DOM Faculty Expectations

2019-2020

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Teaching Services - Attending Expectations

Goal:
To enumerate specific expectations unique to Department of Medicine teaching services.

Background:
The Department of Medicine’s educational goals hinge on engaged clinical educators who both model professional behaviors and demonstrate critical thinking centered on specific clinical cases. To achieve these goals, clinician teachers are expected to round at the bedside with their learners (medical students, residents and fellows) and to provide timely feedback to those learners about their clinical performance.

Bedside Rounding:

Daily teaching rounds should be conducted at the bedside. This offers faculty and trainees a direct view into the practice of medicine. As an attending, you should model good clinical practice, critical thinking skills, and professionalism. The attending, in turn, is granted the opportunity to observe trainees as they interact with patients directly, allowing a more informed assessment of trainee performance. Moreover, patients report a more positive experience when the daily plan is developed at the bedside.

While bedside rounds should be the default, the Department recognizes that there are occasional cases where this may not be possible, perhaps due to social circumstances, delicate topics, or patient preference. In those circumstances, it is recommended that the team address the specific points that can’t be discussed at the bedside prior to entering the room, but that anything not of a sensitive nature be discussed at the bedside.

To expedite rounds, faculty should read about new admissions in eStar before morning rounds. This allows the team to focus on the pertinent information and facilitates efficient discussion of relevant teaching points. Attendings should make every effort to limit morning rounds to no more than two hours. When the census is high, faculty should consider rounding independently on stable patients after a brief discussion with the team.

Availability/Supervision:

As the attending, you are ultimately responsible for the care of each patient on your teaching service. To ensure both patient safety and an optimal training environment for our learners, it is recommended that that you engage in the following tactics:

- At the beginning of each rotation, attendings should exchange contact information with each member of the team. House staff should be explicitly encouraged to reach out with any questions or significant concerns, regardless of the time of day or night. In particular, house staff are expected to contact the attending physician when there is any change in a patient’s status (death, transfer to critical care, rapid-response call, etc.). Attendings should pro-actively check-in with their trainees in the afternoon, either in-person or by phone, to discuss any questions that the team may have about new daytime admissions and/or to discuss any key updates in the clinical status of existing patients on the service.
- Attendings should assist residents with interacting with belligerent or angry patients or family members, facilitating discussions on goals of care and end of life issues, patient disposition, and cross-cultural issues.
- Attendings should hold a debriefing with the team after any patient death. This should encourage a frank discussion of any issues in patient care as well as a discussion of the feelings of the members of the team about the death.

Feedback:

Providing timely verbal feedback to your trainees is essential for promoting reflective practices and professional development. Faculty are expected to provide formal feedback to each resident and student at least twice during the rotation—once at about the halfway point and once near the end. It is recommended that time is specifically set aside for feedback and that you notify the learners in advance. Any feedback that may be considered negative should be done in private.

While all faculty are encouraged to develop their own toolset for delivering trainee feedback, it should be centered on several themes: it should be timely, non-threatening and respectful of the level of trainee. It should contain specific assessment of performance, and review both strengths and weaknesses that have been observed. Feedback should target specific points that can be addressed by the learner, and it should include an action plan for improvement.

Formal Performance Assessment:

In keeping with the expectation that direct verbal feedback be provided, the Department also expects timely and accurate completion of trainee evaluations. These are delivered via the institutional New Innovations account at the close of every block.
Documents are only complete when finalized and signed, including Attending signature for all H&P, Consult notes, Discharge summaries, and Operative reports.

**SIGNATURE** indicates that the Attending has reviewed the document of a Supervisee and agrees with the content; it does not necessarily indicate that the Attending was present or provided a billable service.

**ATTESTATION** of a clinical note signifies that the Attending (or consulting physician) confirms the evaluation, management, and care that has been documented by a member of the house staff. Attestations indicate that the Attending/consulting physician supervised and/or provided care, and typically represents a billable document.

Documents are considered **DEFICIENT** if not completed in the timeframes as follows:

- H&P: within **24 HOURS** of admission or placement in observation status
- Discharge summary: within **3 DAYS** of discharge including deaths during hospitalization
- Brief discharge Note: **at time of discharge** if Discharge Summary not yet completed
- Consult note: within **24 HOURS** of consult performance
- Operative/Procedure report: within **24 HOURS** of operation/procedure
- Immediate post-operative/procedure note: **immediately after the operation/procedure** if Operative/Procedure report not yet completed
- Progress Notes (for inpatients): documented at least **DAILY** by primary team
- Outpatient Notes: within **3 Calendar days** of encounter

Documentation of an outpatient encounter is considered **DELINQUENT** if documentation remains incomplete more than 7 days after the encounter. All other documentation is considered delinquent if requirements established in this policy remain incomplete more than 14 days after the date of the triggering event (e.g., admission, consultation, discharge, etc.).

If documentation is incomplete for 28 or more days, faculty will be placed on a **TEMPORARY SUSPENSION OF PRIVILEGES** until delinquent documentation is completed. Faculty with two or more temporary suspensions for incomplete documentation in a 6 month period will undergo a **FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)** for a minimum of six months. Failure to complete the requirements of the FPPE may result in other corrective or other disciplinary action, as appropriate.

**CLINICAL CODING AND DOCUMENTATION QUERIES**

In an effort to ensure comprehensive capture of key risk factors and comorbid conditions, clinicians will receive periodic queries from VUMC coding specialists. Such queries are intended to provide clinicians the opportunity to improve the quality and completeness of their documentation. It is the VUMC goal that clinicians will review any queries within 2 days and document in the medical record accordingly. It is the expectation that DOM clinicians will respond to queries in a timely, helpful, productive, and professional manner. Clinician-level query response rates will be shared on a regular basis with Divisional leadership.
Follow-up of Pending Tests at Discharge and Abnormal Test Results (May 2019)

If you, as the attending, order a lab test or imaging study you are responsible for following up on the results or ensuring that someone else assumes responsibility for the results.

In the interest of quality patient care, if there is an abnormal result (lab or imaging) that necessitates follow-up or a change in care, and has not already been addressed, it is your responsibility to ensure that the patient has the needed follow-up, regardless of who ordered the test. If the abnormal result requires immediate/same day action, clinicians should use the pager system; otherwise in-basket messaging or other secure messaging may be used. If the abnormal result is outside that clinician’s area of clinical expertise, the appropriate action may include notifying the ordering clinician.

If the patient has non-VUMC follow up please ensure that those clinicians get the results and are aware of the need to address any issues.
Role of Medicine Admission Coordinators (MACs) and the Medicine Triage Attending

The Medicine Admissions Coordinator (MAC) RN is responsible for coordinating communication and patient team assignment for all non-ICU medical clinic/direct admissions, outside transfers, internal transfers (including out-bound MICU transfers), and ED admissions.

The Medicine Triage Attending is an attending from the Section of Hospital Medicine who assists the MAC RN’s and is responsible for making final team assignment decisions if discrepancies arise (staffed in-house 24/7).

Medicine Team Assignments

MAC RN’s, in conjunction with the Triage Attending, assign patients to any Department of Medicine service using the following guidelines:

- The admitting problem is within the scope of practice of the assigned team;
- AND The assigned team has capacity to admit the patient;
- AND The assigned team is the most appropriate team when considering the patient care demands of other potential care teams.

The Medicine Admission Coordinators, Triage Attending, ED and ICU faculty use the Service Designation List as a guide to assign patients with certain diagnoses to subspecialty services.

When contacted for an admission, the subspecialty fellow/attending should generally accept the admission. If the subspecialty team believes there is a more appropriate team for the patient (based on the above criteria), the attending of the subspecialty team can contact the Triage Attending to discuss other options. Respectful and professional behavior is expected in these conversations. Otherwise, the subspecialty service may not refuse an admission unless the service is capped.

To admit a patient from clinic, contact the MAC RN (phone): 615-540-4213
To discuss a team assignment, contact the Medicine Triage Attending (pager): 615-831-4544

Outside Transfers

The Department of Medicine encourages Attending Physicians to accept most patients from an outside facility if they are stable for transfer when they are contacted by the Access Center. MICU attendings accepting transfer should refer to MICU-specific protocols for decompensated liver failure, metastatic malignancy, and in-hospital cardiac arrest.

Team assignment is performed at the time of transfer acceptance. Team reassignment is acceptable upon arrival to accommodate load-balancing, team caps, or other unforeseen circumstances.

Team to Team (Intra-Medicine) Transfers

General Principles for Intra-Medicine Transfers:
- Volume should be the overall guiding factor (both volume of transferring team and
- Call for transfer should be made well in advance of anticipated transfer and should go through the day triage attending.
- Transfer discussions should occur attending to attending or fellow (on specialty service, after talking to their own attending) to attending; transfer discussions should not directly involve residents.

**Transfers from Riven/Morgan to Rogers:**
- If a Rogers specialty team is capped, a specialty patient may be admitted to either Morgan or Riven. Specialty services may request and/or accept transfer of those patients to Rogers when team capacity allows (i.e.: transplant, HIV, CF, IBD).

**Transfers from Riven to Morgan should generally be avoided**

**Transfers from Rogers/Morgan to Riven:**

It is acceptable to request transfer for a stable patient who needs prolonged (i.e. >14 days), clearly defined therapy, if the census of both the transferring and accepting team are acceptable (i.e. transferring teaching team near cap, accepting team has availability).

It is UNACCEPTABLE to request transfer to Riven due to patient with a challenging personality, complicated social barriers, or due to difficulties arranging disposition or SNF placement.

**Patient-initiated requests:**
When a patient requests a change of team, the attending physician should meet with the patient to ascertain the reason for the request. In many of these cases, there may be a lack of rapport between a patient and a physician. In this case, the attending physician is encouraged invite a partner to meet with the patient to assist in reestablishing rapport. If the patient has a grievance or if the team is unable to easily resolve the request, the attending should also contact the Patient Affairs office for support. If this is not successful, the attending should engage the service medical director or the Vice Chair for Clinical Affairs.

In cases in which a patient is attempting to negotiate for inappropriate care, such as excessive pain medication or an extended stay when medically ready for discharge, “firing” the physician may be construed as refusing care. In this case, Medical Center Medical Board policies regarding patient refusal of care should be followed (OP 20-10.18).

In rare cases, Risk Management or the Patient Affairs office may recommend a change of attending. The Vice Chair for Clinical Affairs should be involved in these decisions.

**Short-term readmissions:**
Riven/Geriatrics (non-teaching): If the attending on Riven is unchanged since discharge, and the re-admission occurs within 72 hours of the signed discharge summary, the patient should be re-admitted to the Riven service. Patients may be admitted to another appropriate service if the discharging attending is no longer on service.
Morgan: Any patient who returns to the care of a medicine team within 72 hours is considered a “bounce back” and should return to the original team regardless of admission schedule. Patients who “bounce back” will return to the team that cared for them and do not count towards the admission cap.

The 72-hour window begins at the time the discharge summary is signed. If the patient was admitted to a medical team and then transferred to another service within the hospital (Psychiatry, ICU, Surgery), the 72-hour window begins at the time of the last note written by the medicine team.

If a “bounce back” presents on a nightshift the patient will be directed to the original team the following morning. If a “bounce back” presents during a dayshift when the team is not admitting AND it is after 2pm (weekdays) or 12pm (weekends), then the patient will be admitted by the admitting teams (counting towards their admission cap but not team cap) and transferred to the original team the following morning.

The only instance in which a patient returning to the hospital within 72 hours or transferring back to a medical service without having left the hospital should NOT go back to the original team is if NONE of the house officers who were on the team at the time the patient was taken care of are still on service (the attending does not count in this scenario).

Considerations for patients admitted after specialty clinic dismissal:
If a patient has been dismissed from an outpatient specialty clinic but requires inpatient hospitalization for that specialty condition, patients should still be admitted to the specialty services in this scenario in effort to provide coordinated and most timely care.
Process for Direct Admissions to Medicine Teams
Revised May 2019

DOM clinicians requesting a direct admission to a medical team will contact the MAC RN / Patient Flow Center in the usual fashion. MAC RN: (615) 540-4213

Prior to assigning the bed, the MAC RN will use the stability screening questions below to screen the patient for automatic direct admission. If the patient meets all the stability screening criteria (all “No” responses), the admission will proceed as usual without further approval. Scheduled admissions who do not have any vital signs/labs outside the stability screening range can proceed with admission without further approval.

If there is any “Yes” response, the MAC RN will inform the requesting clinician that the patient does not meet criteria for automatic direct admission. This does not automatically make them ineligible for a direct admission. In this case, the MAC RN will contact the Medical Director, Patient Flow Center (Dr. Kate Wooldridge) and request a case review, to be completed within 15 minutes. If the patient is determined to be appropriate for direct admission, the process will proceed as usual.

If further clarification or data is needed, Dr. Wooldridge will contact the MD/NP directly to discuss the case and confirm the best setting of initial treatment. If treatment can be initiated in clinic (antibiotics, fluids, oxygen, etc.), patients may be able to remain in clinic in a monitored setting and proceed to their bed directly when available. However if a patient is unstable and these resources are NOT available (late in the afternoon, patients that do not have access to a monitored setting to initiate care, or if inpatient beds are not available when these resources close), they may be rerouted to the ED.

If a patient has vital signs or labs that would not meet floor admission criteria (i.e. needs admission to an ICU), they are not eligible for a direct admission and must go to the ED for stabilization.

If it is determined that patient is not appropriate for direct admission and needs transfer to the ED, Dr. Wooldridge will contact the ED triage attending to review the case.

Directions for MAC RN:
Review the following data & ask the following questions of the requesting clinic provider.

Stability Screening Criteria

- Does the patient have vital signs outside any of the following criteria?
  - T > 101F, HR > 120 or < 50, SBP > 200 or < 90
- Does the patient have any change in baseline mental status?
- Does the patient have a serum sodium level > 165 or < 115 or other serious electrolyte derangements or diabetic ketoacidosis?
“The average wait time for a bed for a directly admitted patient is 4 hours but can be 8 hours or more. Does this patient need any of the following sooner than 8 hours?”

- IV fluids or urgent antibiotics?
- Imaging?
- Supplemental oxygen? (above any baseline home oxygen requirement)
- Telemetry or pulse oximetry monitoring?
- Pain medication?

Do you have any concerns about the patient waiting comfortably in the hospital lobby for 8 hours without any medical care, intervention or supervision?
Expectations around Quality and Patient Safety

Faculty in the DOM are required to complete **online training** as assigned by Quality, Safety, & Risk Prevention (QSRP). This may include training in service recovery, professionalism, disclosure and reporting of adverse outcomes, and event reporting.

Faculty in the DOM are required to complete assigned **policy reviews**. This may include policies regarding EMR documentation, healthcare decision making, electronic messaging of identifiable patient information, and occurrence reporting.

Faculty in the DOM are strongly encouraged to complete online surveys as assigned by Quality, Safety, & Risk Prevention. This may include **Culture of Safety Surveys**.

Faculty in the DOM are required to **CLEAN THEIR HANDS** before and after every patient interaction.

**DOM 100% Mortality Review**

All mortalities within VUH are reviewed by physician reviewers. Mortalities occurring on DOM services are reviewed by DOM faculty who have received specialized training by QSRP. The focus of the reviews is to identify systems issues which may be addressed to improve patient care.

**Adverse Event Notification**

Patient safety events are occurrences that are not primarily related to the natural course of a patient’s illness or underlying condition. VUMC utilizes Veritas as the mechanism for reporting serious or significant events that involve either patients or visitors. This can be used to report potential or actual safety hazards, adverse occurrences, near misses, severe or unexpected complications.

Steps to take in an adverse event:

- Immediately take care of the patient to stabilize his/her condition and to mitigate and prevent further harm
- Team members should take necessary actions to eliminate remaining threats to patient safety (e.g., remove faulty equipment, secure implicated drugs, ensure other patients are receiving appropriate care).
- Housestaff and NP/PA covered teams should notify the primary attending (or on-call attending) as soon as possible after the event.
- The attending should notify the Office of Risk and Insurance Management by phone. The main office number is 615-936-0660; the on-call Risk Manager can also be reached at 615-878-0705 or by contacting the hospital operator; risk managers are on call 24/7
- The attending or any other team member should enter a report via the VERITAS II online system. Reporting through either VERITAS or risk management (or ideally both) should take place as soon as possible but MUST take place within five days of the event
- The attending or designee should communicate what happened to the patient or authorized representative, saving all uncertain details for later discussions and avoiding placing blame on any individual person or circumstance. Training in disclosure of adverse events is provided to all faculty members
• DOM attendings should notify the Vice Chair for Clinical Affairs (Cecelia Theobald, pager 615-835-9486) as soon as possible after the event
• The on-call Risk Manager and Dr. Theobald are available to advise the attending and care team regarding the disclosure process. The attending should also brief the care team to ensure consistent communication across team members.
• The attending or designee should complete clinical documentation including the event, assessment of the patient, notification of the attending, and treatment plan.
• Do not use email to communicate any details about patient care or adverse events.
• Do not make promises regarding bills or finances to a patient, if an event or perceived event occurs. Notify RM or refer the patient to Patient Affairs so they can address billing questions.

Disclosure of Adverse Events

When disclosing an obvious, harm-causing error to a patient or family member, use the following basic principles:
• Apologize (be precise, factual); nature of error, harm
• Provide information on when, where the error occurred
• Review the causes, results of harm; actions taken to reduce gravity of harm; actions to reduce or prevent reoccurrence
• Describe who will manage ongoing care
• Be prepared to describe error review process and identification of systems issues
• Provide contact information
• Offer counseling, support

Anytime an adverse event is disclosed to a patient or family member, document the conversation using the eStar Disclosure Note. This template is designed to meet regulatory requirements and includes information about how to contact VUMC Risk Management and other support services. The note template can be found in eStar in both the NoteWriter and Notes activities as a note type titled “Disclosure Event”. In the outpatient setting, the dot phrase .disclosure can be used to import the template.

Reporting to the Medical Examiner

Tennessee law and VUMC policy require that certain deaths are reported to the Davidson County Medical Examiner (ME). These include (but are not limited to) deaths “... during or as a result of a diagnostic or therapeutic procedure, medication error, or adverse, allergic, or toxic reaction to a therapeutic agent...”. Details of other categories of reportable deaths can be found in the VUMC policy Policy IO 20-10.14: Deaths Requiring Reporting to the Medical Examiner.

It is the responsibility of the physician completing the Report of Death to notify the Davidson County ME when a death falls within any of the required categories. The ME makes the final determination of case acceptance for examination. All conversations with the Medical Examiner’s Office are documented in eStar, including the rationale for reporting. This should include the date and time of the call as well as the details reviewed with the ME office.
Event Analyses

All adverse events reported through VERITAS and risk management are reviewed by a clinical risk manager. A safety event decision algorithm is used to determine if an individual event meets the criteria for a serious safety event (SSE); all SSEs undergo a formal event analysis (EA).

Members of the care team, institutional stakeholders, and safety and risk management professionals come together to conduct a formal EA. The aim of this is to determine the root cause(s) of the event, formulate and execute an action plan, and mitigate the risk of a future event. During EAs, all team members have equal value. The focus of EAs is always on systems & process improvement and not on individual blame. All conversations during EAs are protected by the peer review statute of TN and are not to be discussed outside these sessions.

If you are contacted to be a part of an EA, please make every effort to help assist in the gathering of information and be available to attend the EA.

Additional Resources & Links

https://veritas.mc.vanderbilt.edu/
https://www4.vanderbilt.edu/vumcriskmanagement/
https://www.vumc.org/risk-management/introduction-professional-liability
Includes link to disclosure basis & resources at VUMC

https://vanderbilt.policytech.com
- Policy OP 10-10.24: Occurrence Reporting: Patient and Visitor
- Policy OP 10-30.05: Sentinel Event Analysis and Response
- Policy OP 20-10.03: Disclosure of Unanticipated Outcomes
- Policy IO 20-10.14: Deaths Requiring Reporting to the Medical Examiner
Guide to VERITAS

WHAT IS VERITAS?

VERITAS is an internal and confidential online system for Vanderbilt staff to report events (or potential events) involving patients or visitors. Information is used to improve quality and safety at Vanderbilt.

HOW DO I GET TO VERITAS?

At CWS (clinical work station) click on the VERITAS II icon on the desk top.

At other computers – go to home page for the Medical Center at www.mc.vanderbilt.edu. Under “For Employees,” click on “More” and scroll down to “VERITAS.” Click on it.

HOW DO I LOGIN TO VERITAS?

With your VUNet ID and password (the same one you use to access your Vanderbilt email).

HOW DO I REPORT AN INCIDENT?

Along the left side of the screen, click the second icon from the top. (TIP: When you hover over it, it will read "new file.")

Select the icon that best represents the type of event you are reporting.

All areas with green asterisks are required fields (there aren’t very many of them).

Any field that has an arrow to the right side of the field offers a drop down menu. Use it whenever possible, as it makes it much simpler to use the system. If you are unsure about which choice to make, choose one that seems most appropriate. Examples: if the issue is with an IV line, choose “Vascular Access.” If it may be related to an IV fluid or medication, choose “Medication/Fluid.” If someone threatens you at work, choose “Safety/Security/Conduct.”

Choose the options that best describe the event. In some fields, the “Other” option is available.

Some fields have “Search” functions to the right of the field. This is a great feature when entering patient info. Click on “Search,” enter the patient’s medical record number (with no leading zero) or the patient’s last and first name, hit the “Search for Patient” button. Click on your patient to highlight them and then on the “OK” button on the bottom. The selected patient information will populate the “Person Affected” page. The same is true for entering attending physician info. Click on the “Search” button and enter the physician’s last name. Click on “Search for Provider,” highlight the appropriate choice and click on “OK.”
Continue to scroll down the pages using the drop down menu. Try to be as specific as possible when choosing options in the drop down menus.

Once all the required fields are complete and you have entered a “Brief Factual Description,” hit the “Submit Incident” button at the bottom of the page. If any of the required fields are not completed, a screen will pop up telling you what needs to be completed. Go to that field and enter the info needed. HELPFUL HINT – If you’ve typed a note about an event in eStar, you can copy that note and then paste it into VERITAS.

REMINDER: Completing a VERITAS report does not take the place of documentation in the chart.

For more information or to watch step-by-step instructions, visit the Learning Exchange at https://learningexchange.vumc.org/ and search for the course entitled “Entering In a Veritas Report”

WHAT HAPPENS TO THE VERITAS REPORT?

The primary reviewer is a designated individual from the department listed as the “Department Where Incident Occurred." The reviewer for the department listed as “Patient’s Originating Department” also sees events originating from their department. The primary reviewer is responsible for following up on the event, or getting the event to the appropriate person for follow up if it is not theirs.

Risk Management reviews every event for possible risk concerns.

Information from the VERITAS reports may be used to monitor for trends, to identify process issues or audit for changes after a new process is implemented and other quality improvement purposes.
Department of Medicine Professional On-Boarding: Managing Patient and Colleague Complaints and Professionalism Concerns

Updated May 2018

The Center for Patient and Professional Advocacy (CPPA) is an education and research center based at Vanderbilt University that supports professionalism as the foundation of safe, quality healthcare. CPPA’s mission is to promote patient and professional satisfaction with healthcare experiences and restrain escalating costs associated with patient dissatisfaction. Both patient complaints and coworker concerns are processed through the CPPA.

Unsolicited patient complaints are processed through the Patient Advocacy Reporting System (PARS®), a validated tool developed at VUMC and used at more than 140 other health systems. Up to 50% of physicians will have no unsolicited complaints. The PARS program is designed to share information and to identify those clinicians with a disproportionate number of patient complaints. Individual patient complaints are shared with clinicians by patient relations specialists on an ongoing basis. For clinicians with a pattern of complaints, peer messengers share compiled data once a year during informal conversations in order to promote professionalism, reduce malpractice risk and increase patient satisfaction.

Coworker concerns are similarly processed through the Coworker Observation Reporting System (CORS®). More than 90% of physicians are associated with no reports through this system. Individual instances of unprofessional conduct are often related to a single lapse. In these circumstances, a peer messenger shares the observation with the faculty member in an informal “cup of coffee” conversation. This conversation is designed not to be punitive, but to share information with the faculty in a low-risk environment. If additional reports continue, an awareness intervention will take place. These interventions are based on the Professionalism Pyramid, built on a structure of escalated communication as patterns of unprofessional behavior develop and rooted in the concept that the vast majority of professionals conduct themselves in exemplary ways.

The attached illustrations provide additional detail regarding the Professionalism Pyramid and Cup of Coffee Conversation.

https://ww2.mc.vanderbilt.edu/CPPA/
Pyramid for Promoting Reliability and Professional Accountability
**DOM CME Requirements, Conference Attendance, and MOC credit**

Faculty in the DOM are required to obtain **100 hours of CME over the course of 2 years**. Documentation of full CME attendance is needed at the time of reappointment.

Faculty in the DOM are required to attend **at least 21 DOM Grand Rounds sessions per academic year**. DOM Grand Rounds take place on Thursdays from 8 – 9 AM in Light Hall 208.

Department of Medicine faculty who attend DOM Grand Rounds will have the opportunity to earn Maintenance of Certification (MOC) credit for attending Grand Rounds. MOC points earned will count towards all subspecialty certifications. To earn MOC points from CME activities, faculty need to complete a self-assessment activity which is available via email following relevant CME events. Satisfaction requires completion of a 5-question quiz; 60% or greater on the quiz will earn 1.0 unit MOC.

Faculty in the DOM are required to attend **at least one MM&I session per year**. This may occur through attendance of either departmental or divisional MM&I's.

In addition to the VUMC and DOM requirements above, there are separate Tennessee state CME requirements for re-licensure. Tennessee requires:

1. Completion of forty hours of CME in the two calendar years prior to license renewal.
2. At least two (2.0) hours of the required CME credit must be specific to controlled substance prescribing.

All state requirements (including the two hours of controlled substance CME) must be completed by the end of calendar year prior to renewal. For example: if your medical license is renewed in October of 2019, forty hours of CME including two hours of prescribing CME must be completed between January 1, 2017 and December 31, 2018.

With respect to the controlled substance prescribing requirement, VUMC has several mechanisms that can facilitate meeting this requirement. These include scheduled interactive or didactic lectures within your division or the department of medicine, as well as online materials designed to satisfy these CME requirements. In order to access those online resources, go to the CME website at [https://vumc.cloud-cme.com](https://vumc.cloud-cme.com) and login with your VUNet ID.
**Communication Guidelines (May 2019)**

**Clinician-Patient Electronic Communication and Phone Calls**

Much of our communication with patients, colleagues and ancillary staff now occur electronically through secure messaging within the EPIC interface. Secure messaging is an expedient means to answer questions, convey results and opinions, and to provide patient updates. Given that such messaging is stored electronically both within EPIC and – often – within patient e-mail interfaces, the contents remain available for later review and scrutiny. The following recommendations are intended to govern the content and handling of secure messages by faculty of the Department of Medicine. These guidelines will serve as the applied standard when secure messaging is reviewed as part of investigations into adverse outcomes and claims of professional misbehavior.

1. All electronic communications between clinicians and patients should make use of secure messaging through the electronic health record. Note that all electronic communications via secure messaging are part of the legal medical record.
2. Clinicians are encouraged to review with all new patients the advisable uses of secure messaging.
3. Clinicians are encouraged to use the reminder function on secure messages sent to patients to alert them if the message has not been read. Unread messages should be followed up with a phone call or mailed correspondence.
4. Clinicians should respond to patient secure messages in a timely fashion as determined by triaging personnel or less than two business days (whichever is shorter). Best efforts should be made to return urgent messages and phone calls within two hours. Emergent messages are handled immediately.
5. Clinicians should be aware of all attachments made to secure messages and avoid sending them to patients if not appropriate.
6. Clinicians are encouraged to be concise and clear in all secure messaging with patients. They should use non-medical vocabulary appropriate to the patient and avoid using abbreviations, contractions, slang, poor grammar, etc.
7. Clinicians should avoid emotional/non-professional comments or responses in secure messages to patients. Specifically, they should avoid conveying anger, sarcasm, criticisms and/or libelous references to third-parties.
8. If a message is complex, and written communication via messaging may fail to effectively convey a provider’s thoughts or be of excessive length, the clinician is encouraged to call the patient personally. In cases where the messaging string has accrued multiple messages (defined at 6 or more), a phone call may be a more effective way to resolve the issue.
9. If a clinician completes a phone call with a patient, this should be documented in eStar.
10. If a clinician will be out of office, he/she must solicit appropriate coverage for In Basket.
Clinician-to-Clinician Communication Guidelines

Effective communication between clinicians is vital to a safe and reliable healthcare system. Though attendings are ultimately responsible for the care of patients, communication between services often occurs via intermediaries (e.g. intern-to-intern). Direct attending-to-attending communication is, however, valuable and encouraged in many situations including when there are disagreements regarding patient care. Concerns regarding the clinical management by other providers should be handled outside of the electronic health record.

Closed-loop communication is also encouraged in many situations. Occasionally closed-loop communication is mandatory. When a clinician makes a serious diagnosis (e.g. cancer), and they intend to transfer the responsibility for caring for that diagnosis to another provider, then they must ensure the receiving provider acknowledges the transfer of this responsibility. A phone call is often the most expedient and helpful way to perform this.

We have an obligation to keep others on the healthcare team informed of changes in the health of their patients. Hospital discharge summaries should always be sent to the patient’s primary care provider, and outpatient consult notes should be sent to the referring clinician.
In order to improve patient safety and team communication, the DOM Quality Council has developed a policy regarding admissions. VUMC house staff, fellows, and/or advanced practice providers (APPs) will communicate with the service or on-call attending (of the same specialty) about every admission. The primary objectives are to improve patient care while also allowing the house staff and/or APPs the opportunity to discuss treatment plans with the attending promptly after their initial evaluation of the patient. Early communication with the attending not only enhances patient care by establishing the most appropriate treatment plan early in the patient’s hospitalization, but also serves as an important teaching opportunity for the house staff. Faculty are encouraged to allow house staff and APPs to present their findings and plans.

To facilitate communication with the house staff, it is suggested that attending physicians check-in with the team in the mid-late afternoon, and then again in the late evening. This will allow for the ability to discuss new admissions of which the attending has not yet been notified, and also review questions on patients that have ongoing care requirements.

Please note the following lines of communication for each VUMC DOM team:

**MICU HOUSE STAFF AND APP TEAMS**

MICU team admits and evaluates patient → House staff communicates with the MICU fellow → MICU fellow communicates with the MICU attending → MICU fellow contacts house staff if changes to management are needed based on communication with the attending

Pages between midnight-6am may be limited to urgent pages only. Examples of cases where no delay in communication is expected include (but are not limited to) the following: resident/fellow desires attending input; severely ill patients not expected to survive the night; unstable patients or patients with shock refractory to fluid boluses; hemodynamically significant arrhythmias; patients requiring an important new intervention after arriving to the MICU, including intubation/mechanical ventilation, acute dialysis, emergent surgery, etc.

**CVICU**

CVICU house staff team admits and evaluates patient → House staff communicates with the CVICU fellow → CVICU fellow communicates with the CVICU attending → CVICU fellow contacts house staff if changes to management are needed based on communication with the attending

Pages between midnight-6am may be limited to urgent pages only. Examples of cases where no delay in communication is expected include (but are not limited to) the following: resident/fellow desires attending input; respiratory failure requiring intubation; initiation of mechanical circulatory support; initiation of therapeutic hypothermia after cardiac arrest; new hemodynamic instability despite pressors/inotropes; urgent initiation of CRRT; cardiac arrest; discussion of new DNR/withdrawal of care; new hemorrhagic shock; new severe/refractory arrhythmia.
DOM POLICY ON FACULTY NOTIFICATION OF ADMISSIONS

NON ICU ADMISSIONS

House staff or APP team admits and evaluates patient → House staff or APP communicates with the pertinent service fellow (if applicable) → Service fellow or House staff/APP communicate with the service attending → (if applicable) service fellow contacts team if changes to management are needed based on communication with the service attending

Pages between midnight-6am may be limited to urgent pages only. Examples of cases where no delay in communication is expected include (but are not limited to) the following: resident or fellow desires attending input; patient has a rapid response or code called; patient requires ICU transfer.

Some services may have additional specific expectations about the timing of after-hours contact with fellows and/or attendings.
**Inpatient Efficiency Practices**

Vanderbilt Adult Hospital often functions at or above full capacity. DOM attending physicians should work with their clinical teams to facilitate efficient patient care and discharge patients in a timely manner whenever possible to do so safely.

Practices that support timely hospital discharge may include:

- On teaching services, running the list with the housestaff in the afternoon to discuss anticipated discharges for the following day
- Completing medication reconciliation and ordering needed prescriptions the night prior to anticipated discharge
- Prioritizing rounds so that patients anticipated to be discharged are seen first, as long as the stability and safety of other patients allows
- Entering discharge orders during rounds and enabling housestaff to do so
- Occasionally rounding on a few stable patients without the entire team, in order to enable others to work on discharging patients
- Participating in daily huddles with transition management office (TMO) staff (such as case managers and social workers) and providing daily updates on medical readiness for discharge
- Making TMO staff aware early of discharge barriers and patients with challenging discharge situations and escalating situations when appropriate
- Contacting the TMO Administrator On Call (AOC) when needed – pager 615-835-7262
Minimum Length of Service and Attending Handovers

Updated May 2018

In order to preserve patient continuity, attendings on a DOM inpatient service will cover the service a minimum of 7 consecutive days. For consult services, attendings are expected to attend for a minimum of 7 days; however, fellows or advance practice providers who have seen the patients with the physician attending may round on the weekends when a different physician attending covers for the primary service attending. Exceptions to the minimum service length may be granted for specific services with approval of the DOM Chair or Chair designee.

Notes: Minimum service time for DOM advanced practice provider faculty will be left to the discretion of the Division Directors or their designees. Attempts should be made to minimize service handovers and to provide optimal continuity of care.

DOM faculty (physicians and advanced practice providers) attending on VUH inpatient clinical services are expected to provide both a verbal and written review of all patients to the accepting faculty member prior to the transition in service. Ideally, the faculty would round together with the team on the day of transition, however, this is not a requirement.

Notes: The requirement for both a verbal and written handover applies to the change of primary responsibility of the service to another faculty member. It does not apply to handover which occur at times of shift changes or cross-coverage, which have separate expectations and processes.
Patient admitted

ADMISSION PAIN ASSESSMENT
Primary Clinician: Check CSMD for medication verification, order UDS, consult Pharmacy for med rec
Admitting Nurse: Perform bedside assessment

INITIAL TREATMENT STRATEGY
1. Resume home pain medications, if appropriate
   - Check CSMD or have Pharmacist med rec to verify
2. Target analgesics to pain type/source
   - If opiate, bowel regimen recommended
3. Make use of non-pharmacologic options
4. Document management plan & contingency plan in note
5. Provide patient with education on pain expectations/goals

Does the patient have complicated pain?

Definition: COMPLICATED PAIN
1. Prior admissions with difficult pain management
2. History of substance addiction or abuse or high risk for these outcomes
3. Any significant care team concerns about pain management, or conflict between team & patient

PRIMARY TEAM Pain Management

SECONDARY ASSESSMENT
1. Is pain uncontrolled after 24hrs despite escalation in opioids?
   - Re-evaluate every 24hrs
2. Has conflict arisen between patient and primary team regarding pain plan?

CONSULT PAIN SERVICE (phone 615-207-1201)
Specify for Chronic or Acute non-surgical pain

Generates:
Standardized COMPREHENSIVE PAIN ASSESSMENT
Standardized DAILY PAIN ASSESSMENT

FINAL PAIN ASSESSMENT
Standardized DISCHARGE PAIN PLAN
With PCP, Pain Specialist, or Inpatient Clinician, agree upon DISCHARGE PAIN PLAN to include:
1. Maximum 7 day supply of controlled substances
2. 30 day follow-up visit plan for pain management; contact CPS # to request taper or other opiate follow-up, if needed
3. Contingency plan for urgent pain issues (CPS patients may receive Pain pager #)
   - Provide patient with DISCHARGE PAIN PLAN in Patient Letter & (if followed by CPS) pain pager
   - Provide PCP/outpatient provider with DISCHARGE PAIN PLAN in Discharge Summary
DOM Expectations for Discharge Follow-up

All patients discharged to home from DOM teams will be expected to have a follow-up appointment scheduled with a provider within 14 calendar days of the patient’s discharge. Optimally, this visit will occur within 7 days of discharge. Depending on the needs of the patient, this appointment may be with an outpatient provider at VUMC (within primary care or a specialty clinic, as appropriate) or one outside of VUMC; however, the patient should have a specific time and date for his/her scheduled appointment documented in the medical record prior to discharge, rather than a recommendation that the patient make his/her own follow-up appointment. It is suggested that follow-up appointment planning begin shortly after admission.

The Central Access Center is available to help with scheduling of both appointments at VUMC clinics and appointments at clinics outside of VUMC. One business day is needed to complete scheduling, so clinical providers should request assistance with scheduling at least one day before discharge and, ideally, as soon as possible after admission.

The DOM has a strong interest in reviewing and optimizing medications of all patients admitted to the inpatient service. All medications should be reviewed regardless of whether the medication is directly associated to the reason for admission. Any patient discharged on a high-risk medication or medication requiring monitoring (i.e. anticoagulation, insulin, chemotherapy, controlled substances, etc.) should have a specific plan for follow-up and monitoring.

For the DOM inpatient services, the discharging attending is responsible for overseeing home health care until follow-up with a primary care clinician post-discharge, ideally within 14 days and up to 30 days post-discharge. This expectation will complement, rather than replace, current workflows for managing post-discharge orders, such as ID Clinic management of IV antibiotic orders and Nutrition Clinic management of TPN. The Department recommends including the name of the responsible outpatient clinician and date of follow-up appointment in the initial home health orders so additional home health orders can be routed to the correct clinician.
Clinic Template and Cancellations

Clinic appointment templates should be a minimum of three to four hours in length and generally should not cross morning/afternoon hours (for on-campus clinics). Templates must be approved by the clinic medical director and should be in line with accepted clinic standards.

Clinicians are expected to use the Provider Time Away (PTA) tool if any clinic sessions or clinic time slots need to be canceled. It is the responsibility of the clinician to obtain coverage for phone calls, pages, and eStar inbasket messages while they are unavailable (This can be specified in the PTA tool).

Clinic cancellations, including cancellations for vacation, holidays, meetings, and rounding (if applicable) should occur > 6 weeks in advance to allow for adequate rescheduling of patients. Clinic cancellations occurring < 6 weeks in advance require approval by clinic leadership using the PTA tool.
Outpatient Controlled Substance Prescribing
Department of Medicine Expectations
in accordance with CDC guidelines and April 2019 Tennessee state law

In 2017 Tennessee prescribers wrote 94 opioid prescriptions for every 100 persons – representing the 3rd highest prescribing rate in the country. To address this epidemic, the TN TOGETHER legislation was passed in 2018 and revised in April of 2019. The requirements below reflect TN law as of July 1, 2019:

Tennessee law provides rules for prescribing opioids under 5 situations:
1. Acute pain (up to 3 days)
2. Moderate pain (4-10 days)
3. Prolonged pain (11-30 days) *(to be used rarely)*
4. Post-op pain (up to 30 days)
5. Exempt conditions (long term use)

1. Acute pain (up to 3 days)
   a. Patient may be given up to 3 days supply up to 180 MME total dosage
      • Hydrocodone 7.5mg #24, oxycodone 5mg #24, tramadol 100mg #18
   b. Prior to prescription patient must be seen IN PERSON
   c. Patient cannot receive another Rx within 10 days unless seen again in person

2. Moderate pain (4-10 days)
   a. Patient may be given up to a 10 day supply and up to 500 MME total dosage
      • Only one prescription may be provided per encounter
   b. Prescriber must do each of the following AND document each in medical record
      • Check the TN controlled substances monitoring database (CSMD)
      • Evaluate patient including assessment of risks for opiate therapy
      • Document consideration of alternative therapies considered and why an opioid was chosen
      • Obtain informed consent (available in MedEx as Adult Opioid Contract)
      • Include the ICD-10 code on the prescription and on the chart
      • Non-pregnant women of child-bearing age must be advised of the risks and should be offered contraception
      • Pregnant patients should be referred to high-risk OB

3. Prolonged pain (up to 30 days)
   a. Patient may be given up to a 30 day supply and up to 1200 MME total dosage
   b. Must be ONLY used in rare cases AND after documented trial and failure of non-opioid alternatives
   c. Prescriber must do each of the requirements in 3b above AND write “Medical necessity” on the prescription
4. Post-operative pain (up to 30 days)
   a. Patient may be given up to a 30 day supply and up to 1200 MME total dosage
   b. Must be ONLY used for more than minimally invasive surgery
   c. Prescriber must do each of the requirements in 3b above AND write “Surgery” on the prescription

5. Exempt conditions / long-term use
   a. Patient may be given up to a 30 day supply at a time
   b. Prescription must contain the ICD-10 code and the word “exempt”
   c. EXEMPT CONDITIONS
      • Patients receiving active cancer treatment
      • Patients receiving palliative care treatment or hospice care
      • Patients treated with an opioid for 90 days or more in the last year
      • Patients who have suffered severe burns or major physical trauma
         (specific definitions apply)

During ongoing/chronic opiate therapy, a prescriber must:
1. Assess need for opiate therapy at least every 3 months or at each visit, whichever is less frequent.
2. Check the CSMD at minimum every 3 months
3. Strongly consider performing urine drug testing at least twice annually during therapy
   (more frequent testing is recommended for those on higher dose opiates or with aberrant behavior)
4. Use the lowest dose opioid for shortest time possible
5. See patients on chronic opioids in clinic every three months
6. Refer to Pain Management Specialist for consultation and/or management at least annually for opiate use of > 1200 MME
7. Regularly reassess the risk/benefit ratio of opiate therapy

Dot phrases
1. .opioid: for use in note text; describes steps taken for non-exempt prescriptions >3 days
2. .opioidrx: for use on prescriptions; allows for selection of an exempt category


FAQ from Vanderbilt Division of Pain Medicine:
A healthcare practitioner may prescribe:

- Up to 3-day opioid prescription
- 180 MME total dosage

No requirements before prescribing

- Up to 10-day opioid prescription
- 500 MME total dosage

Requirements before prescribing:
- Check the CSMD
- Thorough patient evaluation
- Document consideration of alternative treatments and why an opioid was used
- Obtain informed consent
- Include the ICD-10 code on chart and Rx

For a more than minimally invasive procedure:
- Up to 30-day opioid prescription
- 1200 MME total dosage

For medical necessity (after trial and failure or contraindication of a non-opioid treatment):
- Up to 30-day opioid prescription
- 1200 MME total dosage

The following are individuals exempted if the prescription includes the ICD-10 code and the word “exempt”:
- Patients receiving active cancer treatment, palliative care treatment, or hospice care
- Patients with sickle cell disease
- Patients receiving opioids in a licensed facility
- Patients seeing a pain management specialist
- Patients who have been treated with an opioid for 90 days or more in the last year or who are subsequently treated for 90 days or more
- Patients being treated with methadone, buprenorphine, or naltrexone
- Patients who have suffered severe burns or major physical trauma*


* "Severe burn" means an injury sustained from thermal or chemical causes resulting in second degree or third degree burns. "Major physical trauma" means a serious injury sustained due to blunt or penetrating force which results in serious blood loss, fracture, significant temporary or permanent impairment, or disability.
Provider Rating Transparency FAQ

What is Provider Rating Transparency?
Publicly sharing providers’ star ratings (0-5 stars) and patient comments about experiences with providers as collected from the Press Ganey survey and posted on provider profiles on VanderbiltHealth.com.

Why are we doing this?
This allows VUMC to proactively share scores and comments while also spurring improvement efforts.

Which providers will have their patient satisfaction results made public?
• Medical Practice providers with >300 patients per year (budgeted)
  – Excludes resident clinics
• Only display scores for providers with at least 30 surveys
  – If a provider does not have at least 30 ratings, it will say:
    • “This provider has not yet received the minimum number of surveys to show a star rating.”

How are the scores calculated?
Your overall star rating is the average of all responses in the Care Provider section.

Which questions are used?
Only questions and comments from the Care Provider section of the Medical Practice survey:

<table>
<thead>
<tr>
<th>CARE PROVIDER</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please answer these questions with the Provider named in the first question of this survey in mind.</td>
<td>very poor</td>
<td>poor</td>
<td>fair</td>
<td>good</td>
<td>very good</td>
</tr>
<tr>
<td>1. Friendliness/courtesy of the care provider.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. Explanation of the care provider gave you about your problem or condition</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. Concern the care provider showed for your questions or worries</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. Care provider's efforts to include you in decisions about your treatment</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. Explanations about what would happen during tests or procedures</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. Information the care provider gave you about medications (if any)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7. Instructions the care provider gave you about follow-up care (if any)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8. Degree of which care provider talked with you using words you could understand</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>9. Amount of time the care provider spent with you</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>10. Your confidence in this care provider</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>11. Likelihood of your recommending this care provider to others</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>○</td>
</tr>
</tbody>
</table>

Comments (describe good or bad experience):

Is it statistically significant?
Press Ganey has verified using at least 30 surveys because this is viewed as the sample size that allows us to make valid inferences about the entire population.
Provider Rating Transparency FAQ

What if there are negative comments?
Both positive and negative comments will be posted. However, any comments containing the following will be excluded and not posted:
1. PHI (Patient Health Information)
2. Abusive Language
3. Reference to another provider by name
4. Survey feedback
5. Provider’s personal appearance
6. Reference to another department or area

Can I remove a comment?
All comments will be posted to the APD by the 1st of the month. Providers have until the 15th of the month to review their comments and appeal if they think a comment should be excluded. Appealed comments will not be posted online until they are reviewed by the Appeals Committee. The Appeals Committee will notify providers of its decision to accept/deny appeals.

Who is on the Appeals Committee?
Dr. Paul Sternberg chairs the committee, which also includes two department chairs, two representatives from the Physician Council for Clinical Service Excellence, and one APN representative.

How long will comments be posted?
Comments will be posted publically for at least 1 year and will be listed by received date, with most recent comments listed on top.

What can I do to improve my scores?
Providers are encouraged to review their individual provider reports with their department chairs or division directors to help identify resources and develop plans for improvement.
Regulatory and Quality Reporting Program Check List
Use EHR Tools During a Clinic Visit (May 2019)

It is the expectation that all faculty and staff will participate in programs designed to improve the quality and value of care.

During a Clinic Visit
- Record encounter problems in the patients After Visit Summary (AVS) so Patient Education is automatically identified.
- Finalize the AVS at the end of the visit so it is uploaded to My Health at Vanderbilt (MHAV) for Timely Access and encourage the patient to visit MHAV to see their health information (View Download Transmit).
- If placing orders, use Computerized Order Entry (CPOE) systems for medications, labs, and radiology.
- If referring the patient outside Vanderbilt Medical Group, place a Consult order in Epic indicating outside provider. Follow by sending a Summary of Care document electronically to that provider to support health information exchange efforts. You may also delegate this task to your staff.
- If following up with a patient or reaching out to a patient, use Secure Electronic Messaging and send to the patient’s MHAV (if the patient has an active MHAV account).

NOTE: The terms in bold above represent the EHR measures (aka Meaningful Use measures) used to calculate scores in both Medicare Quality Payment Programs (MACRA/MIPS) and Medicaid EHR Incentive Program.
Department of Medicine Organizational Chart

Nancy J. Brown, M.D., Chair of Medicine

John McPherson, M.D., FACC, FACP, Vice Chair for Clinical Affairs, Director, Internal Medicine Residency Program

Brian Christman, M.D., Vice Chair for Clinical Affairs at the VA, Associate Dir, Internal Medicine Residency Program

Maureen Gannon, M.D. & John Newman, M.D., Vice Chairs, Faculty Development

Roy Zent, M.D., Ph.D., Vice Chair for Research

Leora Horn, M.D., M.Sc. Associate Vice Chair, Faculty Development

Neeraja Peterson, M.D., M.Sc., Assoc Dir, Internal Medicine Residency Program and Assoc Chair, Ambulatory Education

Elizabeth A. Yakes, M.D., MPH, Assoc Director, Internal Medicine Residency Program

Patrick Hu, M.D., Ph.D., Executive Secretary of the Tusley Randolph Harrison Society

Jessica Germain, Ph.D., Vice Chair for Education

Michael Fowler, M.D., Director, Physical Diagnosis Course

Matthew Miller, M.D., Co-Director, Ambulatory Primary Care Medicine Clerkship

Joseph Gigante, M.D. Co-Director, Pediatrics Primary Care Medicine Clerkship

Brie Barnett, Lead Admin Asst

Kristy Braden, Manager, Internal Medicine Residency Program

Faupio Poe, Program Mgr

Maria Kael, Program Mgr

Kim Wilson, Manager, Operations & Development

Ilene Barnett, Lead Admin Asst

Jazmine Caldwell, Admin Asst

Angie Wagner, Assoc Program Manager
Schaffner Society for DOM Clinician-Educators

The Schaffner society is named for William Schaffner, MD, Professor and Chairman of Preventive Medicine and Professor of Medicine at Vanderbilt University School of Medicine. The Schaffner Society is committed to providing services to assist clinician educators in their pursuit to become outstanding clinicians, researchers and educators.

All clinician educators will be awarded membership into the Schaffner Society. While each division will offer support to its members, the society provides additional support beyond the expected activities. This support includes workshops, seminars and career counselling that will serve to promote professional growth and faculty skills.

Members of the Schaffner Society can request career development meetings at any time. There is a link on the departmental website (https://medicine.mc.vanderbilt.edu/schaffner-society) that allows for a request for a meeting to be submitted. The website also offers a calendar of upcoming events and seminars as well as further details regarding the society.

The Schaffner Society is led by Dr. John Newman, Vice-Chairman for Faculty Development, Dr. Leora Horn, Assistant Vice-Chairman for Faculty Development, and Dr. Nancy Brown, Chair of the Department of Medicine. Each division is assigned a mentor to help guide its members through this process (see below).

Schaffner Society Mentors

Division of Allergy, Pulmonary and Critical Care: John H. Newman, M.D. & R. Stokes Peebles, M.D.

Division of Cardiology: Rob Piana, M.D. & Lisa Mendes, M.D.

Division of Clinical Pharmacology: Italo Biaggioni, M.D.

Division of Dermatology: John Zic, M.D. & Jo-David Fine, M.D.

Division of Endocrinology: Howard Baum, M.D.

Division of Epidemiology: Douglas C. Heimburger, M.D.

Division of Gastroenterology, Hepatology & Nutrition: Michael Vaezi, Ph.D, M.D. & Keith Wilson, M.D.

Division of Genetic Medicine: Georgia Wiesner, M.D.

Division of Geriatric Medicine: Laura Dugan, M.D.

Division of Hematology-Oncology: Leora Horn, M.D.

Division of Infectious Diseases: Patty Wright, M.D.

Division of Internal Medicine: Neeraja Peterson, M.D.

Division of Nephrology: Jamie Dwyer, M.D.

Division of Rheumatology: Tom Thomas, M.D. & Leslie Crofford, M.D.
**Elliot Newman Society**

The Elliot Newman Society is a professional organization for all physician-scientists and Ph.D. scientists supported by the Vanderbilt Physician Scientist Development program (VPSD), Vanderbilt Clinical and Translational Research Scholars program (VCTRS), K-12 programs or by individual K-awards. Newman Society members meet annually with the Associate Dean for Clinical and Translational Scientist Development (CTSD) to review the scholar’s career and mentorship plan. As K awardees, all Newman Society members are expected to have at least 75% protected time for research. Failure to meet this requirement will result in withdrawal of institutional salary support or K award. In the case of procedure-oriented specialties, 75% protected time shall be defined as meaning one day or less doing procedures and one half day or less in clinic.

All Newman Society Members are required to file a Career Plan with the Office for Clinical & Translational Scientist Development.

Newman Society website:

https://my.vanderbilt.edu/edgeforscholars/newman/

**Neilson Society**

The goal of the Neilson Society is to support the careers of junior PhD and physician scientists on the tenure track as they develop their independent research careers and national reputations.

Neilson Society Leadership:
- Chair of Medicine: Nancy J. Brown, MD
- Vice Chair for Faculty Development: Maureen Gannon, PhD

Membership eligibility: Assistant Professors of Medicine on the tenure track including:
- all PhD scientists
- Physician scientists who have completed their career development awards and have transitioned out of the Newman Society

The Neilson Society is a resource for junior faculty to enable them to develop the skills they need to navigate the course toward tenure and promotion. The Society holds regular group meetings with the Vice Chair for Faculty Development throughout the year to discuss issues covering all aspects of research scientist and physician scientist career development. In addition the Vice Chair is available for individual mentoring sessions and career counseling.

Neilson Society website:

https://medicine.mc.vanderbilt.edu/neilson-society
Divisional Compliance Expert (DCE) Program

Appropriate documentation is the personal responsibility of each faculty member within the Department of Medicine. The DCE program was developed to assist physicians in producing documentation that accurately captures their professional work, meets compliance standards, and generates appropriate coding and billing for each patient encounter.

DCEs serve as local experts of coding and billing related to clinical activities of their division. DCEs are expected to understand fundamental concepts related to contracting, CMS regulations, and clinic operations that impact documentation and coding, and are tasked with providing education and feedback to members of their division regarding such rules and processes. Additionally, DCEs may be asked to review billing office operations which may lead to enhancements in the billing and collection process for each division. DCEs are also available to meet as needed with individual faculty, the Vice Chair for Clinical Affairs, and representatives from the Office of Corporate Integrity and Compliance when problems with appropriate documentation and coding are identified.

Formal compliance training is conducted twice per year. All full-time, part-time, and adjunct faculty in each division who are credentialed to see patients and who have billing privileges through the VMG billing office are required to complete annual training. Subspecialty fellows are also required to undergo compliance training during the first quarter of the academic year.

The Department of Medicine DCE committee is chaired by Ed Odom and is comprised of one or two faculty members from each division.

Current DCEs:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Faculty Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy, Pulmonary &amp; Critical Care Medicine</td>
<td>John Fahrenholz (Allergy) &amp; Carla Sevin (Pulm/Critical Care)</td>
</tr>
<tr>
<td>Cardiovascular Medicine</td>
<td>Robert Piana</td>
</tr>
<tr>
<td>Clinical Pharmacology</td>
<td>James Luther</td>
</tr>
<tr>
<td>Diabetes, Endocrinology &amp; Metabolism</td>
<td>Chase Hendrickson</td>
</tr>
<tr>
<td>Gastroenterology, Herpetology &amp; Nutrition</td>
<td>Reid Ness</td>
</tr>
<tr>
<td>General Internal Medicine &amp; Public Health</td>
<td>Harley (Ed) Odom</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>Victor Legner</td>
</tr>
<tr>
<td>Hematology &amp; Oncology</td>
<td>Dana Cardin &amp; Frank Cornell</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>Ban Allos</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Anthony Langone</td>
</tr>
<tr>
<td>Rheumatology &amp; Immunology</td>
<td>Bobo Tanner</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>Tyler Barrett</td>
</tr>
<tr>
<td>General Medicine - NP</td>
<td>Jane Case</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Jami Miller</td>
</tr>
<tr>
<td>Hospital Medicine</td>
<td>Kelly Sponsler</td>
</tr>
<tr>
<td>Williamson County</td>
<td>John Scott</td>
</tr>
</tbody>
</table>

Updated August 2019
Clinical Documentation and Coding Excellence (CDACE)

The CDACE program is VUMC’s clinical documentation improvement program, which aims to facilitate accurate representation of a patient’s clinical status and consistent, appropriate translation of clinical information into coded data. This coded data is incorporated into models that directly impact institution-level and physician-level quality metrics, public reporting, and financial outcomes. As such, clinical documentation not only impacts direct patient care, but many other facets of the organization.

The CDACE program consists of a group of Physician Advisors who work within their clinical specialties to ensure that clinical documentation and data capture practices are compliant, accurate and consistent. Physician Advisors provide education to physician peers, clinical documentation specialists, and coding staff within their specialties, and also participate in chart reviews, generate audit reports, and track data related to clinical documentation improvement activities.

Department of Medicine Physician Advisors include:

- Rob Piana (Cardiology)
- Laura Goff (Oncology)
- Victor Legner (GIM & geriatrics)
- Carla Sevin (Pulmonary)
- Kelly Sponsler (Hospital Medicine)
Faculty Contacts for MM&I Conferences

**Department of Medicine:** Dr. Jennifer K Green

**Allergy/Pulmonary:** Dr. James Sheller (F) for Pulmonary; Dr. R. Stokes Peebles (F) for Allergy, Michael Beasley (DA)

**Cardiovascular Medicine:** Dr. Daniel Munoz (F), Cheryl Seneff (DA)

**Clinical Pharmacology:** Dr. Cheryl Laffer (F), Jozee Schnitker (DA)

**Diabetes/Endocrinology:** Dr. Chase Hendrickson (F), Ashlee Robinson (DA)

**Gastroenterology:** Dr. Reid Ness (F), Lisa Dunlop (DA)

**Hematology/Oncology:** Dr. Jill Gilbert (F), Dr. Laura Goff (F), Allen Cantrell (DA)

**Infectious Diseases:** Dr. Paul Jacob (F), Nora Gilgallon-Keele (DA)

**General Internal Medicine & Public Health:** Dr. Jennifer Green (F), Dr. Kathleene Wooldridge (F), M. Holly Jones (DA)

**Nephrology:** Dr. Anna Burgner (F), Dr. Ed Gould (F), Pat Abelson (DA)

**Rheumatology:** Dr. Howard Fuchs (F), Ashlee Robinson (DA)

**Medicine House Staff:** Dr. Jamison Norwood

Updated August 2019
MAC Guidelines for 8MCE Medicine Stepdown Unit
K. Wooldridge

8MCE is considered primarily a unit for the Morgan/Rogers (teaching) teams, but Riven teams may be assigned patients to 8MCE from ED or MICU if there are teaching team census constraints. Riven patients may be moved to 8MCE from floor units for higher level of care—that move does not prompt change to teaching team.

If questions arise regarding patient suitability for the 8MCE unit, triage questions should be directed to the On-Call MICU fellow for review; nursing considerations should be discussed with the 8MCE Shift Leader. You may also contact the MAC RN for assistance or to review nursing criteria.

While the step-down unit may offer intervention frequency <2hrs, confirmation with the shift leader is needed to ensure nursing assignments can accommodate the request in real time. **This is done by the MAC upon initial review of the admit/transfer request.**

The following matrix demonstrates common considerations.

<table>
<thead>
<tr>
<th></th>
<th>General Floor Bed</th>
<th>Step Down Unit Bed</th>
<th>ICU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring: Vital Signs</td>
<td>Max frequency is q4 hours, typical unit standard is q8.</td>
<td>Unit standards are typically q4, can do q2 with orders</td>
<td>Q1h or less if needed</td>
</tr>
<tr>
<td>(T, HR, RR, BP, SaO2),</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus system assessment (neuro checks, pulses, I &amp; O)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasoactive/Anti-arrhythmic infusions (continuous vs titration)</td>
<td>None</td>
<td>Continuous; no RN titration protocols</td>
<td>Titratatable meds</td>
</tr>
<tr>
<td>AccuChecks</td>
<td>qAC+HS</td>
<td>q2H</td>
<td>PRN</td>
</tr>
<tr>
<td>CIWA</td>
<td>Score less than 10</td>
<td>Score =/&lt;14</td>
<td>Score ≥14</td>
</tr>
<tr>
<td>General Admission Criteria</td>
<td>Patients should be hemodynamically stable, requiring no frequency of intervention greater than q4 hours</td>
<td>Patients should be hemodynamically stable, requiring no frequency of intervention greater than q2 hours</td>
<td>Hemodynamically unstable, requiring interventions &gt; q2hrs</td>
</tr>
<tr>
<td>Other considerations</td>
<td>May take art lines/PA caths/Stable vents/home vents not with active respiratory issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

****If the patient needs to move from floor to 8MCE for higher level of care, it will require a TRANSFER order using the TRANSFER tab and transfer the patient, but the TEAM STAYS THE SAME.****

*****Residents will need to notify Attending (Morgan/Rogers) or Fellow (Rogers) to approve escalation in care before transferring a patient from floor to 8MCE.****

Triage Attendings (TA) may be called upon to review cases by the MAC. If the TA feel the patient may be appropriate for ICU, the MICU fellow will assist in determining ICU vs. SDU. If the TA feels patient would be appropriate for SDU if the unit can accommodate a specific request (exa: q2h labs), the MAC should communicate with 8MCE to confirm availability of staffing ratios to perform that task. If they do not have the ratio, pt will need MICU.
04/29/2014

To:

From: Deanna Lawley, MSHA
       Manager, Provider Support Services

Re: Focused Provider Professional Evaluation for

The Joint Commission requires that all practitioners approved to perform new privileges perform an initial period of focused professional practice evaluation (FPPE) of their newly granted privileges, beginning the first day that they begin their patient care activities. The focused practice evaluation should broadly evaluate the ability of the physician to safely and competently perform all the requested new privileges.

You were appointed to serve as the proctor for

who is now due for an FPPE report.

Please complete the attached form and return the form to the address listed below. You may also fax or email the form. Please contact Deanna Lawley at 936-5513 or deanna.lawley@vanderbilt.edu if you have any questions about the FPPE process.
PROCTOR EVALUATION REPORT OF NEW PRIVILEGES

Proctored Physician:

Proctor:

In preparing this report to the Service Chief;

☐ I have NOT had sufficient opportunity to evaluate competency in any of his/her granted privileges.

OR (check all that apply)

☐ I have used direct observation (cross-covering, sequential care, procedural assistance) I have used retrospective medical record review

☐ I have used over-reads

☐ I have used reviews of procedure/surgery case lists

☐ I have used informal reviews with peers, house staff, and/or nursing service personnel

Accordingly, I have found Dr.

(check one)

☐ is a well-trained physician and competent to perform patient care associated with his/her granted privileges. I have no reservations.

☐ is a well-trained physician and competent to perform patient care associated with the majority of his/her granted privileges. The following privileges require additional review, and I recommend another 6 month period of focused review:

☐ requires additional focused review in a number of areas.

_______________________________________
Date

_______________________________________
Date

_______________________________________
Date
# Med/Surg Floor Admission Criteria:

## Vital Signs (If persistently above floor value after resuscitation consider stepdown/ICU)

<table>
<thead>
<tr>
<th>Vital Sign Checks:</th>
<th>SBP (High / Low)</th>
<th>Pulse (Max/Min)</th>
<th>BG Checks:</th>
<th>Temp</th>
<th>RR</th>
</tr>
</thead>
<tbody>
<tr>
<td>No more frequent than Q4H</td>
<td>&gt;200 or &lt;90</td>
<td>&gt;120 or &lt;40</td>
<td>Q4h</td>
<td>&lt;35 deg C</td>
<td>8-30</td>
</tr>
</tbody>
</table>

**Exceptions:**
1. Orthostatic hypotension in GI bleed must go to MICU
2. eStar order may be placed to change BP RRT criteria if there is clear evidence that the patient's baseline is abnormally high or low

## Labs:

**Sodium:**
- Hypernatremia: >165 to ICU unless asymptomatic and presumed chronic
- Hyponatremia: <115 to ICU unless asymptomatic and presumed chronic

**Potassium:**
- Hyperkalemia: Needs ICU if emergent dialysis is indicated and cannot be immediately arranged

**INR:**
- To ICU if inr>1.5 with major* bleeding or >3 with minor* bleeding
- OK for floor at any level if asymptomatic or only inconsequential bleeding

**Platelets:**
- OK for floor if no signs of systemic bleeding besides petechiae or inconsequential bleeding
- ICU if platelets <50k with signs of major* bleeding or <10k with minor* bleeding

1. *Major bleeding is >2 units PRBC’s in 24 hours, minor bleeding is any transfusion needed

**Troponin:**
- Can go to regular floor bed with elevated troponin if non-cardiac cause suspected and delta troponin <10% rise

## Oxygen Requirements:

<table>
<thead>
<tr>
<th>SaO2 (Min)</th>
<th>Supplemental O2</th>
<th>BiPap</th>
<th>Ventilators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>6L NC or ≤50% Venti Mask</td>
<td>8-30</td>
<td>Home Regimen</td>
</tr>
</tbody>
</table>

**Exceptions:**
1. Home Ventilator: Can be assigned to a Non-ICU team if admitted for a non-respiratory cause, contact AC to assist with bed placement
2. Palliative care (must consult) will take BiPap if goal is end of life care
3. Palliative care must consult can accept ventilated patients if goal is end of life care and have ONR
4. Non-Rebreather OK for floor if treating CO poisoning, methemoglobinemia, or a pneumothorax

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The VUH AC (Administrative Coordinator) may be reached at 615-497-2749 with questions and can assist with patient placement.

Some cardiac/surgical/neuro stepdown beds are available with Q2H monitoring/interventions. Contact the AC if an ICU admission may be avoided by assignment to a stepdown bed.

**** Please also note this guide is not an absolute and clinical judgement should always take precedence. Attendings should be involved in discussions early if there are disagreements and PCC nursing/physician leadership is available as is the Chief-Of-Staff on-call.

**S. Russ, Last Modified 09/29/2017**