual practitioner’s employment responsibilities but are activities that individual FGP members, the Department Chairperson, and the Dean of the College of Medicine feel will contribute to the individual physician’s professional advancement or correlate usefully with their primary responsibilities at UAMS.

Obviously, there are some policies that provide guidance and requirements regarding outside employment that must be met including the Faculty Handbook as well as the FGP Bylaws. In addition, the UAMS FGP Principles and Rules of Operation addresses income that may or may not be retained by the faculty member and the faculty member should review these various requirements.

In the event an FGP faculty member would like to engage in outside or volunteer activities, the following process should be followed:

1. The individual desiring to perform outside activity should submit a request for such activity to the Department Chairperson.

2. The Department Chairperson shall determine if the activity will or will not be considered a “UAMS Approved Activity”.
3. If the Department Chairperson does not approve the activity, the Department Chairperson will indicate on the form that the activity is not a “UAMS Approved Activity” and return the form to the individual submitting the request.
4. If the activity is to be considered a “UAMS Approved Activity”, the Department Chairperson shall indicate their approval for the activity to be designated as a “UAMS Approved Activity” and submit the request with their approval to the Dean of the College of Medicine.
5. Upon receiving the form with the Department Chairperson’s approval noted, the Dean shall review the request and note their decision regarding the outside activity. If the activity is not approved by the Dean, the appropriate box will be checked and the form returned to the Department Chairperson and, in turn, to the individual who submitted the request.
6. If both the Department Chairperson and the Dean of the College of Medicine authorize the activity as a “UAMS Approved Activity” then the request with appropriate approvals will be sent to the FGP Risk Management Department as notification that the activity has been approved and malpractice coverage should apply to the activity.
7. Upon receipt of the completed form with the approvals from the Department Chairperson and the Dean of the College of Medicine, the FGP Risk Manager will notify the Department Chairperson and the individual submitting the request that the activity has been approved and that the malpractice coverage provided through the FGP will apply to the outside activity.
8. In the event there is a malpractice coverage issue with the activity, the FGP Risk Manager will notify the Dean of the College of Medicine, the Department Chairperson, and the individual submitting the request of the issue.

If the activity is approved as a “UAMS Approved Activity” then the malpractice coverage that applies to the faculty member’s UAMS duties will also apply to the outside activity. If the activity is not approved as a “UAMS Approved Activity”, but the faculty member receives approval to engage in the outside activity, the malpractice coverage will not apply and the faculty member would be wise to obtain other coverage to protect themselves for the activity in which they plan to engage.

QUALITY MANAGEMENT

Survival Guide for Continuous Survey Readiness

What has UAMS Medical Center done to improve our culture of Safety?

- An annual employee survey is conducted relating to patient safety.
- An online event reporting system, Patient Safety Net, is available to all staff.
- A multidisciplinary Patient Safety Advisory Team was created in 2003.
- An Associate Hospital Medical Director is assigned as our Patient Safety Officer.

What abbreviations are included in the “Do Not Use” list?

U– Use “units”

IU– Use International units

QD, qd– Use “daily”

QOD, qod– Use every other day

Trailing “0”– Use 5 NOT 5.0

Leading decimal– Use 0.5 NOT .5

µg– Use mcg or microgram

MS– morphine

MSO₄– morphine (sulfate)

MgSO₄– magnesium sulfate

AU, AD, AS– both, right, left, ear

Investigational drug nicknames– Use generic or commercial names

How do we ensure that surgery and procedures are performed correctly?

We follow the Universal Protocol which includes:

- Verifying patient information including consent.
- Marking the site as needed.
- Observing a “Time out” immediately prior to the initial action of the procedure.
- “Time Out” is documented for checking for the correct patient, procedure, site, position, implants and equipment.

What can I do to promote the control of infections?

- Scrub hands with soap and water for at least 15 seconds when soiled.
- Use alcohol-based cleaners after each patient contact.
- Follow protective apparel requirements, then dispose of properly when leaving the room.
- Clean hands before gloving and after removing gloves.
- Do not wear artificial nails.
- Stay home when sick.
- Complete TB screening annually.
- Consider flu vaccine when offered.

What method do we use at UAMS for performance improvement?

- Plan– identify and plan a change.
- Do– pilot the change.
- Check– monitor the effectiveness.
- Act– make the change become a part of every day practice or revise it if not effective.

How do we report Medication Errors or Adverse Drug Reactions (ADR) at UAMS?

- Document basic information in chart
- Complete a Patient Safety Net report

How do all clinical disciplines communicate the plan of care for the patient?

- The UAMS Interdisciplinary Plan of Care (IPOC) consists in part of the H&P, Progress Notes by all disciplines, Orders, Nursing documentation;
- This is supplemented by e-chart physician rounds summary and nursing care summary sheets;
- Patients with stays greater than 4 days will be discussed in IPOC formal meetings to expedite care and discharge.

How does UAMS monitor quality and handle serious/sentinel events?

- Medical Staff and administrative committees monitor and analyze quality measures such as The Joint Commission (TJC), Center for Medicare/Medicaid Services (CMS), Core Measures for AMI, CHF and Pneumonia (see page 44), the use of approved guidelines and patient length of stay.
- Events reported on Patient Safety Net are tracked and trended quarterly.
- Serious or sentinel events are followed up by a Root-cause Analysis (RCA) to identify the causes leading to that event and an action plan is developed to prevent future occurrences.
- A sentinel event is defined as an occurrence that has resulted in unanticipated death, psychological injury or major permanent loss of function not related to the course of the patient's illness or underlying condition. Guidelines for disclosure to the patient or family are available.
- Sentinel Event Alerts received from TJC have included: prevention of OR fires, safe use of patient controlled analgesic (PCA) pumps, and prevention of adverse events caused by emergency power system failures.
- Failure Mode Effect Analysis (FMEA) is used to proactively identify risks in a process and actions are taken to prevent the failures identified. These are conducted with a multidisciplinary team actively involved in that process. Examples of FMEAs done at UAMS are preventing infant abduction, patient identification, and the medication process in the outpatient chemotherapy clinic.

How do we handle medications patients bring from home when admitted?

- Medications brought with patients are sent to Pharmacy for identification and storage.
- Patients may not self-medicate or take their own medications except in unusual circumstances approved through pharmacy.

What is my role in Patient Safety at UAMS?

Know and practice the Patient Safety Goals:

1. Ensure I have the right patient by checking the two identifiers:
 - Name
 - Birth date
2. Promote effective communication by listening carefully, writing down, and then confirming by reading back critical value test results and by requesting a read back of any verbal or telephone orders given.
NOTE– Telephone orders require the physician 4-digit ID number for validation.
3. Avoid using the “Do Not Use” abbreviations.
4. Follow the CDC hand hygiene guidelines.
5. Improve the safety of using medications by being alert to sound-alike, look-alike drugs (SALAD).
6. Work to accurately and completely reconcile medications across the continuum of care, including home meds on admission, medications at transfer and discharge teaching of all medications.
7. Assess and take actions to prevent harm from patient falls.
8. Participate in a standardized, interactive exchange of patient information when handing off the care of a patient to another caregiver.
9. Assure that patients being treated for emotional or behavioral disorders are screened for risk of self-harm.
10. Encourage patients to be actively involved in their own care, including reporting their concerns about safety.

How can I assure that my patient’s rights are maintained?

- Knock on patient doors before entering.
- Use privacy curtains when needed.
- Do not discuss patients in public areas.
- Use care with patient information with fax machines, computers or papers.
- Protect your personal passwords for patient information systems.
- Do not leave patient records unattended.
- Do not remove patient records from the hospital.

What are the rules for using physical restraints?

- Restraints for cognitive impairments related to the patient’s condition, such as confusion and disorientation, to avoid the patient pulling out lines or tubes are called Medical/Surgical restraints. These require a physician order for the initial application and then a renewal order every 24 hours. A progress note must be written daily outlining the continued need for the restraints.
- Restraints for behavioral intervention of violent, aggressive behavior, not specific to the patient’s treatment, require an immediate physician assessment and order, within one hour of the application, and a face-to-face reassessment and renewal order every eight hours.
- Alternative methods should be tried prior to the use of any restraints, whenever possible, and they are to be discontinued at the earliest opportunity based on the patient’s condition.

How can I contact the UAMS Ethics Committee? Call the Ethics Consultation Service at: 405-8134

Quality Management Department 296-1325

Clinical Guideline Reminders

Acute Myocardial Infarction

- Aspirin at Arrival
- Aspirin Prescribed at Discharge
- ACEI or ARB for Left Ventricular Systolic Dysfunction
- Adult Smoking Cessation Advice/Counseling
- Beta Blocker Prescribed at Discharge
- Beta Blocker at Arrival
- Thrombolytic Agent Received Within 30 Minutes of Hospital Arrival
- PCI Received Within 90 Minutes of Hospital Arrival
- Document Any Contraindications to ASA, Beta Blockers, ACEI and ARB

Congestive Heart Failure

- Discharge Instructions
- Diet, Activity, Follow-Up, Weight Monitoring, Symptoms Worsening, Medications
- LVEF Assessment
- ACEI or ARB for LVSD
- Adult Smoking Cessation Advice/Counseling
- Document Any Contraindications to ACEI or ARB
- Document LVEF Assessment, i.e. Moderate, Severe or EF<40%
- Document Discharge Medications on Chart – must agree with discharge summary

Surgical Infection Prevention

- Administration of a prophylactic antibiotic within one hour prior to incision (must include the route)
- Use of an antimicrobial consistent with current recommendations for that procedure
- Discontinuation of the prophylactic antibiotic within 24 hours of surgery end time (48 hours for CABG procedures)
- Glucose control in cardiac surgery patients post-operatively
- Proper hair removal (avoid the use of razors)
- Normothermia in colorectal surgery patients
- Perioperatively administer a beta blocker to patients on beta blockers before surgery and those at cardiac risk
- Venous thromboembolism prophylaxis to those patients at risk
- Use of ventilator bundle for ventilated patients:
 - Head of bed elevated at least 30 degrees
 - Rapid weaning protocol (sedation vacations and assessments to extubate)
 - Peptic ulcer disease prophylaxis

Pneumonia

- Oxygenation assessment (pulse Ox or ABGs)
- Blood cultures performed prior to initial antibiotic for ED admissions
- Initial antibiotic received within 4 hrs. of hospital arrival
- Pneumococcal vaccination for patients over 65 years old, unless contraindicated
- Adult smoking cessation advice/counseling
- Influenza vaccination* for patients over 50 years old, unless contraindicated
- *Influenza vaccination is from October-February
-

DISCLOSURE STANDARDS

Errors, unplanned or unwelcome outcomes happen in hospitals. With the heightened awareness toward patient safety, hospital environments are changing to ones that encourage error identification along with remedial steps to reduce the likelihood of future occurring errors while minimizing individual blame. Patient safety encourages effective communication with the patient and/or the patient's family about the results of care, including the unplanned or unwelcome outcomes. These are new standards set forth by TJC.

<http://www.jacaho.org/about+us/index.htm>

TJC is a volunteer organization involved in the accreditation process of healthcare organizations. TJC's accreditation process is fundamentally a risk reduction activity. This derives from the thesis that organizational compliance with safety and quality-related health care standards reduces the likelihood of adverse outcomes and increases the likelihood on achieving positive patient care outcomes. TJC undertook an intensive five-year review of sentinel events that have occurred in accredited organizations and determined that a more intensive focus on patient safety in health care organizations was needed.

Developments at the national level, coupled with TJC's own experience in addressing sentinel events have now led to new standards and revisions in existing standards that address patient safety and medical/health care error reduction.

Along with the focus of preventing errors comes the new Patient Rights standard (R.I.1.2.2) which this module is focused. TJC and the National Patient Safety Foundation believe that patients are entitled to information on outcomes and that the disclosure of this information is part of the communication process that forms the context for the caregiver-patient relationship.

The standard set forth by TJC which this module is focused states:

Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes.

The accompanying intent provision (R.I. 1.2.2) indicates that:

The responsible licensed independent practitioner or his or her designee clearly explain the outcome of any treatments or procedures to the patient, and when appropriate the family, whenever those outcomes differ significantly from the anticipated outcomes.

As a result, each healthcare institution is to develop an organizational policy for communicating unanticipated outcome information to patients and family members. UAMS Medical Center has developed a Disclosure Guidelines brochure made available to all UAMS physicians and nurses. (For a copy of the Disclosure Guideline brochure, contact Hospital Risk Management, 603-1150.)

GRIEVANCE PROCEDURE

Purpose

It is a declared objective of the College of Medicine that an individual faculty member may have prompt resolution of his/her personal grievance(s) and that this is accomplished under orderly procedures. This policy replaces the “Academic Employee Grievance Procedure” which appears in the UAMS Faculty Handbook, section G-3, and shall be used for College of Medicine faculty, as defined below.

The grievance process shall not be used to question a rule, procedure, or policy established by an authorized faculty or administrative body. It shall be used as due process by a faculty member who believes that a rule, procedure, or policy has not been followed or has been applied in an inequitable manner.

Definitions

Faculty: For purposes of this policy, “faculty” includes those holding the rank of Instructor, Assistant Professor, Associate Professor, Professor, or Distinguished Professor, in the UAMS College of Medicine.

College of Medicine Appeals Board: A group of faculty members appointed annually by the Dean of the College of Medicine to hear formal grievances.

Grievance: An expression of dissatisfaction when a faculty member believes that a rule, procedure, or policy has been applied in an unfair or inequitable manner or that there has been unfair or improper treatment by a person or persons. Such grievance may concern, but is not limited to, the following: duties assigned to a faculty member; application of College of Medicine or UAMS policies; and discrimination because of race, national origin, gender, religion, age, disability, or status as a disabled or Vietnam-era veteran; subject to the exception that complaints of sexual harassment will be handled in accordance with the specific published policies of the University of Arkansas for Medical Sciences. (See UAMS Administrative Guide No. 3.1.05.) (Specifically not included in this grievance procedure are matters of non-reappointment, dismissal, tenure or promotion decisions for which other policies and procedures exist. See UA Board Policy 405.1.)

Grievance Panel: Those members of the College of Medicine Appeals Board selected, by a drawing, to hear a grievance in accordance with Step II of the grievance procedure.

Grievant: Any faculty member submitting a grievance as defined above.

Respondent: A person or persons alleged to be responsible for the violation(s) alleged in a grievance. The term may be used to designate persons with direct responsibility for a particular action or those persons with supervisory responsibility for procedures and policies in those areas covered in the grievance.

Working Days: Monday through Friday, excluding official UAMS holidays.

Policy

When an incident forming the basis for a grievance arises, the grievant must follow the procedure outlined below. Each grievance shall be handled promptly and impartially, without fear of coercion, discrimination, or reprisal. Each participant in a grievance procedure shall do his/her part to protect this right.

No student, resident, faculty member, member of the Grievance Panel or College of Medicine Appeals Board, administrator, or witness shall suffer loss of compensation or leave time for the time spent in any step of this procedure.

Records shall be kept of each grievance process. These records shall be confidential to the extent allowed by law, and shall include, at a minimum: the written grievance complaint filed by the grievant, the written response filed by the respondent, the recording and documents of the hearing, the written recommendation of the Grievance

Panel, the results of any appeal, the decision of the Dean, and any other material designated by the Dean or the Dean's designee. A file of these records shall be maintained in the office of the Associate Dean for Faculty Affairs for four years.

Procedure

Step I: Initial Attempt of Resolution

- A. The grievant must submit a written statement to his/her department chair identifying the respondent, specifying the violation(s) alleged, the basis for the grievance, and the remedy sought. This written statement must be submitted within fourteen (14) working days following the incident which forms the basis for the grievance. The grievant shall provide a copy of this written statement to the Associate Dean for Faculty Affairs. If the grievance is against the chair, the written statement must be submitted to the Associate Dean for Faculty Affairs instead of to the chair.
- B. Within ten (10) working days of receipt of the written statement, the department chair will attempt to resolve the grievance by a discussion with the grievant. Following discussion with the grievant, the department chair may, at his/her discretion, discuss the grievance with the respondent in an effort to resolve the grievance. If the grievance is against the department chair, the Associate Dean for Faculty Affairs will attempt resolution of the grievance.
- C. If the grievance is satisfactorily resolved by this discussion, the terms of the resolution shall be written and signed by the grievant, the department chair, and the respondent (if the respondent has participated in any discussions in an effort to resolve the grievance and is affected by the resolution). A copy of this document shall be sent to and maintained by the Associate Dean for Faculty Affairs. If the grievance was against the chair, and is satisfactorily resolved by this discussion, the terms of the resolution shall be written and signed by the grievant, the Associate Dean for Faculty Affairs and the chair (who is the respondent, if the chair has participated in any discussions in an effort to resolve the grievance and is affected by the resolution).
- D. This initial attempt of resolution must conclude within ten (10) working days of the initial discussion with the grievant. At the end of this ten-day period, if the grievance cannot be resolved, the grievant can immediately proceed to Step II, presentation of a formal grievance to the Dean of the College of Medicine.

Step II: Formal Grievance to the Dean

- A. Filing a grievance:
 - 1. Grievances submitted to the Dean of the College of Medicine shall be in writing and shall provide the following information: name and address of the grievant; nature, date, and description of the alleged violation(s); name(s) of person(s) responsible for the alleged violation(s); requested corrective action or remedy sought; and any background information the grievant believes to be relevant.
 - 2. A grievance must be submitted to the Dean within ten (10) working days of the completion of the initial attempt of resolution, outlined in Step I above.
- B. Immediately upon receipt of a formal grievance, the Dean will give the respondent a copy of the grievance and will direct the respondent to submit to the Dean a written response to the charges within ten (10) working days. The respondent will be specifically warned not to retaliate against the grievant in any way. Retaliation will subject the respondent to appropriate disciplinary action.

- C. Following receipt of the written response, the Dean may elect to review and decide the issue, or the Dean may refer the issue to the Appeals Board for a hearing. If the Dean decides the issue, the decision shall be final, and there shall be no appeal. If the Dean refers the issue to the Appeals Board, the grievance will be heard pursuant to the Pre-Hearing Procedures and Hearing Procedures listed below.
- D. Pre-Hearing Procedures:
1. Selection of Grievance Panel: When a grievance is referred to the Appeals Board, a Grievance Panel, composed of five (5) faculty members shall be selected as follows: The Dean, or the Dean's designee, and the grievant will meet to review the members of the College of Medicine Appeals Board, removing from consideration any member who may with reason be considered inappropriate for the hearing.(e.g., a faculty member directly involved in the issue being appealed should not sit on the panel for that complaint). The names of the remaining members will then be written on tabs of paper, folded, and randomized by mixing. The grievant will draw names from the container. The first five names will constitute the Grievance Panel, provided they are available to attend the hearing. The sixth name drawn is the first alternate, the seventh name drawn is the second alternate, respectively, etc., until all faculty names are listed in a sequence of priority.
 2. Scheduling of Hearing: The Hearing will be conducted no sooner than ten (10) working days and no later than twenty (20) working days after the drawing unless the Dean, or the Dean's designee, determines there is a specific reason why another time must be selected.
 3. Representation: The grievant and the respondent may each have one (1) person, who may be an attorney, to assist in the initiation, filing, processing, or hearing of the formal grievance; however, these people may not address the Grievance Panel, speak on behalf of the grievant or respondent, question witnesses, or otherwise actively participate in the hearing. The Grievance Panel may also be assisted and advised by University counsel at its discretion.
 4. Evidence: No later than five (5) working days prior to the hearing, the grievant and the respondent shall provide the Dean, or the Dean's designee, with two (2) complete sets of documents to be used and relied upon at the hearing and, also, with the name, address, and telephone number of any representative and witnesses. There will be a simultaneous exchange of this information between the parties, which will be facilitated by the Dean, or the Dean's designee, five (5) working days before the date of the hearing.
 5. Information to the Grievance Panel and Election of Chairperson: No later than three (3) working days prior to the Hearing, the Dean, or the Dean's Designee, shall assemble the five members of the Grievance Panel. The Grievance Panel will be supplied with the documents and information submitted by the parties (as specified in paragraph 4 above), and the date of the hearing will be confirmed. The Dean or the Dean's Designee will then withdraw from the room. The Grievance Panel should convene briefly for the sole purpose of electing a faculty member as chairperson and deciding whether the Grievance Panel requests the assistance of University counsel. It is the responsibility of the chair to conduct the hearing in an orderly and efficient manner. The substance of the grievance shall not be discussed at this initial meeting, and neither the grievant, the respondent, nor their respective representatives are permitted to attend.
- E. Hearing Procedures:
1. Record of the Hearing: The hearing will be recorded by recording devices supplied by UAMS. These recordings shall be maintained for a period of four (4) years after resolution of the grievance in the office of the Associate Dean for Faculty Affairs. The grievant or respondent may obtain a copy of the tapes from any recorded hearing, at the requesting party's expense. The deliberations of the Grievance Panel will not be recorded.

2. Attendants: Attendants at the beginning of the hearing are limited to the Dean or the Dean's designee, the members of the panel, the grievant and the grievant's representative, the respondent and the respondent's representative, and counsel representing the panel.
3. Dean's Announcement: At the beginning of the hearing, the Dean, or his/her designee, will announce the date, time, place, and purpose of the hearing, and will ask the members of the Grievance Panel to identify themselves by name and department. The grievant and the respondent will then identify themselves by name and department. Finally, any representative accompanying the grievant, the respondent, or the panel shall identify himself or herself by name and title. The Dean or his/her designee will then give the Grievance Panel its charge. Following the charge, the Dean (or designee) will withdraw from the room.
4. Private Hearing: The hearing shall be conducted in private. Witnesses shall not be present during the testimony of any party or other witness. Witnesses shall be admitted for testimony only and then asked to leave. The grievant and the respondent may hear and question all witnesses testifying before the Grievance Panel.
5. Presentation of Case: The grievant and respondent shall be afforded reasonable opportunity for oral opening statements, closing arguments, their own testimony, and presentation of witnesses and pertinent documentary evidence, including written statements.
6. Grievance Panel Rights: The Grievance Panel shall have the right to question any and all witnesses, to examine documentary evidence presented, and to summon other witnesses or review other documentation as the Grievance Panel deems necessary. The Grievance Panel has the right to limit testimony and presentation of other evidence to that which is relevant to the violation(s) alleged and to further limit testimony and other evidence that is cumulative and unnecessary.
7. Grievance Panel Deliberation: After the hearing is concluded, the Grievance Panel shall convene to deliberate in closed session and arrive at a majority recommendation. The Grievance Panel shall make its determination of whether or not a rule, procedure or policy was not followed or was applied in an inequitable manner based upon the evidence presented at the hearing, which is relevant to the issue(s) before the Grievance Panel. The Grievance Panel may make recommendations for resolution of the dispute. Neither the grievant, the respondent, nor their representatives may be present during the Grievance Panel deliberations.
8. Transmittal of the Recommendation: Within four (4) working days after the hearing is concluded, the Grievance Panel shall transmit a written copy of its recommendation to the Dean (or Designee). The Dean (or Designee) will then mail, by certified mail, return receipt requested, a copy of the written document to the grievant and respondent and the Associate Dean for Faculty Affairs at addresses previously provided by the grievant and the respondent.
9. Appeal of Recommendation of the Grievance Panel: If either the grievant or the respondent wish to appeal the recommendation of the Grievance Panel, the grievant or respondent shall, within five (5) working days of the receipt of the recommendation, appeal the grievance recommendation to the Dean. The appeal shall be in writing, and it shall be based on one of the following: a substantial mistake of fact occurred, a fundamental misinterpretation of official policies is evident, or a significant procedural defect took place. These are the only grounds for contesting the determination of the Grievance Panel. Within five (5) working days of the receipt of the appeal, the Dean may, at his/her discretion, order the Grievance Panel to reconvene, in private, to consider whether there is merit to the appeal, review its previous determination, and revise it if appropriate. No new evidence or testimony shall be introduced at this time. Neither the grievant, the respondent, nor their representatives may be present during this Panel deliberation. Within two (2) working days of its having reconvened, the Grievance Panel will present its determination, revised or unchanged, in writing to the Dean. Within five (5) working days of receipt of

the determination from the Panel, the Dean may accept it, amend it, reverse it, or refer it back to the Panel for reconsideration. The grievant and the respondent shall be notified in writing of the Dean's decision by certified mail, return receipt requested. The decision of the Dean shall be final, and there shall be no appeal.

If the Dean receives no appeal, by either the grievant or the respondent, within the five (5) working day period described above, the Dean may consider the recommendation at the end of that time period. The Dean may accept the Grievance Panel recommendation, amend it, reverse it, or refer the grievance back to the Grievance Panel for reconsideration. The decision of the Dean shall be final, and there shall be no further appeal.

Approved by the Executive Committee of the UAMS College of Medicine May 22, 2006.

EMTALA

Emergency Medical Treatment and Active Labor Act

In the early 1980s, cuts in Medicaid coverage and other health care cost containment measure led to an alarmingly high number of people without medical insurance. Special concern was expressed regarding the refusal of hospital emergency rooms to provide emergency treatment for these individuals. These were the concerns that prompted EMTALA. The crux of the Act states:

"In the case of a hospital that has a hospital emergency department, if any individual comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the ED, to determine whether or not an emergency medical condition...exists. "

If it is determined that an individual is experiencing an emergency medical condition, that individual must be stabilized before being discharged or transferred, if necessary, to another hospital. If there is no emergency condition, the Act no longer applies. "Coming to the ED" now include all property even if not in the hospital, outpatient clinics, ambulances owned or operated by the provider, parking lots, sidewalk and driveways, and all property within 250 yards of the ED. The individual who presents must request examination or treatment for a medical condition.

Requirements:

- Must provide a medical screening exam to all whom present, regardless of ability to pay.
- Stabilization of patient within facilities capabilities.
- Transfer of patients only when medically necessary or upon patient request, only after stabilization.
- Financial screening or interview cannot delay treatment.

Penalties under EMTALA:

- Fines up to \$50,000/violation for both hospital and physician.
- Exclusion from Medicare program for both hospital and physician.
- Private civil suits.
- Hospital has right to sue physician to recover costs.
- Physician medical malpractice does NOT cover EMTALA violations.
- Agencies involved in enforcement: State Dept. of Health, HCFA, OIG, PRO, OCR (civil rights)

Medical Screening Exam (MSE):

- Triage is not an MSE.
- MSE must be performed by individual granted authority under hospital bylaws.
- All patients who present must receive an MSE. The MSE must include all tests necessary to rule out an emergency medical condition, within the hospital's capabilities.
- Must provide same MSE for all patients with like condition.
- May not delay treatment for financial screening. Financial discussion should be deferred until after MSE.

Emergency Medical Condition:

- Acute symptoms that need immediate medical attention.
- Might result in serious impairment of bodily function, organ or body part if not immediately treated.
- Includes labor, severe pain, psychiatric disturbance and substance abuse.

Stabilization:

- Must provide treatment reasonably needed to ensure that deterioration is unlikely during transfer or after discharge. There is no guarantee of a good outcome, just proper treatment of the patient.
- For pregnant patients who are in labor, this means delivery of baby and placenta.
- Stabilization for transfer means: patient will not deteriorate during transfer AND receiving facility can manage condition and complications that may arise.
- Stabilization for discharge means: further care could reasonably be performed on an outpatient basis or during scheduled inpatient admission later, AND patient is given reasonable plan for follow-up care and discharge instructions.

Transfer:

- Transfers can only occur if the patient requests the transfer in writing or the facility lacks the resources to treat the patient. The receiving physician must explain the risks and benefits of the transfer to the patient or patient's legal representative.
- Transfer can only occur after a MSE has occurred and the patient has been stabilized.
- The transferring facility MUST receive acceptance of patient by the receiving facility and receiving physician.
- The transferring facility arranges for the appropriate personnel and mode of transportation for transfer.
- The receiving hospital must accept the transfer if they have the capacity to treat or they are a specialty hospital with capacity to treat.
- Lack of capacity means the receiving hospital has no availability of beds and staff to render care for the patient.
- The receiving hospital may refuse the transfer if the transferring hospital has the capacity to treat the patient.

Documentation:

- The transferring physician is responsible for acquiring the written request and consent from the patient or legal representative.
- The transferring physician certifies that transfer is medically necessary and states the reasons.
- The transfer form shall have the transferring physician's signature, the name of the accepting facility and accepting physician, mode of transportation, and the risks and benefits of the transfer.

On-Call Physicians:

- On-call physicians must respond to the ED within a reasonable period of time.
- EMTALA applies to on-call physicians and on-call consultants.
- Physicians must respond to all patients the same way, regardless of payment source.
- Hospitals must have appropriate on-call arrangements.
- On-call physician acts as hospital's agent when making determinations about transfers.
- Hospital must monitor response times and follow-up accordingly.
- On-call physicians must respond when called to evaluate patients to determine if an EMC exists, to stabilize a patient in the ED or hospital, or requested to accept a transfer.

As of January 2001, EMTALA applies to all locations and locations that have provider-based status: off-site OP testing facilities, non-acute treatment areas and remote locations that provide acute care. Outpatient settings must treat and stabilize within the "capabilities of the hospital," not just off-campus locations. There must be an emergency response plan and procedures for all sites.

Prepared by University Hospital Risk Management
Rebecca Tutton, R.N., J.D., 603-1150

TRANSFER POLICY

CAVHS Inter-Facility Transfer Policy

Purpose: To reissue policy on the transfer of patients between the Central Arkansas Veterans Healthcare System (CAVHS) and other medical facilities, including Department of Veterans Affairs (VA) and non-VA facilities.

Background: Inter-facility transfers are frequently necessary to provide patients access to specific providers or services. The movement of acutely ill people from one institution to another exposes the patient to risks. VA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately, under circumstances that provide maximum safety for patients and comply with applicable laws and standards.

Policy

- a. This medical center will ensure the safe, appropriate, orderly, and timely transfer of patients. Transfers must comply with Joint Commission on Accreditation of Healthcare Organizations (THE JOINT COMMISSION) provisions of care.
- b. Transfers must conform with all provisions of Title 42 United States Code (USC) § 1395 dd(a)-(c). This statute and the guidelines of the U.S. Department of Health and Human Services (HHS) require Medicare and/or Medicaid participating hospitals with emergency departments to provide appropriate screening examinations, necessary stabilizing treatment for emergency medical conditions and active labor, and restriction of transfer until the patient is stabilized.
- c. Transfers will be monitored and evaluated as part of our Performance Improvement Program.

Duties and Responsibilities

General: A patient at another facility (VA or non-VA) will not be transferred to CAVHS without prior approval by an appropriately credentialed and privileged CAVHS physician or designee who must speak directly with the referring physician or designee, regarding the care of the patient. The accepting physician will agree to admit after conferring with the Central Business Office (CBO) staff on eligibility criteria being met. If eligible, CBO staff will contact the Bed Control Coordinator to determine bed availability. If the referring facility is a VA facility (including Community Based Outpatient Clinics), the patient is an appropriate candidate for admission, and the referring facility contact believes the patient must be transferred before the next regular workday, CAVHS will accept the transfer without delay or will defer if a bed is not available. The referring facility assumes responsibility for travel arrangements, including family notification and payment coordination.

1. When a patient is accepted for transfer, the accepting and transferring physician or designee, should agree on and document the following information in the medical record:
 - a. Date and Time transfer will occur.
 - b. Documentation of the patient's (or legally responsible person acting on the patient's behalf) informed on-sent to transfer.
 - c. Medical and/or behavioral stability of the patient for transfer.
 - d. Mode of transportation and equipment needed.
 - e. Appropriate level of care required during transportation and a healthcare professional trained to provide that care.
 - f. Identification of transferring and receiving physicians.
 - g. Details of the need for care and the proposed level of care after transfer.
 - h. Documentation of the patient's advance directive made prior to the transfer, if any.

2. Patient transfers will comply with Sections 1866 and 1867 of the Social Security Act. The intent of these sections is to ensure all individuals with an emergency medical condition, regardless of ability to pay, have equal access to emergency treatment in hospitals. An emergency medical condition is defined as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual, or fetus, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of bodily parts.
 - a. If a patient at a hospital has an emergency medical condition that has not been stabilized, the hospital should not transfer the patient. However, the transfer could occur if:
 1. The patient (or a legally responsible person acting on the patient's behalf) makes an informed request, in writing, that the transfer be effected against medical advice.
 2. A physician, or designee, certifies in writing that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks of transfer.
 - b. Any hospital transferring patients with unstable medical conditions must:
 1. Provide all medical treatment, within its capacity, which minimizes the risk to the individual.
 2. Send all pertinent medical records available including advance directives.
 3. Effect the transfer using qualified personnel and equipment.
 4. Obtain consent of the receiving hospital.
3. Any credentialed and privileged CAVHS physician or designee may deny or defer a transfer request when there is reasonable doubt about the safe transfer of the patient to an appropriate bed.
4. A patient accepted for transfer will be screened for stability to the receiving bed by the Emergency Department staff. If the transfer is deemed to be appropriate, the patient will be directly admitted to the accepting Service. If the patient's condition warrants a bed of higher intensity of care (Surgical Intensive Care Unit (SICU), Medical Intensive Care Unit (MICU), Coronary Care Unit (CCU), Telemetry bed, etc.), arrangements will be made for such a bed. If the patient is unstable and requires emergent care, the patient will receive that care in the Emergency Department and will be admitted to the appropriate unit when stable.
5. If the patient is accepted for transfer from the North Little Rock VA, and upon arrival the bed is not available, the patient will be held in the Emergency Department.

Transfers to CAVHS during Irregular Tours

1. The referring physician is routed to the Administrative Officer of the Day (AOD), who will verify the patient's eligibility.
2. After verifying eligibility and obtaining information about the patient's condition and bed availability, the AOD contacts the on-call physician of the appropriate receiving service.
3. The AOD coordinates the acceptance or denial of the patient transfer with the referring and on-call receiving physicians. The mode and time of transportation will be identified during the call. The on-call CAVHS physician will not refer the outside referring physician to another in-house physician to manage unless the patient requires a special level of care, i.e., SICU, MICU, CCU, and telemetry. The AOD will maintain communication between the referring and on-call physicians to ensure continuity of patient's care and that a decision is made regarding the patient's transfer status.

4. After admission to the medical center, if the patient requires care by a different clinical specialty, the appropriate clinical specialty will respond promptly to the consultation, and the patient will be transferred as appropriate.

The Chief of Staff (COS), through the Performance Improvement Program (PIP), will review any transfer to CAVHS which occurred without approval of a CAVHS credentialed and privileged physician. The investigation will include discussion with all medical center staff involved in the transfer, including the COS or Medical Center Director at the transferring facility. If there is reasonable suspicion that the transfer violated Section 1866 or 1867 of the Social Security Act, the information will be reported to the network director for appropriate action.

Through the patient expeditor during regular tours or the AOD during irregular tours (*see the VA website for current policies: <http://vaww.little-rock.med.va.gov/pip2/index.htm>*), the CAVHS CBO will:

- a. Ensure that VA Form 10-2649A guidelines for transferring patients from emergency department has been initiated when a patient from CAVHS is being transferred to another VA or non-VA facility or when a patient has been accepted as a transfer to CAVHS from a VA or non-VA facility.
- b. Contact their counterpart at the receiving or referring facility (VA or non-VA) to obtain or provide eligibility and administrative data.
- c. Coordinate with the CAVHS physician and social work service in notifying the patient's family regarding transfer plans.

ACH Transfer Policy

1. Patients may be transferred to another acute or sub-acute care facility upon the order of the attending physician.
2. Patients shall be medically stabilized prior to transfer within the capabilities of this facility.
3. Reasons for transfer of a patient to another facility may include but are not limited to:
 - a. Medical or psychiatric care required by the patient is not available at ACH;
 - b. Request by the patient or family;
 - c. Change in the level of care required by the patient;
 - d. Patient does not meet eligibility criteria for admission.
4. The transfer of patients to another medical facility shall be coordinated by the social worker and review coordinator in collaboration with the physician, nursing staff, and admissions.

Procedure

1. The physician shall write an order (on an order sheet) to transfer the patient to another facility.
2. The Patient Transfer Form shall be initiated by the patient's nurse. Assistance in completing the form shall be provided by the physician, social worker, or review coordinator.
3. The physician shall document on the Patient Transfer Form:
 - a. Name of the accepting facility
 - b. Name of the accepting physician
 - c. Date/time of contact with accepting facility/physician
 - d. Reason for the transfer
 - e. Expected date of transfer
 - f. Mode of transportation to accepting facility
4. The physician shall explain the risks and benefits of transfer to the patient or guardian and obtain consent for transfer.

5. The consent for transfer and consent to release of medical information to the accepting facility shall be documented on the Patient Transfer Form.
6. Admissions shall be informed of the transfer order by the unit secretary or nurse.
7. The social worker and review coordinator shall assist with arranging an appropriate means of transportation. Modes of transportation may include: patient's own transportation, ambulance service, ACH transport
8. The unit secretary shall be responsible for getting a copy of the entire medical record or the specific contents requested by the accepting facility to be sent with the patient. The chart may be copied by the unit secretary or may be sent to medical records department to be copied.
9. On the day of transfer, the physician shall write a discharge order.
10. At the time of transfer, the nurse shall document on the Patient Transfer Form:
 - a. Date and time of transfer;
 - b. Medical records copied and sent with patient;
 - c. Patient's condition at time of transfer;
 - d. Signature of nurse.
11. The top copy of the Patient Transfer Form shall be sent with the patient.
The yellow copy of the Patient Transfer Form shall be placed in the patient's medical record.

IT SYSTEMS

CAVHS

Computerize Patient Record System (CPRS)

Training is required Contact for training: Janice Bowyer @ 501-2574981 or email: Janice.bowyer1@va.gov

IT helpdesk : 257-1543

VA IT policies: <http://vaww.little-rock.med.va.gov/pip2/index.htm> (Note: this is an Internet Site, not an Intranet Site)

Annual Mandatory HIPAA Training: <http://www.vhaprivacytraining.net/frame.htm>

Annual Mandatory Cyber Security Training

<http://vaww.ces.aac.va.gov/librix/loginhtml.asp?v=ees>

Arkansas Children's Hospital IT Systems

Meditech - Training required - orientation by Chris Smith, Help Desk-364-1111 or email helpdesk@archildrens.org

UAMS Medical Center Transfer Policy and Procedure

Non-Emergent Transfers

Step One Referring physician or facility contacts UAMS attending/resident who will, after consulting with the attending and, after determining that the transfer is clinically appropriate, begin the transfer process by saying:

“We will be happy to care for the patient clinically, but our TransferTeam must make the specific arrangements”

*Please refrain from indicating bed availability, or lack thereof. Instead, allow transfer team to deliver that message. It will help avoid confusion.

Step Two Transfer team is contacted by UAMS attending/resident

Step Three Transfer team contacts referring facility for necessary information, determination of whether transfer meets criteria for appropriate transfer, and complete the process

Emergent Transfers

Call the Emergency Room at 686-6337

Note: Day Transfers 8 a.m. – 5 p.m.
Inpatient transfers should be fielded by an attending physician

Night Transfers 5 p.m. – 8 a.m.
Referring physicians will be asked if they prefer to speak to an attending or if a Resident can help facilitate the transfer

*Transfer Team 688-9553
Emergency Department 686-6337
FGP Risk Management 614-2082
Hospital Risk Management 603-1150
Medical Director 686-8153*

UAMS IT Systems

Web-Chart Portal for physician results, clinical documentation, clinic schedules. Available from UAMS or remote location. Training is required.

Logician Outpatient electronic medical record. Training is required.

eChart Inpatient electronic medical record. Training is required.

EPF Official medical record – document management system allowing on-line document review and signature. For on-line training, please visit: Clinical Computer Training Center web-site. One-on-one training, please call: **HIM 686-6038**

Soft-Med Transcription system allowing on-line dictated document review and signature. Training is required. To schedule, please call: **HIM 686-6038**

To schedule other training:
intranet.uams.edu/it

UAMS IT Helpdesk:
686-8555

UAMS MEDICAL CENTER

KEY TELEPHONE NUMBERS

HOSPITAL	686-7000	TOXIC DRUG LINE	1-800-3POISON
DEPARTMENT/NURSING UNIT	PHONE NUMBER	TRAUMA HOTLINE/ER	686-8888
ADMINISTRATION	686-5660	TRAUMA COORDINATOR OFFICE	686-8159
ADMISSIONS	686-6236	NURSING UNITS	
APPOINTMENT CENTER	686-8000	2A	686-7250
BED CONTROL	686-5641	2B	686-7260
CLINICAL LAB (FOR RESULTS)	603-1178	SICU	614-2400
EMERGENCY DEPARTMENT	686-6333	MICU	614-2400
FGP RISK MANAGER	614-2082	3A	686-7350
HOSPITAL OPERATOR	686-7000	3B	686-7360
HOSPITAL RISK MANAGER	603-1150	3C	686-7370
MEDICAL RECORDS (RELEASE OF INFO.)	686-6083	4A	686-7450
MEDICAL RECORDS (DRS. DICTATION)	686-6038	4B	686-7460
MEDICAL RECORDS (DIRECTOR)	686-6263	4E ICU	614-2400
NUCLEAR MEDICINE	686-6662	5A	686-7550
ONE DAY SURGERY	686-6364	5B	686-7560
OUTPATIENT SERVICES	686-6107	5C	686-7573
PHARMACY	686-6220	5D	686-7580
PHYSICIAN RELATIONS	603-1440	NURSERY	686-6053
PUBLIC INFO/PR/COMMUNICATION	686-8992	CVICU	686-7660
QUALITY MANAGEMENT	296-1325	6C	686-7670
RADIOLOGY	686-5740	7A	686-7750
REHABILITATION SERVICES	296-1500	NICU	686-7580
SPEECH THERAPY	686-8178		
OCCUPATIONAL THERAPY	686-6121	TRANSFER NUMBERS	
INPATIENT PHYSICAL THERAPY	686-6120	TRANSFER TEAM	688-9553
OUTPATIENT PHYSICAL THERAPY	661-7955	EMERGENT TRANSFERS	688-2134
HAND THERAPY	686-6102	OTHER/CAMPUS	
RESPIRATORY THERAPY SERVICES	686-6285	CHANCELLOR'S OFFICE	686-5680
SECURITY (UAMS POLICE)	686-7777	COM DEAN'S OFFICE	686-5350
SOCIAL SERVICE	686-5870	CHIEF MEDICAL OFFICER	686-8111
SURGERY (INFO)	686-7874	FGP RISK MANAGEMENT	614-2082
SCHEDULING (MAIN OR)	614-2900	HOSPITAL RISK MANAGEMENT	603-1153
PACU (RECOVERY ROOM)	614-2900	IT HELP DESK	686-8555
		COMMUNICATIONS	686-8992
		CREATIVE SERVICES	686-5570
		PUBLIC SAFETY	686-7777

ACH KEY TELEPHONE NUMBERS

MAIN HOSPITAL #	364-1100	RADIOLOGY	364-1175
ADMINISTRATION	364-8000	REHABILITATION	364-1192
ADMISSIONS	364-1230	RESPIRATORY THERAPY	364-3530
AMBULATORY SURGERY	364-1336	SOCIAL WORK	364-1406
APPOINTMENT CENTER	364-4000	SCHEDULING (MAIN OR)	364-2795
CLINICAL LAB (FOR RESULTS)	364-1300	PACU (RECOVERY ROOM)	364-1334
EMERGENCY DEPARTMENT	364-1185	TRANSPORT	364-6429
MEDICAL RECORDS	364-1152	MEDICAL DIRECTOR	364-1401
PHARMACY	364-4697	IT HELP DESK	364-1111
PHYSICIAN SERVICES	364-5901		

VA KEY TELEPHONE NUMBERS

MAIN HOSPITAL #	296-1000		
SURGERY		SOCIAL WORKERS: GWEN ALLEN PGR	67-1509
VASCULAR SURGERY OFFICE	56901/56902	DEBRA TURNER PGR	67-1588
ORTHOPEDIC SURGERY OFFICE	56899/56900	MICU	74660
UROLOGY CLINIC	76903	SOCIAL WORKERS: HELEN MCKEE PGR	67-1211
ENT CLINIC	75757	CCU	74659
PLASTIC SURGERY STAFF: DR. YUEN	1-888-929-5364	SOCIAL WORKERS: MARTY JOHNSON	67-1515
THORACIC/GENERAL SURGERY OFFICE	55460/74799	CARDIOLOGY TEAM 7	74662
NEUROLOGY OFFICE	76067/56067	SOCIAL WORKER: MARTY JOHNSON PGR	67-1515
EYE CLINIC	76781	HEALTH TECH: LEAH NATHANIEL PGR	67-1699
GYNECOLOGY CLINIC	75662	6C - HEM/ONC WARD	74669/54750
NEUROSURGERY OFFICE	76775/76778	SOCIAL WORKER: TERESA HOOKS PGR	67-1912
SOCIAL WORK OFFICE	76740	CHIEF RESIDENT- DR. MATT SPARKS	688-2808
SOD PGR	67-1378	CPRS HELP - JANICE BOWYER X74981	67-1175
GEN SURGERY CONSULT PGR	67-1378	PC SUPPORT	X71543
		STAT BLOOD GAS	(1678)
MEDICINE		STAT EKG HEALTH TECH	(1584)
FIRM A	(SSN #00-49)	BED CONTROL	(1092)
6D	74673	NLR EKG HEALTH TECH	(1530)
SHARON YORK-MINTON, RN	(1813)	MEDICINE OFFICE	257-5866
HEALTH TECHS: GERALD SCHAMP	405-0964		FAX/ 257-5867
BEN EVANS PGR	67-1345		
SOCIAL WORKERS: WINNIE PARSONS	67-1200		
LASHUN SMITH PGR	67-1707		
FIRM B	(SSN #50-99)		
4B	74653		
AURORA DICKEY, RN	(1238)		
HEALTH TECH: SHELBY CONLEY PGR	67-1369		
RAQUEL BATES PGR	67-1655		

