Atrium Health

COLLABORATIVE PHYSICIAN ALLIANCE

Collaborative Physician Alliance

Clinical Documentation Standards

Publication: January 2015, Revised January 2018

Applies To: Carolinas Healthcare System Medical Group Division

Policy:

RE: Medical Records Standards

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Background

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

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

Purpose

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

Applicability

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

Timeliness of Record Completion

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

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

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

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

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

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

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

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

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

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

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

CHS Medical Group Division Standards for Documentation Integrity

General Principles:

- Maintenance of the information in Canopy is all of our responsibility.
- Providers and staff should document factual and clinically appropriate/relevant information in the medical record. Cases involving deviations from this standard maybe reviewed by the practice/department manager, Site Based Medical Director, Corporate Compliance, Corporate Privacy and Risk Management as indicated. Documentation of subjective negative personal comments regarding patients, providers or staff is strongly discouraged and subject to additional review.
- Having good provider documentation (notes) is only part of the expectation. These are static documents reflecting the work done at a particular encounter. Providers are also responsible for the dynamic parts of the EMR that exist apart from the H&P, progress note, or office visit note,etc.
- While team members may support the provider in some aspects of charting, the provider remains ultimately responsible for the information in the record. It is our responsibility to oversee and direct the maintenance of our patient's medical records.
- Any team member may record positive family history information obtained from the patient (e.g., Father had Type II diabetes at age 50). However, only providers should document all or part of a patient's Family History as "negative."
- Avoid copying and pasting text from another provider's note without attribution to theauthor.

- Unless essential to support medical decision making, avoid wholesale inclusion in the note pieces of information readily available elsewhere in the EMR (e.g., Family History, Social History, lab and diagnostic reports). To support coding and compliance, these data can be referenced in the note as having been reviewed.
- Always review dictated notes to verify that they have been accurately transcribed, especially when using voice recognition programs such as Dragon.
- Provider notes will be viewable by the patient, who are ultimately the ones most concerned about and impacted by our documentation of their health issues.
- Encourage a culture of mutual responsibility for integrity of our documentation. All who view documentation should be responsible to identify and report examples of poor or inappropriate medical record entries. If possible, feedback about concerns should be directed to the initial author of the entry in question. If not feasible, these concerns can be directed to HIM.

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

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

Specific Issues:

Template Use

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

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

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

Copy Forward and Copy/Paste

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

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

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

Proofreading

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

Keeping the Record Current

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

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

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

[2] CMS Documentation Guidelines

Reporting Past, Family and/or Social History

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

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

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

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

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

- Noncontributory
- Negative
- Not significant
- Unremarkable

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

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

Inappropriate Use of the Message Center

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

Medical Scribes

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

Teaching Physician/Resident Linkage Statement

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

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

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

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

Amendments, Corrections, and Deletions

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

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

Abbreviations

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

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

EMR Minimal Use Expectations for CHS Provider

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

For Primary Care Providers:

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

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

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

For Specialty, ED and Urgent Care Providers:

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

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

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

For Surgical and Procedural Specialists:

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

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

Acute and Post-Acute Care Providers:

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

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

Appendix

Physician Not Available to Complete Record.

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

At the top of the note under the Final Report heading, insert the following statement:

The patient encounter has been signed by Dr. *Available* for Dr. *Unavailable* who is no longer employed by Practice *XXX* and unavailable to sign/close this record.

At the bottom of the note above the Signature Line, insert the following statement:

Dr. *Unavailable's* signature below was generated as part of the Cerner signature proxy process. Dr. *Unavailable* performed/authored the original note and no portion of this note has been altered as a result of the signature proxy process.

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

Appendix

Unsafe Abbreviations

Do Not Use!

The following is a list of prohibited abbreviations specified by JCAHO. These abbreviations should not be used in any of their forms - upper or lower case; with or without periods. These *Do Not Use* abbreviations apply to ALL clinical documentation including all types of orders, progress notes, consultation reports and operative reports.

Abbreviation/ Intended Meaning	Misinterpretation	Acceptable Format
U or u (units)	"U" may be mistaken as a zero, a "4" or "cc" leading to overdoses	Write out "units"
I.U. (international units)	I.U. has been interpreted and mistaken as IV or 10 (ten)	Write out international units
Trainling zero (X.0 mg); lack of leading zero (.X mg)	Decimal point can be missed	Never write a zero by itself after a decimal point (Xmg) and always use a zero before a decimal point (0.Xmg)
Q.D. (daily)	May be mistaken as QID if the period or another mark is inserted between the "Q" and "D"	Write out "daily"
Q.O.D. (every other day)	May be interpreted as QID	Write out "every other day"
MS (morphine sulfate)	Has been interpreted as magnesium sulfate	write out "morphine"
MSO_4 (morphine sulfate)	Has been interpreted as magnesium sulfate	Write out "morphine"
$MgSO_4$ (magnesium sulfate)	Has been interpreted as morphine sulfate	Write out "magnesium sulfate"

PITAC Approval: Last Updated: 7/14/2014,10/2018

Appendix

CHS Scribe Policy

The purpose of this policy is to ensure proper documentation of clinical services when the billing provider has elected to utilize the services of a scribe.

INTRODUCTION:

For the purpose of this policy, a scribe is defined as an individual who is present during the provider's performance of a clinical service, and documents (on behalf of the provider) relevant details related to the encounter, and as directed by the provider during the course of the service. Any individual serving as a scribe must not be treating the patient in a clinical capacity and must not interject their own observations or impressions. The scribe's role is limited to **documentation**, and they are not intended to act as a surrogate for CPOE. The Joint Commission and CHS do not support scribes being utilized to enter orders for physicians or Advanced Clinical Practitioners (ACP) due to the additional risk added to the process, however, scribes may also assist the provider in navigating the EMR and in locating information such as test results and lab results. They can support work flow and documentation for medical record coding.

Definitions:

CMS provides the following description of a scribe:

"A scribe is one who follows the doctor around and writes word for word, what the doctor says as he's examining the patient – a sort of human tape recorder."

This description makes it clear that the provider is rendering the service and determining the content of the documentation, while the scribe is only recording information as directed by that provider.

The Joint Commission definition:

"A scribe is an unlicensed person hired to enter information into the electronic medical record (EMR) or chart at the direction of a physician or practitioner (Licensed Independent Practitioner, Advanced Practice Registered Nurse or Physician Assistant). It is the Joint Commission's stand that the scribe does not and may not act independently but can document the previously determined physician's or practitioner's dictation and/or activities."

http://www.jointcommission.org/mobile/standards_information/jcfaqdetails.aspx?StandardsFAQId=426&StandardsFAQChapterId=66

POLICY:

1. Physicians and ACPs may utilize scribes if this has been approved by their department, clinic facility or other governing organizational structure.
2. Any individual desiring to serve as a scribe must review the CHS policy on the use of scribes and sign an agreement which states that the scribe will adhere to the policy. Each department is responsible for maintaining a copy of the agreement and providing a signed copy upon request. The department or provider using scribes must ensure that the individual receives:

   - A job description that recognizes the unlicensed status and clearly defines the qualifications and extent of the responsibilities
   - Orientation and training specific to the organization and role
   - Competency assessment and performance evaluations

   Additionally:

   - If the scribe is employed by the provider all non-employee HR standards also apply.
   - If the scribe is provided through a contract then the contract standard also applies.

- Scribes must meet all information management, HIPAA, HITECH, confidentiality and patient rights standards as do other CHS personnel.

3. Who may serve as scribes:
   - Ancillary staff including medical students, ACPs, MAs, CNAs, MOAs, RNs, and secretaries may serve as scribes.
   - Only individuals who have completed orientation for their specific role as a scribe, and who have signed a scribe agreement may serve as scribes.
   - Residents, interns, fellows and medical students on their active rotation **may not** act as scribes. ACPs, when acting as scribe, **may not also** participate as a care delivery provider.

4. A scribed note must accurately reflect the service provided on a specific date of service. The billing provider is ultimately responsible for the content of a scribed note.

5. A scribe's entry can be dictated or created/typed in an electronic medical record (EMR). In circumstances where use of the EMR is impossible, a scribed note may be legibly hand written and scanned into the EMR after signature by the attending.

6. Documentation of a scribed service must include the following elements:
   - A personal, dated note from the scribe that:
     - Identifies them as the scriber of the service
     - Attests that the notes are written / recorded contemporaneously in the presence of the provider performing the service
     - Identifies the provider of the service
   - Evidence of review and signature of the billing provider. This authentication must take place in a timely manner as with any other note since other providers may be depending the documentation to inform their decisions regarding care, treatment and services.
   - Notation by filling provider stating: "I have reviewed the above documentation for accuracy and completeness, and I agree with the above."
   - Individuals can only create a scribe note in an EMR if they have a password/access to the EMR. Documents scribed in the EMR must clearly identify the scribe's identity and authorship of the document – in both the document and the audit trail. **The scribe is strictly prohibited from using the provider's login at any time in the process**.
   - Providers are required to document (via the scribe) in compliance with all federal, state and local laws as well as with CHS policy.
   - The organization must implement a performance improvement process to ensure that the scribe is not acting outside of his/her job description, that authentication is occurring as required and that no orders are being entered into the medical record by scribes.
   - *Example of a compliant scribe statement – "I (scribe's name) am acting as scribe for (provider's name)."*

Addendum regarding the use of medical students as scribes:

Can medical students serve as scribes?

Yes, medical students can also act as scribes. The medical student that is scribing is functioning as a "living recorder", recording in real time the actions and words of the provider. The medical student scribe must not be seeing the patient in any clinical capacity and must not document or interject their own observations or impressions.

This ability to scribe is sometimes confused with the medical student's ability to individually document information for a billable service. There are strict rules regarding the manner in which the teaching physicians can reference medical student documentation. Medicare will allow teaching physician and residents to use medical student documentation for E/M services when:

- The teaching physician or resident verifies in the medical record, all student documentation/findings, including history, exam and/or medical decision making;
- The teaching physician or resident re-performs the history, physical exam and medical decision-making activities of the E/M service being billed; and
- The modified student note contains an attestation statement attesting to the teaching physician's or resident's personal presence and/or re-performance of the history, physical exam and medical decision making activities. (Refer to Attestation Statement Requirements on eLink)

Appropriate utilization of medical students as scribes:

A medical student who only writes down what the provider says during the assessment, observing and learning, but not touching the patient, and not documenting his/her own findings.

A medical student may independently record the past family and social history (PFSH) and review of systems (ROS) in their role as medical students. The provider reviews and confirms the PFSH and ROS and performs the entire service. During the performance of the service the provider dictates to the medical student his/her findings which are then recorded by the medical student.

Inappropriate utilization of medical students as scribes:

A medical student evaluates the patient with the attending provider and the medical student documents the service. The physician edits, corrects and signs the note. This does not represent a scribed service.

Carolinas Healthcare System
Scribe Agreement*

I hereby certify that I have reviewed the CHS Use of Scribes Policy. I understand that as a scribe I am:

- Required to be present during the provider's performance of a clinical service and document (on behalf of the provider) relevant documentation as directed by the provider during the course of the service.
- I am not seeing the patient in any clinical capacity, and,
- I must not interject my own observations or impressions.

- Documentation of my scribe service must include a personal, dated note that:
  - Identifies me as the scribe of the service rendered by the provider
  - Attests that the notes are written/recorded contemporaneously in the presence of the provider performing the service
  - Identifies the provider
  - Includes my signature as the scribe (process to be finalized in FAQ's and instructions)

Example of a complaint scribe statement – "I (scribe's name) am acting as scribe for (provider's name)."

I am aware that documenting in the EMR requires having a CHS issued access/user identification and password to the EMR. **Documenting under some else's login is prohibited.**

Name: _____
(Please Print)

Department: _____

Signature: _____

Date: _____

This document should be retained in the scribe's personnel folder as appropriate for future reference.

PITAC Approval: Last Updated:
7/14/2014,10/2018

References:

http://www.acep.org/Content.aspx?id=85988

http://www.jointcommission.org/mobile/standards_information/jcfaqdetails.aspx?StandardsFAQId=426&StandardsFAQChapterId=66

http://www.wpsmedicare.com/part_b/departments/medical_review/2009_1221_scribes.shtml

http://www.hsc.unt.edu/policies/QuAssure/Clinical%20Documentation&ComplianceManual042704.pdf

http://www.medicalscribeblog.com/tag/cms/

Collaborative Physician Alliance, LLC
Clinical Integration and Antitrust Policy

I. BACKGROUND: Collaborative Physician Alliance, LLC ("**Company**") is a physician-led organization that, in collaboration with The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System ("**CHS**"), is engaged in the development, implementation and operation of an active and ongoing program to evaluate and modify practice patterns by physicians who agree to participate in Company's clinical integration program (as described in Section 2 of the Network Participation Agreement) (the "**Clinical Integration Program**") and care delivery of CHS. Pursuant to Company's Clinical Integration Program, Company's purpose is to coordinate, on a non-exclusive basis, contracts on behalf of its participating physicians and other healthcare practitioners ("**Participating Providers**") with purchasers of health care services, including but not limited to employers, trusts, insurance companies, health maintenance organizations, and preferred provider organizations (collectively, "**Purchasers**").

II. PURPOSE: Clinically integrated provider networks promise significant procompetitive benefits for consumers of healthcare services by developing mechanisms that encourage physicians to collaborate in practicing efficiently as part of a network, leading to improved quality of care and lower health care costs. The formation and operation of a clinically integrated network can, however, entail antitrust risks for participating providers that otherwise may be viewed as actual or potential competitors in the market. For example, without appropriate safeguards, discussions or the exchange of information among participating providers may facilitate collusion or otherwise reduce competition on prices for services provided outside of the network, resulting in increased prices or reduced quality for those services in violation of state and federal antitrust laws, including without limitation, Section 1 of the Sherman Act, 15 U.S.C. § 1 (collectively, the "**Antitrust Laws**"). Thus, while it is appropriate for providers to engage in discussions that are necessary for developing and operating their clinically integrated network, such discussions must be carefully managed.

To minimize potential antitrust risks associated with the formation and ongoing operation of Company's Clinical Integration Program, Participating Providers, Company's Board of Managers, Company's officers, and all committees of Company shall adhere to the following policies and procedures. Adherence to these guidelines will help ensure that the pro-competitive purposes of Company's Clinical Integration Program are achieved.

III. SCOPE: Board of Managers, officers, committee members, and Participating Providers.

IV. RESPONSIBILITY: Board of Managers, officers, committee members, and Participating Providers.

V. COMPLIANCE: This policy shall be administered and enforced in accordance with all applicable state and federal laws, rules, and regulations, including without limitation, the Antitrust Laws.

VI. DEFINITIONS: Capitalized terms not otherwise defined herein shall have the meanings set forth in Company's Operating Agreement and the Network Participation Agreement.

A. "**Competitively Sensitive Information**" means: (i) prices, bids, fee schedules, pricing policies, rates, discounts, contracting methodologies or formulas, or profitability; (ii) confidential cost information (including salaries and benefit information); (iii) marketing plans, market evaluations, or strategic plans (including those related to payer contracting); (iv) information about present or potential customers (including Purchasers) or suppliers, including costs, prices, profitability, marketing plans, product development plans, proposals, or other specific customer or supplier information; (v) status of negotiations with present or potential customers or suppliers, including Purchasers; (vi) intention to compete or not to compete for specific customers or specific services; and (vii) any other confidential business information that could be used to reduce competition.

B. "**Confidential Information**" includes any information about any Participating Provider, Company or CHS (hereinafter referred to as the "**Disclosing Party**") and its affiliates and business partners that is collected or exchanged pursuant to the Network Participation Agreement or Company Policies that is not generally available to the public or that has value to the Disclosing Party and its affiliates and business partners because it is not known to others (the individuals or entities receiving the information is referred to as the "**Receiving Party**"). Without limiting the generality of the foregoing, (i) Confidential Information of Company shall include (A) Clinically Integrated Purchaser Contracts and Purchaser Contract Terms; (B) clinical data and information of Company and CHS; (C) performance results regarding Company and CHS; and (D) business operations, practices and procedures of Company and CHS, including staffing, strategies and financial plans and budgets, contractual relationships or terms, practice management procedures, health information technology systems and/or systems or processes related to the specific operation of Company or CHS; and (ii) Confidential Information of Physician Practice shall include (A) clinical data and information of Physician Practice, whether collected from Physician Practice or a data source described in Section 2(b)(v) of the Network Participation Agreement; (B) performance results regarding Physician Practice; and (C) business operations, practices and procedures of Physician Practice, including staffing, strategies and financial plans and budgets, contractual relationships or terms, practice management procedures, health information technology systems and/or systems or processes related to the specific operation of Physician Practice.

C. "**Network Participation Agreement**" means the written agreement between each Participating Provider's Physician Practice and Company for participation in Company's Clinical Integration Program.

D. "**Physician Practice**" means the physician practice entity that has entered into a Network Participation Agreement with Company on behalf of a Participating Provider.

VII. POLICY AND PROCEDURE:

A. Contracting. On behalf of its Participating Providers, and in accordance with all Company Policies and any applicable regulatory requirements, Physician Practice shall participate in the Company contracting activities with Purchasers for the purpose of entering into contracts with network incentives such as pay for performance, shared savings, bonuses or such other arrangements whereby Purchasers recognize the value of the Clinical Integration Program and agree to provide an incentive to reward and recognize the efforts of Company and the Participating Providers to improve quality, cost-effectiveness and efficiency through the Clinical Integration Program ("**Clinically Integrated Purchaser Contracts**").

1. Physician Practice shall designate Company to act as its agent in negotiations with Purchasers for Clinically Integrated Purchaser Contracts.

2. Physician Practice agrees to participate in all such Clinically Integrated Purchaser Contracts, including compliance with any and all fee schedules, payment criteria, standards, policies, procedures, programs, rules, and regulations ("**Purchaser Contract Terms**") applicable to Physician Practice. Company will provide Physician Practice with all applicable Purchaser Contract Terms.

3. During the term of this Agreement, Company will have the right to utilize the name, trademarks, trade names, logos and symbols identifying Physician Practice for any provider list for the Clinical Integration Program. For any other use of such name, trademarks, trade names, logos and symbols identifying Physician Practice, Company shall obtain the express written consent of Physician Practice, which shall not be unreasonably withheld.

B. Information Exchange. Discussions among Participating Providers will be critical during the planning process for the Clinical Integration Program. Participants in that planning process may engage in discussions about the structure and operations of the Clinical Integration Program, the types of activities the Company will engage in, the clinical protocols and other guidelines under which the Clinical Integration Program will operate, the mechanisms for developing and maintaining these guidelines, and other similar topics. However, discussions and exchanges of Competitively Sensitive Information concerning the Participating Providers must be avoided. Prior approval of counsel experienced in antitrust matters ("**Counsel**") must be obtained before discussing or exchanging Competitively Sensitive Information.

C. Meeting Rules. Any meeting involving two or more competitors must be based on, and not depart from, a written agenda approved in advance by Counsel. All attendees will ensure strict adherence to the agenda items and not discuss any Competitively Sensitive Information. Each attendee who observes any non-

compliant conduct will be empowered to call the meeting to a close and should alert Counsel.

D. Competitor Agreements. It is critical that planning related to Company's Clinical Integration Program not impair or otherwise impact competition among the Participating Providers outside of the Clinical Integration Program. Thus, there should be no discussion or disclosure of information about the Participating Providers' independent activities outside of the context of the Clinical Integration Program with respect to:

1. Contract rates, other prices, discounts, co-pays, or other price-related terms;

2. Specific health plans, types of health plans, or other customers or Purchasers, or whether to do business with them;

3. Allocation of geographic or service markets, such as who should or should not provide certain services;

4. Any refusal to deal with a customer, supplier, or Purchaser;

5. How to deal with the market behavior of a competitor; or

6. Any other topic that could lead to an anticompetitive agreement.

The above guidelines apply both to official meetings of the Clinical Integration Program and to informal discussions among Participating Providers.

E. Treatment of Confidential Information.

1. All Confidential Information disclosed or otherwise received by a Receiving Party will be received, kept and maintained by such Receiving Party in confidence, and no Receiving Party will disclose to others (except other members of the Board of Managers or committee thereof, as appropriate), or make a copy of or reproduce in any form, any Confidential Information without the prior approval of the Disclosing Party.

2. Each Receiving Party will (i) protect and safeguard Confidential Information against unauthorized use, publication or disclosure; (ii) not use any Confidential Information to compete with, obtain an advantage against, or use adversely to any Disclosing Party in any commercial activity or legal proceeding; and (iii) maintain Confidential Information in accordance with Company safeguards. A Receiving Party will return all Confidential Information in tangible form and in the possession of a Receiving Party, or will delete or destroy the same, upon the request of and as directed by a Disclosing Party.

3. Company will educate members of the Board of Managers, and other Company management, on the appropriate protocol and manner in which to conduct collective negotiations with Purchasers in compliance with the Regulatory Laws on behalf of the Participating Providers.

4. Where practicable, Company will implement reasonable measures to prevent or limit access to Confidential Information (e.g., placing in a locked or electronically restricted file) by unauthorized persons.

F. Negotiations with Purchasers. The Board of Managers will have the authority to:

1. Review information in order to make an informed decision to contract or work with a Purchaser during the negotiation process to determine whether the Clinical Integration Program's goals can be accomplished within the framework proposed by the Purchaser;

2. Assume authority for the negotiation of all contracts with Purchasers, based upon a supermajority vote of the Board of Managers, subject to the reserved powers of the Member set forth in Company's Operating Agreement;

3. Conduct negotiations with Purchasers in compliance with all applicable state and federal laws, rules, and regulations, including without limitation, the Antitrust Laws;

4. Develop specific programs or pay-for-performance initiatives with Purchasers;

5. Conduct an annual review of the overall effectiveness of each Purchaser relationship; and

6. Develop a methodology to share financial rewards and may engage an independent, third party valuation firm to determine the fair market value and commercial reasonableness of any distribution methodology.

G. Prohibited Practices. All individuals subject to the scope of this policy will NOT engage in any of the following practices:

1. Discuss or agree with any competitor to raise, lower, fix, stabilize or in any way affect fees, prices, or costs of services;

2. Discuss or agree with any competitor to limit the quality or quantity of services provided;

3. Discuss or exchange information with any competitor regarding market power, market shares, or ways to dominate the market;

4. Compare or otherwise discuss with any competitor contract negotiations involving other physician groups or payers;

5. Discuss rates or other Competitively Sensitive Information or Confidential Information, including any contract terms related to the Clinical Integration Program, with physicians who are not also Participating Providers;

6. Discuss ways to eliminate or reduce competition or ways to exclude other physicians or physician groups;

7. Propose refusals to deal with or boycotts of particular providers or Purchasers;

8. Demand that Purchasers contract exclusively with Company Participating Providers through the Clinical Integration Program;

9. Discuss or agree with any competitor to divide or allocate markets or customers; and

10. Share information about what Participating Providers charge for patients that are not covered under the Clinical Integration Program.

H. Document Drafting. As planning and operations for Company's Clinical Integration Program moves forward, care must be taken when drafting documents or making statements about the Clinical Integration Program to avoid unnecessary antitrust concerns. It is imperative that all individuals subject to the scope of this policy, along with their advisors, adhere to the following:

1. Always be careful of what they write and say.

2. Understand that, in the antitrust context, perception is as important as reality.

3. DO NOT use "guilt complex" language like "destroy after reading," "for your eyes only," or "I should not tell you this, but . . ."

4. DO NOT use power language like we will "dominate the market," "exclude competition" or "obtain negotiating leverage over payers," or language that similarly overstates the significance of the Network's competitive position.

5. DO NOT create documents that purport to define a relevant market or market shares. Certain terms such as "market," "market power," "monopoly," "dominate," "foreclose," or "leverage" have particular significance for antitrust purposes. Use of such words should be avoided when possible, since they may convey erroneous or incomplete impressions contrary to actual facts.

6. DO NOT ignore troublesome documents. Upon receipt of a document which could give rise to a suspicion of questionable antitrust activity, contact Counsel.

7. DO remember that a record is created every time you write, and any document – including email, papers kept at home, or even notes on desk calendars or scratch pads – may be produced to the government and/or made public. Also remember that deleting e-mail or text messages does not necessarily permanently delete those messages. Document retention and destruction should be in accordance with Company policy.

8. DO have Counsel review sensitive documents before they are circulated.

9. DO document the procompetitive business justifications and necessity for any restriction on Participating Providers' conduct, including in connection with the development of clinical protocols, mandatory participation requirements, referral policies, and decisions to include certain providers as part of, or exclude certain providers from, Company's Clinical Integration Program.

10. DO limit the number of individuals who are authorized to make statements on behalf of Company's Clinical Integration Program. Erroneous statements that do not reflect the views and purposes of the Clinical Integration Program can lead to unwarranted scrutiny and unnecessarily complicate the network planning process.

11. DO mark all drafts as such. Do not use the name or logo of Company on a document that remains a draft.

Collaborative Physician Alliance, LLC
Clinical and Performance Data Submission Policy

I. BACKGROUND: Collaborative Physician Alliance, LLC ("**Company**") is a physician-led organization that, in collaboration with The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System ("**CHS**"), is engaged in the development, implementation and operation of an active and ongoing program to evaluate and modify practice patterns by physicians who agree to participate in Company's clinical integration program (as described in Section 2 of Network Participation Agreement) (the "**Clinical Integration Program**") and care delivery of CHS. Pursuant to Company's Clinical Integration Program, Company's purpose is to coordinate, on a non-exclusive basis, contracts on behalf of its participating physicians and other healthcare practitioners ("**Participating Providers**") with purchasers of health care services, including but not limited to employers, trusts, insurance companies, health maintenance organizations, and preferred provider organizations (collectively, "**Purchasers**").

II. PURPOSE: The purpose of this policy is to outline the standards with which Participating Providers must comply when submitting Clinical and Performance Data to Company. In order to monitor performance, identify opportunities for improvement and otherwise support the Clinical Integration Program, Company will collect, analyze track and report data on behalf of its participants. Pursuant to the terms of the Network Participation Agreement, Company requires each Physician Practice, for and on behalf of its Participating Providers, to participate in Company's program for collecting and analyzing care performance data, including utilization, cost and/or quality data on both an individual and aggregate basis; developing and utilizing clinical performance standards along with a system to enforce such standards; developing information systems to facilitate the exchange of health information across Company's network of Participating Providers; and using evidence-based medicine to establish evidence-based guidelines for support of clinical decision-making, care coordination, and continuing of care and treatment. Participating Providers that provide Clinical and Performance Data to Company will assist Company in effectively managing care across an entire population by allowing Company to:

- Understand and identify trends of the population under care or management by the Company or its Participating Providers;
- Identify and provide proactive management of gaps in care by patients;
- Identify high risk patients by Participating Provider for quality program inclusion;
- Provide care management reports and patient profiles to facilitate outreach to patients;
- Create and deliver Participating Provider performance management and quality reporting with comparison to targets;
- Develop and integrate care management protocols; and
- Monitor Participating Provider performance, identify opportunities for improvement, and otherwise support the Clinical Integration Program.

III. SCOPE: Participating Providers.

IV. RESPONSIBILITY: Board of Managers and officers.

V. COMPLIANCE: This policy shall be administered and enforced in accordance with all applicable state and federal laws, rules and regulations.

VI. DEFINITIONS: Capitalized terms not otherwise defined herein shall have the meanings set forth in Company's Operating Agreement or the Network Participation Agreement.

A. "**Clinical and Performance Data**" means medical, performance, and health care-related data and information that is (i) contained in a Participating Provider's medical records, billing or claims records, practice management records or other systems or records, electronic or otherwise; and (ii) reasonably related to the requirements of Company's Clinical Integration Program, as Company's Board of Managers shall determine, including without limitation, utilization, cost and/or quality or other similar data and information to assess the performance of professional medical and related health care services by Participating Providers for Participating Providers's patients.

B. "**CDE**" means a Clinical Data Exchange.

C. "**EHR**" means electronic health record.

D. "**Network Participation Agreement**" means the written agreement between each Participating Provider's Physician Practice and Company for participation in Company's Clinical Integration Program.

E. "**Patient Registry**" means Company's electronic registry that holds clinical information specific to a disease, disease process, implant, drug, etc.

F. "**Physician Practice**" means the entity that has entered into a Network Participation Agreement with Company for and on behalf of a Participating Provider.

VII. POLICY AND PROCEDURE:

A. Although Company prefers a common EHR platform among Participating Providers to facilitate the submission of Clinical and Performance Data, Company recognizes that Participating Providers and their respective Physician Practices may utilize different EHR platforms or may not have an EHR platform and therefore require alternate methods of transmitting Clinical and Performance Data. To achieve clinical integration, all Participating Providers, through their respective Physician Practices, must provide Clinical and Performance Data to Company for analysis and quality improvement reporting purposes using one of the methods identified below:

1. Agreed-Upon Method. If Physician Practice does not have an EHR platform, then until Company establishes its Patient Registry, Physician Practice may provide Clinical and Performance Data to Company through a method as agreed upon between Company and Physician Practice.

2. Patient Registry. If Physician Practice does not have an EHR platform, then Company will provide Physician Practice access to Company's Patient Registry for the Physician Practice to manually enter Clinical and Performance Data. If Physician Practice utilizes the Patient Registry, then Physician Practice must submit the Clinical and Performance Data in a format as agreed upon between Company and Physician Practice.

3. Clinical Data Exchange. If Physician Practice utilizes an EHR platform, Physician Practice may submit Clinical and Performance Data to Company utilizing a CDE. The CDE is a monthly exchange of specified Clinical and Performance Data from Physician Practice's EHR that will be sent securely to Company staff. Physician Practices utilizing the CDE must submit the Clinical and Performance Data described in the format as agreed upon between Company and Physician Practice, and must send using a secure file transfer protocol.

B. All Clinical and Performance Data that Physician Practice provides to Company through one of the sharing methods outlined above must be submitted for every patient encounter of a Physician Practice's Participating Provider. Physician Practice must also include in the submission of Clinical and Performance Data a certification from an individual with authority to bind Physician Practice as to the accuracy, completeness, and truthfulness of the submitted Clinical and Performance Data, to the best of the information and belief of the certifying individual.

C. Clinical and Performance Data for Participating Providers will also be provided to Company directly by hospitals within CHS. The Clinical and Performance Data provided by CHS hospitals is of critical importance to the performance monitoring and improvement objectives of the Clinical Integration Program.

Collaborative Physician Alliance, LLC
Performance Evaluation, Improvement & Participant Disposition Policy

I. BACKGROUND: Collaborative Physician Alliance, LLC ("**Company**") is a physician-led organization that, in collaboration with The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System ("**CHS**"), is engaged in the development, implementation and operation of an active and ongoing program to evaluate and modify practice patterns by physicians who agree to participate in Company's clinical integration program (as described in Section 2 of the Network Participation Agreement) (the "**Clinical Integration Program**") and care delivery of CHS. Pursuant to Company's Clinical Integration Program, Company's purpose is to coordinate, on a non-exclusive basis, contracts on behalf of its participating physicians and other healthcare practitioners ("**Participating Providers**") with purchasers of health care services, including but not limited to employers, trusts, insurance companies, health maintenance organizations, and preferred provider organizations (collectively, "**Purchasers**").

II. PURPOSE: Company's Board of Managers will monitor and evaluate the ongoing clinical performance of Participating Providers, and provide support, counsel, and accountability for Participating Providers whose clinical outcomes fall below Company standards.

III. SCOPE: Participating Providers.

IV. RESPONSIBILITY: Board of Managers, officers, committee members, and other personnel of Company responsible for monitoring Company's clinical quality standards.

V. EXCEPTIONS: Notwithstanding the timeframes and processes set forth below, the Board of Managers may apply different timeframes and processes to the extent that it is reasonably necessary to achieve the goals of the Clinical Integration Program and the purpose of this policy. Notwithstanding the Board of Managers's ability to apply different timeframes and processes to the extent it is reasonably necessary, the Board of Managers shall have no right to eliminate a Participating Provider's right of appeal, as set forth in Section VIII.E of this policy.

VI. COMPLIANCE: This policy shall be administered and enforced in accordance with all applicable state and federal laws, rules and regulations.

VII. DEFINITIONS: Capitalized terms not otherwise defined herein shall have the meanings set forth in Company's Operating Agreement and Network Participation Agreement.

VIII. POLICY AND PROCEDURE:

The Board of Managers will proceed as follows with respect to Participating Providers who are not meeting the standards established for the Clinical Integration Program. The Board of Managers may delegate its responsibilities under this policy to one or more appropriate

committees of the Board of Managers, subject to the oversight and ultimate authority of the Board of Managers.

A. On at least a quarterly basis, or at such interval or frequency determined by the Board of Managers, the Board of Managers will analyze reports from Company's provider profiling system regarding the performance of all Participating Providers against the measures and initiatives established for the Clinical Integration Program.

1. The Board of Managers will present individual results to each Participating Provider.

2. Between each review, the Board of Managers may engage in informal and collegial process evaluation and improvement with Participating Providers, as needed, to assist in quality improvement efforts.

3. With respect to individual Participating Providers who consistently fall out of compliance with the standards established for the Clinical Integration Program or otherwise fail to comply with Company's policies and procedures, including without limitation, the Code of Conduct, the Board of Managers shall follow the process set forth in Section VIII.B.

4. Any final action taken in accordance with the Medical Staff Bylaws of any CHS Hospital resulting in a letter of reprimand or the revocation, reduction, suspension or other limitation on the exercise of clinical privileges and/or a termination of medical staff appointment will be considered in an evaluation of a Participating Provider's compliance with the standards established for the Clinical Integration Program, including the Code of Conduct.

B. Appropriate Company personnel shall deliver to the Board of Managers a summary list of the Participating Providers who fail to meet the standards established for the Clinical Integration Program based upon the timeline required by the Board of Managers. After at least two (2) consecutive reports where a Participating Provider fails to substantially meet the quality benchmarks of the Clinical Integration Program, the Participating Provider will be subject to a more formal performance review as set forth herein. Company will send a notification (the "**Notice**") to the Participating Provider on behalf of the Board of Managers to meet with designated physician representatives of the Board of Managers (collectively, the "**Designated Representatives**"). The Designated Representatives shall constitute an ad hoc performance improvement committee and may invite other physicians or management personnel to participate in meetings with the Participating Provider.

1. Designated Representatives should be chosen on the basis of relevant practice area, peer relationship, and understanding of the goals and standards of the Clinical Integration Program.

2. Company shall send the Notice to the Participating Provider for such Participating Provider's meeting with the Designated Representatives via certified mail, addressed to the Participating Provider's office, which shall be deemed conclusive evidence of the Participating Provider's receipt of the Notice.

3. Following receipt of the Notice as described in Section VIII.B.2, the Participating Provider will have ten (10) business days to schedule a meeting with the Designated Representatives. If the Participating Provider does not make contact with the Designated Representatives during such ten (10)-day time period, the Designated Representatives shall make contact with the Participating Provider to schedule the meeting. Such meeting shall occur within thirty (30) business days after the date of receipt of the Notice. If the Participating Provider does not cooperate with the Designated Representatives in scheduling the meeting, the Designated Representatives may make a recommendation to the Board of Managers to remove the Participating Provider from Company.

4. During the meeting with the Designated Representatives, the Participating Provider and the Designated Representatives will develop a written focused review (the "**Focused Review**"). Included in the Focused Review will be recommended quality steps, availability of resources, and a timeline for improvement. The Designated Representatives and the Participating Provider will sign the Focused Review. Company will safeguard and maintain the Focused Review in a secure and password-protected electronic database.

5. After the initial meeting with the Participating Provider, the Designated Representatives and the Participating Provider will make their best efforts to discuss on at least a monthly basis, generally in person, by phone, by email, by Skype, video conference or other electronic means, the progress made in regards to the Focused Review and to provide additional support when needed.

6. The Designated Representatives will provide a summary report to the Board of Managers as to the status of all meetings, calls, or other conversations with Participating Providers to discuss the Focused Review. The summary report should include, at a minimum, the date of the meeting and a brief summary of the meeting. Company shall keep and maintain such summary reports confidential in accordance with applicable North Carolina law.

7. Generally, the timeline for improvement will have a duration of between ninety (90) to one hundred eighty (180) days, but the Designated Representatives shall have the discretion to shorten or lengthen the timespan, with notification to the Board of Managers of the same, based on the nature of the clinical initiative and the time necessary to show improvement.

C. At the end of the designated timeline for improvement, the Designated Representatives mayrecommend to the Board of Managers the following based on the Participating Provider's performance:

1. If, based on reasonable clinical judgment, the Designated Representatives determine that the Participating Provider has completed necessary improvement steps, the Designated Representatives will recommend no further action.

2. If, based on reasonable clinical judgment, the Designated Representatives determine that the Participating Provider is showing significant improvement but is not yet in compliance with the standards established for the Clinical Integration Program, the timeline may be extended, typically for an additional three (3) to six (6) months.

3. If, based on reasonable clinical judgment, the Designated Representatives determine that the Participating Provider has failed to show significant improvement, the Designated Representatives shall recommend immediate probation of the Participating Provider to the Board of Managers. The Board of Managers shall consider the Designated Representatives' recommendation and make the final determination on probation. If the Board of Managers places a Participating Provider on probation, the Board of Managers shall send notice of such decision to the Participating Provider via certified mail, addressed to the Participating Provider's office (the "**Probation Notice**"), which shall be deemed conclusive evidence of the Participating Provider's receipt of the Probation Notice.

D. If the Board of Managers places a Participating Provider on probation, the following steps will take place:

1. Following the Probation Notice as described in Section VIII.C.3, the Participating Provider will have ten (10) business days to schedule a meeting with the Designated Representatives. If the Participating Provider does not make contact with the Designated Representatives during such ten (10)-day time period, the Designated Representatives shall make contact with the Participating Provider to schedule the meeting. Such meeting shall occur within thirty (30) business days after the date of receipt of the Probation Notice. If the Participating Provider does not cooperate with the Designated Representatives in scheduling the meeting, the Designated Representatives may make a recommendation to the Board of Managers to remove the Participating Provider from Company.

2. During the meeting, the Designated Representatives and the Participating Provider shall develop a second focused review (the "**Second Focused Review**"). The Designated Representatives and the Participating Provider will sign the Second Focused Review. Company will safeguard and

maintain the Second Focused Review in a secure and password-protected electronic database.

3. The Designated Representatives shall inform the Board of Managers of the Participating Provider's Second Focused Review.

4. The Participating Provider shall remain on probationary status for a duration of three (3) months, unless otherwise extended in the discretion of the Designated Representatives.

5. At the end of the probationary period, the Designated Representatives will confer to determine if the Participating Provider should be released from probation or be recommended for removal from Company, or whether to extend the probationary period, typically for an additional three (3) to six (6) months.

6. The Designated Representatives shall inform the Board of Managers of both the results of its deliberations and the rationale for its recommendation.

7. Upon receipt of a recommendation from the Designated Representatives, the Board of Managers shall consider such recommendation and make the final determination on removal. If the Board of Managers removes a Participating Provider, the Board of Managers shall send notice of such decision to the Participating Provider via certified mail, addressed to the Participating Provider's office (the "**Removal Notice**"), which shall be deemed conclusive evidence of the Participating Provider's receipt of the Removal Notice.

8. The Participating Provider shall forfeit all incentive distributions from Company that the Participating Provider is eligible to receive for the calendar year(s) in which the Participating Provider is placed on probation.

E. Appeals

1. If the Participating Provider disagrees with the determination of the Board of Managers in Section VIII.D.7, the Participating Provider may appeal the decision as set forth herein. Participating Providers may only utilize this appeals process for determinations of removal and not for determinations of probation or other grievances.

   a. The Participating Provider must notify the Board of Managers in writing of such Participating Provider's decision to appeal a determination of probation or removal within ten (10) days following receipt of the Removal Notice.

   b. The Board of Managers will make best efforts to assemble an appeals committee composed of at least three (3) Physician Managers (the "**Appeals Committee**") to hear the Participating

Provider's appeal within one (1) month of receiving notification from the Participating Provider. In assembling the Appeals Committee, the Board of Managers shall seek the advice of counsel of Company and take into account conflicts of interest and other regulatory considerations. The Board of Managers shall have the discretion to designate alternate physicians within Company to serve on the Appeals Committee.

c. During the meeting between the Appeals Committee and the Participating Provider to discuss the Participating Provider's appeal, the Participating Provider may present material facts that the Participating Provider believes either were not taken into account or were misinterpreted by the Designated Representatives. Neither party is entitled to counsel at this meeting.

d. Decisions of the Appeals Committee will be decided by a majority vote, with a written report delivered to the Board of Managers providing a recommendation and the rationale for such recommendation.

2. If, based on the Appeals Committee's determination and recommendation, the Board of Managers reasonably believes that it decided in error as to the disposition of the Participating Provider, the Board of Managers may reinstate the Participating Provider upon a majority vote of the Board of Managers.

F. Following the date of removal of a Participating Provider, Physician Practice of the removed Participating Provider may not reapply for his or her participation in Company for a period of six (6) months.

Collaborative Physician Alliance, LLC
Code of Conduct

I. **BACKGROUND:** Collaborative Physician Alliance, LLC ("**Company**") is a physician-led organization that, in collaboration with The Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas HealthCare System ("**CHS**"), is engaged in the development, implementation and operation of an active and ongoing program to evaluate and modify practice patterns by physicians who agree to participate in Company's clinical integration program (as described in Section 2 of the Network Participation Agreement) (the "**Clinical Integration Program**") and care delivery of CHS. Pursuant to Company's Clinical Integration Program, Company's purpose is to coordinate, on a non-exclusive basis, contracts on behalf of its participating physicians and other healthcare practitioners ("**Participating Providers**") with purchasers of health care services, including but not limited to employers, trusts, insurance companies, health maintenance organizations, and preferred provider organizations (collectively, "**Purchasers**").

II. **PURPOSE:** All Participating Providers are expected to display a high level of professional behavior, decorum, compassion and ethics. In accordance with this expectation, the Company's Code of Conduct is designed to clarify common expectations and facilitate unity among Participating Providers. The guidelines set forth in this Code of Conduct govern interactions with patients, their families, Participating Providers, government agencies and their representatives, and the public at large.

III. **SCOPE:** Participating Providers.

IV. **RESPONSIBILITY:** Board of Managers and officers.

V. **COMPLIANCE:** This policy shall be administered and enforced in accordance with all applicable state and federal laws, rules and regulations.

VI. **DEFINITIONS:** Capitalized terms not otherwise defined herein shall have the meanings set forth in Company's Operating Agreement.

A. "**Adverse Action**" shall mean any reduction, restriction, suspension, revocation, or denial of a Participating Provider's status as a Participating Provider in Company's Clinical Integration Program.

B. "**Network Participation Agreement**" shall mean the written agreement between each Participating Provider's Group Practice and Company for participation in Company's Clinical Integration Program.

C. "**Summary Suspension**" shall mean emergency or urgent Adverse Action taken against a Participating Provider before a hearing is held.

VII. POLICY AND PROCEDURE:

A. All Participating Providers will abide by the principles of medical ethics (primacy of patient welfare, patient autonomy, and respect for human dignity and rights), the policies and procedures of Company, and the laws and regulations of the State of North Carolina regarding medical practice.

B. All Participating Providers will interact and communicate with patients, all other Participating Providers and their employees and agents in a courteous, respectful and dignified manner.

C. All Participating Providers have the primary responsibility for effective communication.

D. All Participating Providers must:

1. Seek out assistance in conflict resolution when managing disagreements with others.

2. Address dissatisfaction with policies, administrative or supervisory actions through the proper leadership channels at Company.

3. Communicate quality and patient safety concerns to Company leadership as appropriate.

4. Regard patients and their families with respect and consideration.

E. Participating Providers will not engage in disruptive behaviors, including without limitation, the following:

1. Sexual harassment and sexual innuendos;

2. Use of abusive language, including the use of foul language, screaming or name calling;

3. Making direct or indirect threats of violence, retribution, litigation or financial harm;

4. Making racial or ethnic slurs;

5. Intimidation;

6. Criticizing or embarrassing Company staff in the presence of others;

7. Slander or libel;

8. Inappropriate physical expressions of anger;

9. Treating patients, coworkers or others in a discriminatory way, including without limitation, discrimination based on race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, medical condition, medical history, genetics, evidence of insurability, or claims history;

10. Providing patient care while impaired by alcohol, drugs or illness;

11. Dishonesty; and

12. Any other behavior that the Board of Managers determines to be inappropriate.

F. Optimal health care depends on the harmonious interaction, communication and combined efforts of a multidisciplinary team that includes without limitation, physicians, dentists, advanced clinical practitioners, affiliated health care providers, students, residents, social workers, patients, families and others. As Participating Providers strive to provide the highest level of care to patients, they will engage in the following behaviors:

1. Respond promptly and professionally when called upon for consultative and clinical services from Participating Providers;

2. Respond to patient and staff requests for information promptly and appropriately;

3. Respect the confidentiality and privacy of patients in accordance with applicable law;

4. Seek and obtain appropriate consultations;

5. Arrange for appropriate coverage in accordance with Company policies;

6. Prepare and maintain medical records in accordance with the Network Participation Agreement;

7. When terminating or transferring care of a patient, provide a prompt handoff that has pertinent and appropriate medical information to ensure continuation of care, medication reconciliation, and adequate follow-up; and

8. Be collaborative with and respectful of all multidisciplinary team members and individuals involved in the care of patients.

G. Participating Providers are strongly urged to contribute meaningfully to the Company community by:

1. Serving on Company committees when requested and available;

2. Notifying appropriate Company management of any Participating Provider who may be impaired, disruptive or who repeatedly violates the Code of Conduct;

3. Following and obeying applicable law at all times;

4. Holding in strictest confidence all information pertaining to peer review, and quality review improvement activities concerning Participating Providers;

5. Protecting the confidentiality of log-in IDs and passwords that access any Company health care data as well as protecting patient identifiable information or other confidential Company information from loss or theft; and

6. Reporting to appropriate Company management all variances from quality and safety initiatives.

H. The medical record is a vital legal document that records all aspects of a patient's health care. This document should include without limitation all information regarding patient histories and physicals, diagnostic evaluations, treatment plans and outcomes. All entries in the medical record must be dated. Additionally, they should accurately reflect the professional recommendations and actions taken by all health care providers. Medical record entries should reflect the same level of respect that is expected of interpersonal and verbal communications previously set forth in this Code of Conduct. The medical record should not include irrelevant narratives that are inappropriate, judgmental, or unprofessional regarding subjective views towards other individuals.

I. All Participating Providers are expected to adhere to the principles and guidelines outlined in this Code of Conduct. All Participating Providers will receive a copy of the Code of Conduct with the understanding that they will review the Code of Conduct and consent to its terms and conditions.

J. Participating Providers who do not abide by the Code of Conduct are subject to disciplinary and/or corrective actions, and if warranted, termination, in accordance with the terms of Company's Performance Evaluation, Improvement & Participant Disposition Policy. The Board of Managers shall have the authority to recommend and will coordinate with Physician Practice on any Adverse Action against, or a Summary Suspension of, a Participating Provider for violation of this Code of Conduct. If Adverse Action is recommended, the procedures set forth in the Performance Evaluation, Improvement & Participant Disposition Policy would then take effect.

K. Any final action taken in accordance with the Medical Staff Bylaws of any CHS Hospital resulting in a letter of reprimand or the revocation, reduction, suspension or other limitation on the exercise of clinical privileges and/or a termination of medical staff appointment as a result of a violation of the CHS Medical Staff

Physician Code of Conduct will be considered in an evaluation of a Participating Provider's compliance with the Company Code of Conduct.

Collaborative Physician Alliance, LLC
Corporate Conflict of Interest Policy

I. **PURPOSE:** The purpose of this policy is to protect Collaborative Physician Alliance, LLC's ("**Company**") interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of a Manager, officer or committee chair of Company, or when a Manager, officer or committee chair of Company seeks to take advantage of a Business Opportunity. This policy is intended to supplement but not replace any applicable North Carolina laws governing conflicts of interest applicable to limited liability companies.

II. **SCOPE:** Board of Managers, officers, committee chairs.

III. **RESPONSIBILITY:** Board of Managers, officers, committee chairs.

IV. **DEFINITIONS:** Capitalized terms not otherwise defined herein shall have the meanings set forth in Company's Operating Agreement or Network Participation Agreement.

A. "**Business Opportunity**" shall mean an opportunity that is presented to a Manager, Officer or committee chair that—

- Company is financially able to undertake;
- is in Company's line of business and would be of practical value to Company;
- Company has an interest in or reasonable expectation of the opportunity, and by taking the opportunity, the Manager, Officer or committee chair will create a conflict with Company; and
- the opportunity, in fairness, should belong to Company.

A Business Opportunity is not necessarily a conflict of interest. Under Section V.B, a person who seeks to take advantage, directly or indirectly, of a Business Opportunity may have a conflict of interest only if the Board of Managers decides that a conflict of interest exists.

B. "**Compensation**" shall mean direct and indirect remuneration for administrative services as well as gifts or favors that exceed the amount of allowable nonmonetary compensation for purposes of the Stark Law, set forth at 42 C.F.R. § 411.357(k), as adjusted each year for inflation based on the CPI-U. For the avoidance of doubt, Compensation shall not include remuneration for clinical services at fair market value, remuneration derived from Company's Clinically Integrated Purchaser Contracts, or remuneration derived from the Company's Hospital Quality and Efficiency Program Agreement with Carolinas Healthcare System.

Collaborative Physician Alliance, LLC
Incentive Payment Distribution Eligibility Policy

I. BACKGROUND: Collaborative Physician Alliance, LLC ("**Company**") is a physician-led organization that, in collaboration with The Charlotte-Mecklenburg Hospital Authority d/b/a Atrium Health ("**AH**"), is engaged in the development, implementation and operation of an active and ongoing program to evaluate and modify practice patterns by physicians who agree to participate in Company's clinical integration program (as described in Section 2 of the Network Participation Agreement) (the "**Clinical Integration Program**"). Pursuant to Company's Clinical Integration Program, Company's purpose is to coordinate, on a non-exclusive basis, contracts on behalf of its participating physicians and other healthcare practitioners ("**Participating Providers**") with purchasers of health care services, including but not limited to employers, trusts, insurance companies, health maintenance organizations, and preferred provider organizations (collectively, "**Purchasers**"), in accordance with all applicable state and federal laws, rules and regulations. The Participating Providers are members of physician practice groups ("**Physician Practices**") that have entered into an agreement to participate in Company's Clinical Integration Program ("**Network Participation Agreement**").

II. PURPOSE: The purpose of this policy is to outline the criteria through which Company will pay Physician Practices incentive payment distributions based on certain eligibility requirements.

III. SCOPE: Physician Practices and Participating Providers.

IV. RESPONSIBILITY: Board of Managers, officers, committee members, and other personnel of Company responsible for monitoring and evaluating eligibility requirements for incentive payment distributions.

V. COMPLIANCE: This policy shall be administered and enforced in accordance with all applicable state and federal laws, rules and regulations.

VI. DEFINITIONS: Capitalized terms not otherwise defined herein shall have the meanings set forth in Company's Operating Agreement, the Network Participation Agreement, and applicable Company policies and procedures.

- "**Performance Year**" shall mean a calendar year consisting of a twelve (12) month period starting on January 1st and ending on December 31st, unless otherwise noted in other contractual provisions.

VII. POLICY AND PROCEDURE:

A. Network Participation Agreement.

1. In order to be eligible to receive an incentive payment distribution under the Clinical Integration Program for a Performance Year, a Physician Practice must have a valid Network Participation Agreement with Company at the time of the incentive payment distribution for such Performance Year (the "**Payment Date**"). Company intends to pay incentive payment distributions for a Performance Year as soon as practicable and within ninety (90) days of Company receiving payment from a Purchaser, unless Company's Board of Managers extends such period of time for legitimate reasons, such as the need to validate or reconcile data or if such delayed distribution is needed to meet the requirements of the incentive programs.

For example, if the Payment Date is June 30, 2018 for the 2017 Performance Year, a Physician Practice must have a valid Network Participation Agreement with Company on June 30, 2018 in order to receive an incentive payment distribution for the 2017 Performance Year.

2. In order for a Physician Practice to be eligible to receive an incentive payment distribution under the Clinical Integration Program for a Performance Year, its Participating Providers must have active employment agreements "Float" providers and locum tenens are not eligible to participate in the incentive program on behalf of a Physician Practice.

B. Pro-Rated Incentive Payment Distributions.

1. If a Physician Practice has a valid Network Participation Agreement with Company on the Payment Date, Company will pay an incentive payment distribution to the Physician Practice based on the number of Participating Providers in the Physician Practice eligible to receive an allocation of the incentive payments based upon their performance. In order for the Physician Practice to receive a full (100%) incentive payment distribution amount with respect to an individual Participating Provider's performance, such Participating Provider must be in good standing in the Clinical Integration Program for a period of twelve (12) months during the applicable Performance Year.

2. On the other hand, if a Participating Provider participates in the Clinical Integration Program for less than the twelve (12) month period, the Physician Practice will receive a pro-rated incentive payment distribution amount for such Participating Provider as set forth in the table below:

Period of Time Participating Provider in Physician Practice and in Good Standing in Clinical Integration Program during Performance Year	**Incentive Payment Distribution Credit to Physician Practice for the Participating Provider**
$\geq$ 12 months	1.0 Full Distribution
$<$ 12 and $\geq$ 9 months	0.75 Distribution
$<$ 9 and $\geq$ 6 months	0.5 Distribution

< 6 months	Ineligible for Distribution

In order to distribute all funds in the incentive program for a Performance Year, if the Company will be making pro-rated incentive payment distributions as set forth above, the Company will make adjustments to the distributions to ensure that all funds in the incentive program be distributed to Physician Practices. Below is an example illustrating the pro-rated incentive payment distribution:

For example, assume that the total amount in the incentive program is $1,000. Physicians A and B were in good standing in the Clinical Integration Program for twelve (12) months during the Performance Year. Physician C was in good standing in the Clinical Integration Program for ten (10) months during the Performance Year and Physician D was in good standing in the Clinical Integration Program for seven (7) months during the Performance Year. Physicians A and C are in Group 1, and Physicians B and D are in Group 2.

	Group	**Base Payout**	**Eligibility Share**	**Adjusted Payout**
Physician A	Group 1	$250	1.0	$307.69
Physician B	Group 2	$250	1.0	$307.69
Physician C	Group 1	$250	0.75	$230.77
Physician D	Group 2	$250	0.5	$153.85
TOTAL		**$1,000**	**3.25**	**$1,000**

The calculation sequence is as follows:

- *Divide the total base payout by the total eligibility shares to determine the payout per share ($1,000/3.25 = $307.69).*
- *Multiply the payout per share by each Participating Provider's eligibility share to determine the adjusted payout for each Participating Provider.*
- *Payout to Group 1 is $538.46 ($307.69 from Physician A + $230.77 from Physician C).*
- *Payout to Group 2 is $461.54 ($307.69 from Physician A + $153.85 from Physician D).*

3. Company (through its Board of Managers or designee) will verify the period of time a Participating Provider has been in the Physician Practice and in good standing in the Clinical Integration Program through the Participating Provider's respective Physician Practice at the conclusion of each Performance Year. Company, Physician Practice, and/or Participating Provider shall cooperate in a reasonable manner if any additional eligibility information is necessary for verification.

4. Notwithstanding the foregoing, effective July 1, 2017, all Participating Providers who joined a Physician Practice prior to June 30, 2017 will be

grandfathered for the 2017 Performance Year and are eligible to receive credit for a full incentive payment distribution amount.

5. Notwithstanding the foregoing, if a Participating Provider moves to another Physician Practice during a Performance Year, each Physician Practice with which the Participating Provider is affiliated during the Performance Year will receive a proportional credit for the amount of time such Participating Provider was affiliated with the Physician Practice, so long as the Participating Provider was in good standing in the Clinical Integration Program for at least six (6) months during the Performance Year.

   For example, assume that a Participating Provider is in Physician Practice A for a period of nine (9) months and in Physician Practice B for a period of three (3) months during a Performance Year. In such case, Physician Practice A would receive a 0.75 distribution for such Participating Provider and Physician Practice B would receive a 0.25 distribution for such Participating Provider (even though such Participating Provider was not in Physician Practice B for a period of at least six (6) months).

6. For the avoidance of doubt, if a Participating Provider is on approved leave from a Physician Practice during a Performance Year (*e.g.,* disability, maternity) in accordance with Physician Practice's policies and procedures, such leave will not count against the time such Participating Provider is in the Physician Practice and in good standing in the Clinical Integration Program.

7. Notwithstanding the foregoing, if a Participating Provider retires from or departs the Physician Practice after minimum of six months into the Performance Year, such Participating Provider will be considered to be in good standing and is eligible to receive credit for purposes of a full incentive payment distribution amount to his/her Physician Practice if such Participating Provider also completes the annual CPA Citizenship criteria for the pertinent performance year. Physician Practices are responsible for providing this information through the roster update and verification process as determined by CPA.

8. Participating Providers that do not practice primarily within service area definitions incorporated within each CPA value contract will be excluded from incentive eligibility for their Physician Practice. Application and approval of this provision will be reviewed by the CPA Finance Committee and approved by the Board of Managers on an annual basis.

C. Active Performance Monitoring and Probation.

1. All Participating Providers must comply with Company's policies and procedures, including the Code of Conduct, Performance Evaluation, Improvement & Participant Disposition Policy, as well as other

requirements of the incentive programs. Any "Adverse Action" (as defined in Section VI.A of the Code of Conduct) will be considered, in addition to all other Company policies and procedures and program requirements, when evaluating whether a Participating Provider is eligible to receive any credit for an incentive payment distribution.

2. If a Participating Provider is subject to active performance monitoring at any time during a Performance Year or on the Payment Date, such Participating Provider will be considered to be in good standing and the Physician Practice will receive credit for such Participating Provider for the Performance Year's incentive payment distribution amount.

3. If a Participating Provider is placed on probation at any time during a Performance Year or on the Payment Date, such Participating Provider will not be considered to be in good standing and the Physician Practice will not receive any credit for such Participating Provider for the Performance Year's incentive payment distribution amount.