BAPTIST HEALTH®

NEW PROVIDER ORIENTATION

Provided by:

Medical Staff Services

BHPADMedicalStaff@bhsi.com

BAPTIST HEALTH®

WELCOME TO:

BAPTIST HEALTH PADUCAH

ABOUT BAPTIST HEALTH

- Our Mission:

  To demonstrate the love of Christ by providing and coordinating care and improving health in our communities

- Our Vision:

  Baptist Health will lead in clinical excellence, compassionate care and growth to meet the needs of our patients.

- Our Faith-Based Values:

  As a faith-based health system, Baptist Health places special emphasis on our core Values, treating all with **Integrity**, **Respect** and **Compassion**, with a focus on **Excellence** and **Collaboration** in all that we do, helping us to experience the **Joy** of caring for others.

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BAPTIST HEALTH

Baptist Health hospitals and clinics follow a Christ-centered mission to bring medical care, health, and wellness to the communities they serve. Medical technologies, facilities, and knowledge combine with compassion and caring in our not-for-profit hospitals to make them the hospitals of choice in Kentucky. Our eight acute-care hospitals, with more than 2,700 licensed beds, provide healthcare on a deeply personal level.

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BAPTIST HEALTH PADUCAH

- Key part of community since area churches supported the opening of Western Baptist Hospital in 1953.
- Approximately 2,000 employees, alternates with marine industry as region's largest employer.

- Main campus covers eight square blocks, plus off-site outpatient rehab, occupational medicine, primary care, imaging and lab.

BAPTIST HEALTH®

SERVICES

Comprehensive services include:

- Accredited chest pain center
- Accredited comprehensive cancer care
- Medical and surgical weight loss management
- Wound care

Pictured from left to right:
Dr. Bradley McElroy, Cardiology and Dr. Carl Johnson, Cardiothoracic Surgery

BAPTIST HEALTH®

REGION'S ONLY…

- Pathways to Excellence facility
- Neonatal Intensive Care Unit
- Certified Advanced Primary Stroke Center
- Center of Excellence in Minimally Invasive Gynecology, and da Vinci robotic surgery
- 3-D mammography and stereotactic radiosurgery linear accelerator

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CANCER CARE

- Began with first cobalt treatment in 1967
- Nationally-accredited since 2001
- Paducah's only radiation therapy
- American College of Radiology designated Lung Cancer Screening Center

- Advanced technology includes stereotactic radiosurgery and stereotactic body radiosurgery
- Prevention, outreach, education and support programs

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RAY & KAY ECKSTEIN REGIONAL CANCER CARE CENTER

- New $19.1 million Regional Cancer Care Center, first of its kind in the region, opened in 2017.

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CARDIAC CARE

- Dozens of cardiac "firsts" for region, including open-heart surgery in 1985 and chest pain accreditation in 2008.
- September 2015 – Accreditation for Cardiovascular Excellence in percutaneous coronary intervention and cardiac catheterization.
- June 2016 – Get With The Guidelines® - Resuscitation Silver Quality Achievement award.

Kentucky's first heart center west of Louisville opened in 2007.

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MOTHER & BABY CARE

- 4 times more babies delivered here than at all other region's providers combined.
- Newborn care in private room with family; Kangaroo*Care* offers special bonding time after delivery.
- Neonatal Intensive Care Unit opened with 6 beds in 2011, now grown to 14 Level II beds.

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NEUROSURGERY / STROKE CARE

- Brain and spine specialists offer the latest in technology, including SRS and SBRT, functional MRI and Brainlab surgery navigation system.
- Baptist Health Paducah has been certified each consecutive survey, following the initial Joint Commission Seal of Approval as an advanced primary stroke center in 2010. In addition, it has achieved Stroke Gold Plus Quality Achievement Award, Target: Stroke Honor Roll.

The Joint Commission
Gold Seal Of Approval™

2016
GET WITH THE GUIDELINES®
STROKE
TARGET: STROKE HONOR ROLL ELITE
GOLD PLUS
American Heart Association | American Stroke Association
life is why

BAPTIST HEALTH®

SURGICAL CARE

- 50 surgeons in 15 surgical specialties
- About 10,000 surgeries a year
- 2/3 outpatient

Pictured left to right:
Dr. S. Blair Tolar, OB/GYN; Dr. Lauren Jackson, Anesthesiology & Matthew Aydt, CRNA

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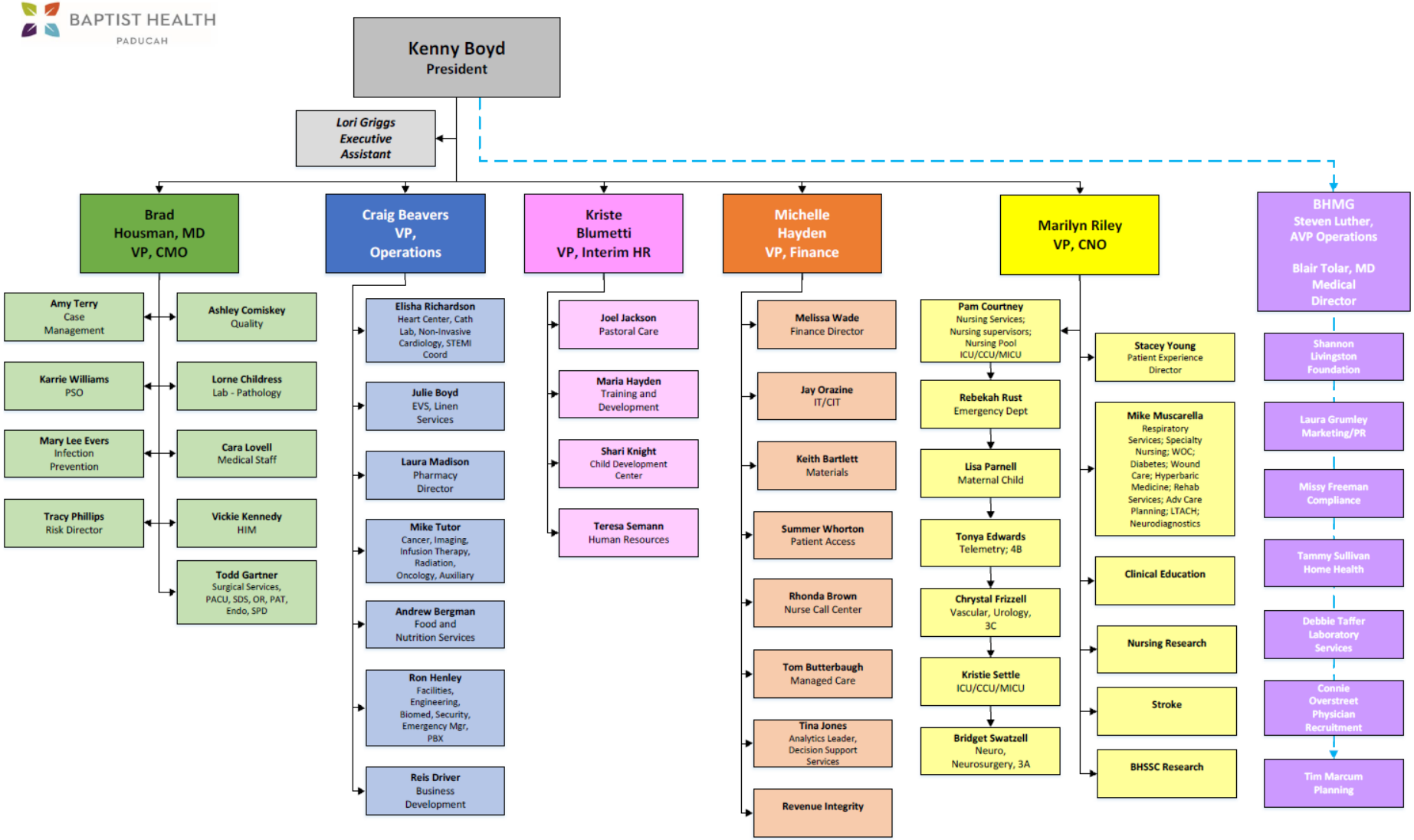
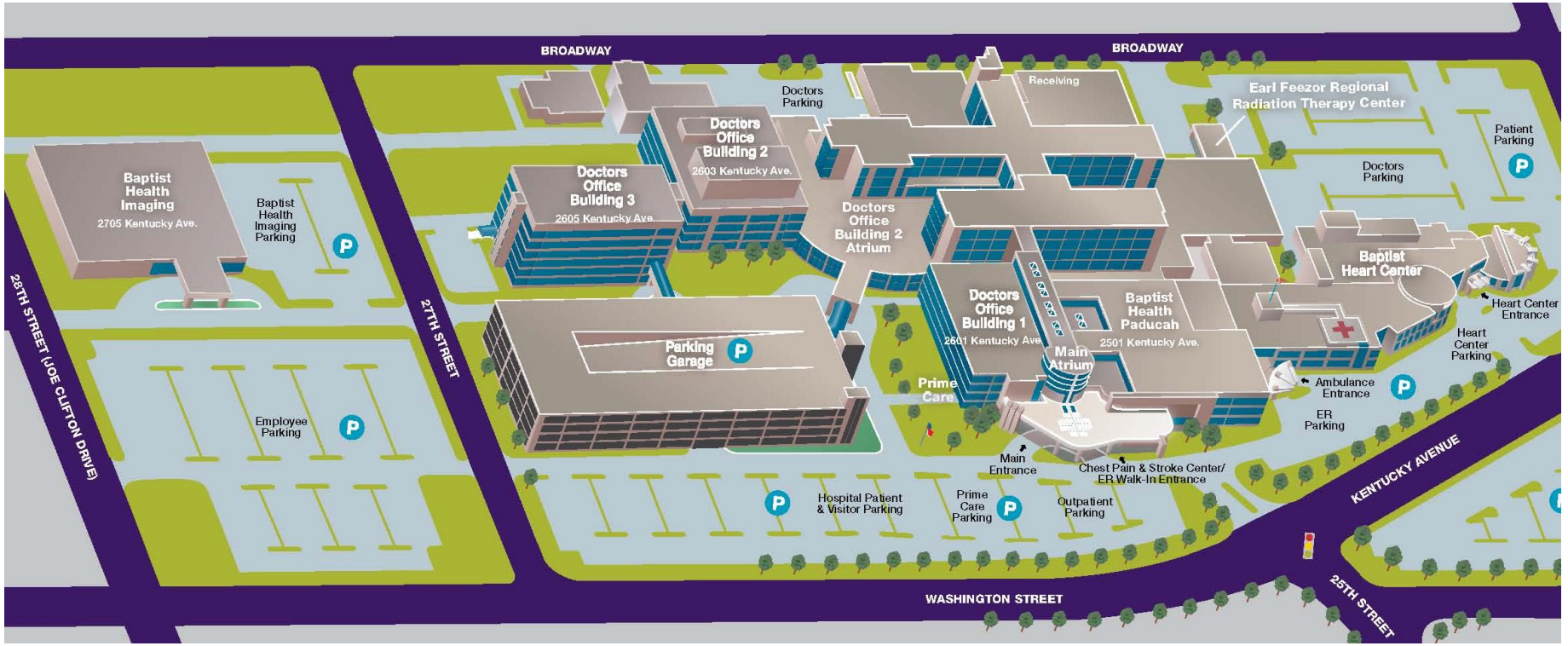
Organizational Chart



BAPTIST HEALTH®

BAPTIST HEALTH PADUCAH



Note: Doctors Office Buildings 1, 2 and 3 have been renamed Medical Park 1, 2 and 3.

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EXECUTIVE LEADERSHIP

KENNY BOYD, FACHE
HOSPITAL PRESIDENT

MARIYN RILEY, APRN
CHIEF NURSING OFFICER

CRAIG BEAVERS, PharmD
VICE PRESIDENT
PROFESSIONAL SERVICES

MICHELLE HAYDEN, MBA
VICE PRESIDENT FINANCE

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EXECUTIVE LEADERSHIP

BRADLEY W. HOUSMAN, MD, MHCM, FACOG
VICE PRESIDENT & CHIEF MEDICAL OFFICER

KRISTIE BLUMETTI
INTERIM VICE PRESIDENT OF HUMAN RESOURCES

BLAIR TOLAR, MD, FACOG
MEDICAL DIRECTOR, BHMG PADUCAH
PRACTICE: BHMG OB/GYN

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MEDICAL STAFF LEADERSHIP 2023

MEDICAL STAFF PRESIDENT

LAUREN JACKSON, M.D.
ANESTHESIOLOGY

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MEDICAL STAFF LEADERSHIP 2022

MEDICAL STAFF
PRESIDENT-ELECT

MARTIN RAINS, M.D.
CARDIOLOGY

MEDICINE
DEPARTMENT CHAIR

KYLE PARISH, M.D.
FAMILY MEDICINE

SURGERY
DEPARTMENT CHAIR

WILLIAM TITSWORTH, MD
NEUROSURGERY

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MEDICAL STAFF COMMITTEES

- MEDICAL EXECUTIVE COMMITTEE (MEC)
- CREDENTIALS COMMITTEE
- SURGERY SERVICE COMMITTEE
- MEDICINE SERVICE COMMITTEE
- OB/GYN SECTION COMMITTEE
- PEDIATRICS / NEONATAL SECTION COMMITTEE

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GENERAL OVERVIEW

- MEDICAL STAFF BYLAWS
- MEDICAL STAFF CATEGORIES
  - Active
  - Affiliate
  - Consulting
  - Courtesy
  - Honorary
- MEDICAL STAFF POLICIES

MEDICAL STAFF EXPECTATIONS

- Provide the highest quality of care
- Use best practice protocols
- Use standardized order sets
- Support core measures
- Adhere to National Patient Safety Goals
- Maintain infection control
- Participate in Professional Practice Evaluation
  - Ongoing (OPPE)
  - Focused (FPPE)

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MEDICAL STAFF EXPECTATIONS

- Communicate clinical plans and orders clearly
  - Communicate directly with attending and consulting physicians
  - Avoid verbal and telephone orders
  - Write legibly
  - Never utilize unapproved abbreviations
  - Sign, date and time orders with credentials

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MEDICAL STAFF EXPECTATIONS

- Maintain accurate medical record keeping
  - Medical H&P within 24 hours of admission and before any operative or invasive procedures
  - Operative / procedure note immediately after a procedure
  - date, time and sign medical record entries
  - Complete all medical records within 15 days of discharge

COMMUNICATION

- Email
  - Personal
  - Business
  - Medical Staff Group List
- Fax
- Newsletter from Administration
- Annual Staff Meetings

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MEET THE DEPARTMENTS

- Baptist Health Line / Baptist Transfer Center
- Case Management
- Clinical Documentation Integrity (CDI)
- Clinical Informatics Technology (CIT)
- Compliance
- Patient / Customer Relations
- Education / Development
- Infection Control
- Lab / Pathology
- Neurodiagnostics / Sleep Lab
- Marketing
- Medical Staff Services
- Physician Recruitment
- Quality Department
- Risk Management / Patient Safety

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BAPTIST HEALTH LINE & BAPTIST TRANSFER CENTER

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BAPTIST HEALTH LINE / BAPTIST TRANSFER CENTER

- Baptist Health Line:
  - Serving 24 hrs./day, 7 days/week, with an all RN staff to serve the general public for triage and health information questions
  - After hours calls for contract physician practices
  - Post-discharge calls to all patients based on acuity (LACE score 7 or >) for all of BHS
  - All throughout BHS patients are given the call center's phone number for post-discharge questions/concerns

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Baptist Health Line / Transfer Center

- Baptist Transfer Center
  - Serving 24 hrs./day, 7 days/week
  - Transfer requests are received from outlying facilities for patients requiring a higher level of care
  - All transfers are facilitated, recorded and documented by an all RN staff

Baptist Health Line / Transfer Center

- Contact Information
  - Baptist Health Line: 270-575-2918
  - Baptist Transfer Center: 1-877-924-8373
  - Chest Pain/Stroke Hotline: 1-800-575-1911
  - Storkline: 270-575-2229

Manager of Call Center: Bonnie Bullard, RN
270-575-2917
bbullard@bhsi.com

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CASE MANAGEMENT

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Case Management Department

- The Case Management Department (CMD) is made up of a variety of roles.
  - Case Managers
  - Utilization Review (UR) nurses
  - Social Workers

- The goal of the case management department is to move the patient and family through the continuum of care in the most efficient and effective manner possible.

- The focus of the CMD is to provide holistic care addressing all aspects of an individual/families life.

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Case Manager Role

- Identifies patients needing Case Management services. The Case Manager facilitates collaborative management of patient care across the continuum, intervening as necessary to remove barriers to timely and efficient care delivery.
- Screens for discharge planning
- Run interference for scheduling problems
- Round with physicians
- Evaluates variances in hospital stay
- Review charts for medical necessity and appropriate level of care (InterQual) 1st level review
- Forwards clinical information to Executive Health Resources for 2nd level review as indicated.

Utilization Review (UR) Nurse Role

- Responsible for completing admission and concurrent reviews for third party payers, Medicaid, and Commercial payers.

- Submits medical documentation to Insurance for authorization of hospitalization.

- Notifies physician when insurance has denied services.

Social Worker Role

- Intervenes with patients who have complex psychosocial needs, require assistance for social programs and funding sources, and qualify for community assistance.
- Coordinate and facilitate complex discharge-planning efforts.
- Early identification of high-risk patients and assess for discharge planning needs.
- Determines need for post care
- Arranges transfers to skilled nursing facilities, rehabs, LTACHS, etc.
- Coordinates with physician and ensures Acute-Care Transfers have accepting physician and bed availability at accepting facility.


Admission
Alert

Admission Status

- Hospital Conditions of Participation requires all Medicare hospital stays be reviewed for medical necessity.
- CMS requires use of appropriate Criteria for 1st level review. BHP uses Interqual (IQ) criteria based data set that is made up of 3 components. They are:
- **Severity of Illness** (SOI) – What brought the patient into the hospital?
- **Intensity of Service** (IOS) – What care is being provided that can only be accomplished at the hospital level?
- **Responder Criteria** – Certain parameters that must be met to demonstrate the patient is ready to move to the next level of care

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Admission Status

- An admission status is required on all Medicare, Medicaid, and commercial insurances.

- For **MEDICAL ADMISSIONS** there are two types of status that may be used.
  - **Observation** – Medicare's definition for observation is the use of a bed and periodic monitoring by hospital staff to evaluate a patient's condition to determine the need for possible inpatient admission.
  - **Inpatient** – is used when the patient is anticipated to stay greater than 24 hours and they meet medical necessity criteria.

- For **SURGICAL ADMISSIONS** there are two types of status that may be used.
  - **Outpatient** – to be used on all surgery cases that are not on Inpatient only list
  - **Inpatient** – only if procedure is listed on Center for Medicare/Medicaid Services (CMS) INPATIENT ONLY LIST

Admission Status

- IQ is used by 1st level non-physician reviewers (Case Managers & Utilization Review Nurses)
- When patient has Inpatient order and does not meet IQ for Inpatient, the case is referred to the 2nd level reviewer.
- BHP 2nd level review is provided by Executive Health Resources (EHR) a physician based organization.
- If EHR does not have enough information to make a determination, they will contact the physician to discuss the case.

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Executive Health Resources

- To assist the physician, BHP has contracted with Executive Health Resource.
- They serve as a resource to assist the physician with determining status based on documents in the medical records. This allows the physician to be confident in meeting compliance as set by the government and third party payers.
- The EHR physician may contact you for additional information during this process.

- **The attending physician has the final decision/responsibility, as defined by Medicare.**

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Appropriate Admission Status:

- Inpatient versus Observation sometimes is difficult to determine.
- Reach out to any Case Manager and they will be able to assist you with making determination.
- Please remember that the attending physician still has the final decision on status.

Appropriate Admission Status:

- Use of **OUTPATIENT/OBSERVATION** is appropriate under the following circumstances.
  - ❖ The physician is unsure about the patient's need for inpatient admission and requires additional time to evaluate the patient.
  - ❖ The physician anticipates that the patient's condition can be evaluated and/or treated within 24 hours and/or rapid improvement of the patient's condition can be anticipated within 24 hours.
- There must, be medical necessity of observation services and the medical necessity must be documented in the medical record.
- Routine stays following late surgery, diagnostic testing, or outpatient therapy or procedures may not be billed as observation unless there is documentation that the patient‘s condition is unstable. Normal postoperative recovery time following surgery cannot be billed as an outpatient observation.

Outpatient / Observation Status

Outpatient Observation Services

- Observation status is commonly assigned to patients who present and require less than 24-48hours of treatment or monitoring before decision is made concerning their admission or discharge.

- Observation services **BEGIN** and **END** by the order of a physician or another individual, who is authorized by state licensure law and hospital staff by-laws to admit patients to the hospital.

- Orders should be clear for the level of care intended, such as "**admitted to inpatient**" or **“place in observation services."**

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How to Navigate the Medicare Maze

- When admitting a patient to the hospital, as a direct admit or through the Emergency department, physicians or their extenders must write orders for admission status, according to Medicare guidelines. These orders must be signed, dated, and timed by the physician prior to patient discharging from hospital.

- Regardless of the admission status, the patient will receive the same high quality care.

- The admission status order should include the order to be written in CMS directed language:
  - **Admit as an Inpatient** or **Place in Outpatient/Observation**. To assist with the process, Outpatient, Observation and Inpatient boxes have been placed on physician specific orders allowing the physician to select the appropriate status. Surgical procedures listed by Medicare as Inpatient only – the Inpatient order within the selection or Outpatient order has been placed on the physician specific order sets.

Billing Condition Code 44

- Medicare Hospital's Conditions of Participation (CoP) require all hospitals to have a utilization review (UR) plan.
- Used if a patient is admitted as INPATIENT and it has been determined that patient does NOT qualify for inpatient level of care.
- The use of Condition Code 44 can be used then to reverse the order to observation status.
- Medicare regulations require the attending physician to be consulted to present his or her views before downgrade from Inpatient to OBS can occur.

Billing Condition Code 44 *cont'd*

- Discussion allows the physician to provide information that may not be in medical record that will assist with determining a compliant recommendation.

- If the attending agrees with downgrade then an order will need to be placed for OBS status and documentation that physician concurs with determination.

- **The attending physician has the final decision/responsibility, as defined by Medicare.**

- The Utilization Review committee will also review the decision and concur with determination for downgrade.

Code 44

- Criteria that must be complete prior to billing for Condition Code 44 is:
  - Outpatient claims only
  - Status changed from inpatient to observation status while the patient is still a patient in the hospital
  - The hospital has not submitted a claim for the inpatient admission
  - The attending physician concurs with the UR committee's opinion
  - The physician's concurrence is documented in the medical record

Admission Status: Compliance

Why is it important to the physician? COMPLIANCE!!!

- CMS (Cigna Government Solution – MAC) plans to have in place, a program that will compare hospital status billing with physician status billing.
  - When discrepancy occurs, both bills with be frozen until an investigation is completed.
  - It is anticipated non-supported status orders could negatively impact physician reimbursement.

Admission Status: Compliance

Why is it important to the physician? COMPLIANCE!!!

- When a patient's admission status does not correlate with the medical record documentation and we are unable to obtain the appropriate status order, the hospital must:
  - Bill the claim with a zero dollar reimbursement.
  - Issue a Hospital Issuance of Non-Coverage Notification (at a certain time period the patient becomes responsible for all cost of care).

Assure Compliance

How can physicians and extenders assure compliance?

- Sign, date and time admit orders.
- Specify the level of care -"place in observation" or "admit as inpatient."
- When OBS status has been used, make a decision within 24 hours to either admit as inpatient if patient meets medical necessity criteria or discharge the patient.
- Monitor post surgery, document -after the surgery -the reason patient is being placed in observation (according to Medicare, this cannot be for patient and/or family convenience).
- Bill the same as the hospital (both should bill as observation or both as inpatient).

For more information, contact the Case Management Department at ext. 8474; the Medicare Provider Help Desk at 1-800-300-8190 or hce.org.


Q&A

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Kentucky Medicare Quality Improvement Organization (QIO) Q&A:

Question:

Would it be permissible for a hospital to routinely care for all patients in outpatient observation prior to making a decision about their need for inpatient admission?

Answer:

No - Hospitals should not routinely default to outpatient observation status. The status should be determined for each patient based on his or her particular condition and needs. Outpatient observation should be used when a physician needs additional time to evaluate the patient and determine the need for inpatient admission, or when the physician has reason to believe that the patient will respond to treatment within 24 hours.

Kentucky Medicare Quality Improvement Organization (QIO) Q&A:

Question:

If a physician writes a clear admission or outpatient observation order and the patient is receiving the level of care ordered, but an error by business office or other staff results in an incorrect level of care designation being noted in the billing system, can this type of clerical transcription or designation error be corrected?

Answer:

Yes. A clerical error that involves only an incorrect level of care status being assigned, not a problem with the physician's order or the level of care the patient is receiving, can be corrected so that it is in alignment with the patient's status as ordered by the physician. This type of error correction should be documented and tracked in an administrative system to determine if patterns to the occurrences can be identified and processes corrected to prevent a recurrence.

Kentucky Medicare Quality Improvement Organization (QIO) Q&A:

Question:

If a physician orders (verbally or by telephone) a patient to be treated in observation, but the hospital staff transcribes the order incorrectly, indicating that the patient is an inpatient, can the hospital correct this?

Answer:

Yes – The hospital can correct this situation because this is a clerical-type error, not a problem with the physician order or the level of care the patient is receiving. The admitting physician is expected to enter a clarification and/or correction note or order in the medical record in a timely fashion, normally within one working day. The physician should sign and date this note or order. The patient status may not be "corrected" after the patient is discharged. Again, hospitals are encouraged to monitor these types of situations to determine if processes can be put in place to eliminate them.

Kentucky Medicare Quality Improvement Organization (QIO) Q&A:

Question:

If a physician determines that a patient is acute and is not responding to treatment after a stay in outpatient observation, can the patient then be admitted as an inpatient?

Answer:

Yes - An outpatient observation stay can be converted or progressed from observation to inpatient admission if the patient has an acute condition that requires treatment in an inpatient setting. A physician order is required. The physician should document the medical necessity of admission in the medical record. Admission criteria should be met at the time the inpatient order is written.

Kentucky Medicare Quality Improvement Organization (QIO) Q&A:

Question:

Is a physician actually required to write an inpatient admission order when a patient is progressed from outpatient observation to inpatient admission?

Answer:

Yes. The hospital cannot bill an inpatient admission without a physician order. The order must clearly indicate the level of care required, and documentation in the medical record must support medical necessity of the inpatient admission.

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Kentucky Medicare Quality Improvement Organization (QIO) Q&A:

Question:

When does a Medicare observation end?

Answer:

It is expected that a decision will be made within 24 no more than 48 hours regarding whether the patient is admitted as an inpatient or discharged. With Medicare, there is no automatic progression to inpatient status; once ordered, observation status continues until a physician order is received for discharge or inpatient admission.

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Discharge Planning Topics

- Discharge planning starts at the time of admission
- Case Management Department uses a High Risk Screen policy, referrals and physician orders for discharge planning case finding. We attempt to early on identify services patient currently have in place and possible services they may need post hospitalization.
- Case Management communicates these findings under Progress Notes in EPIC.
- Issues that can impact the discharge plan include but are not limited to:
  - Patient's right to refuse treatment or discharge plans
  - Patients that would benefit from alcohol or drug rehab
  - Homeless patients
  - Post hospitalization medication needs
  - Questions on competency/need for POA/guardianship
  - Mental health issues
  - Insurance coverage and approval

Discharge Planning Cont'd

- The hospital has certain processes in place to address those issues. We also recognize that there may be some limitations in their scope to address all issues the patient may be experiencing.

- The most common mechanism we use to assist patients is to draw on community resources. Due to changes in the economy issues related to homelessness, drug assistance, mental health has become more challenging and requires us to be more creative in identifying ways to meet the patient's needs.

Acute Care Transfer (ACT)

- Acute Care Transfer to another facility occurs for two reasons:
  - patient requires service(s) that cannot be provided/available at current facility
  - patient/family request transfer

- ACT's can occur from the ER or from in-house. When they occur in the Emergency Room they fall under EMTALA regulations.

- Certain components must be in place before the actual transport of the patient can take place.

Acute Care Transfer: Components Required

- Sending physician must have acceptance of the transfer to a receiving physician – **MD is responsible for finding accepting MD**
- Facility must have bed that will be available when the patient arrives
- Documentation of physician order
- Documentation that supports reason for transport
- Physician order of mode of transportation to be used
  - CMS regulations do not dictate the type of transportation that must be used, the language is vague and states “appropriate mode of transportation”.

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Acute Care Transfer: Transportation Types

- There are 3 types of transport available.
  - Ground ambulance-requires a physician order for transport, meet medical necessity guidelines, and details if additional staff must be present during transport (nurse; respiratory therapist).
  - Air ambulance should be used only for critical patient that ground ambulance is not appropriate for. Short distances can use helicopters and long distances require fixed wing. Must have documentation of loss of life or limb.
    - (NOTE: BYPASS MILES become an issue when a closer facility that can provide that level of care is not selected. The patient may become responsible for the cost of the additional miles. Documentation of the reason the more distant facility was used may prevent the financial liability from occurring.)
  - Private car-this type of transport has the highest risk for the patient clinically and the physician from a liability standpoint. If private car transport is to occur the following in place:
    - Order from the physician stating transport by private automobile
    - Specific directions from the physician covering: dietary status (NPO or limitations), can they stop places or directly go to facility they are being transferred to, any special directions, and documentation in medical record the specific risk and benefits have been discussed.

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Acute Care Transfer: Case Management Role

- Verify physician and bed availability at receiving facility
- Arrange transportation
- If transport by private vehicle:
  - Will verify receiving facility will accept patient by this mode of transport
  - Provide specific directions on where to register

LTACH-Long Term Acute Care Hospital

- LTACH's are specialty care hospitals that provide a full range of care to patients suffering from extreme accident to serious medically complex illnesses.
- The Average Length of Stay (ALOS) is 25-35 days.
- Oftentimes the patient is transferred from the acute care facility Intensive Care Unit to the LTACH.
- To initiate an evaluation to see if an LTACH is appropriate for your patient contact Social Service/Case Manager.
- They in turn will contact admission intake coordination to discuss the case. The admission coordinator will do an on-site visit to evaluate the medical record and possibly speak to the patient/decision maker. They will notify the SW with a bed offer or a denial.

LTACH Cont'd

- Certain criteria must be met for an LTACH to accept the patient:
    - meet medical necessity criteria
    - have an anticipated LOS of 25 days or more
    - must require hospital care (complex)
- Physician communication early on is a key component to acceptance by patient and family for this type of disposition

Guardianship

Petition for Guardianship is initiated when the patient is unable to make healthcare decisions and there are no known advanced directives available.

Patients that are at risk for need of guardianship are:

- Homeless
- Cognitively impaired
- No family or family not willing to be decision maker
- Suspected abuse/neglect/ financial gain in which the state will be notified and if necessary will initiate the process

Guardianship Types

EXTERNAL (family/friend willing to initiate guardianship process)

1. Identify patient is unable to make own decision
2. Validate there is no POA, healthcare surrogate or family issues
3. Give instructions to person initiating guardianship process
    1. Obtain letter of support from physician regarding need for guardianship (If doctor dictates on our system is easier to obtain than thru doctor's office)
    2. Go to County Attorney Office in patient's county of residence
    3. Provide patient's: SS #; DOB; Demographic info
    4. Return signed emergency guardianship
    5. Make a copy and provide for placement on patients chart
4. Depending on situation, it could take approximately 24 hours to one week to complete the process

Guardianship Types

HOSPITAL (AKA as court appointed guardian)

- Senate bill 35 “Guardianship and conservatorship for disabled persons shall be utilized only as is necessary to promote their well-being, including protection from neglect, exploitation, abuse”)

- Disabled means a legal not a medial disability, and is measured by functional inabilities. It refers to any person 14 years of age or older who is :
  - Unable to make informed decisions with respect to his personal affairs to such an extent that he lacks the capacity to provide for his physical health and safety, including but not limited to health care, food, shelter, clothing, or personal hygiene; or
  - Unable to make informed decisions with respect to his financial resources to such an extent that the lacks the capacity to manage his property effectively

Guardianship Process

1. Identify patient is unable to make own decision, validate there is no POA, healthcare surrogate , family members willing to assume the decision making responsibility, issues that would preclude them from initiating guardianship
2. Obtain letter of support from physician regarding need for guardianship (If doctor dictates on our system is easier to obtain than thru doctor's office)
3. Provide information to the Co. Attorney regarding the reason for guardianship appointment. Provide for the Co. Attorney the following information:
   - ❖ name and address of the respondent
   - ❖ date of birth of the respondent if known
   - ❖ nature and degree of the alleged disability of the respondent
   - ❖ facts and reasons supporting the need for guardianship
   - ❖ a description and approximation of the value of the respondent's financial resources, including government benefits, insurance entitlements, and anticipated yearly income, if known (this information may be the most difficult for us to obtain, if unable to access document on fact sheet) To obtain information from social security office and obtain form-this will require a signed H&P from physician
   - ❖ names and addresses of the respondent's next of kin if known
   - ❖ name and address of the individual or facility if any having custody of the respondent
   - ❖ name, address and interest of the petitioner (use your name, hospital name and address and the interest is for provision of continuity of care)
4. Hearing set
5. Judge appoints Guardian
6. Guardian papers are provided to the hospital by court appointed Guardian and placed on chart
7. Contact Guardian for health care decision

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CLINICAL DOCUMENTATION INTEGRITY (CDI)

Ben Thompson, M.D.
Facility Medical Director
Hospitalist Medicine – Baptist Health Paducah

First, if you were to tell me that the documentation discussion is:

- ✓Frustrating
- ✓Time Consuming
- ✓Complex
- ✓Another “hoop” to jump through
- ✓Yet another task that pulls the healthcare provider away from the bedside
- ✓“Paperwork versus Patient-Care”
- ✓Does it really add any value for my patient?
- ✓I was trained to be a doctor, not a documentation specialist!!
- ✓I received no training about these things in medical school or residency

My response:

But…..given our current field of play, and with the current rules in place, excelling at good documentation is vital.

Here's why:

- Healthcare is rapidly transforming to a pay-for-performance model.
- So….how does a coder, insurance company, auditor, healthcare provider colleague, etc., assess performance?
- In the past = reimbursement primarily reflected volume of services
- In the present (and most certainly in the future) = reimbursement will reflect quality of services and the accuracy and completeness when documenting those services.

Here's why:

- Scoring algorithms are everywhere…
  - Quality and Best-Practice Outcomes Data
  - Physician Quality of Care scores such as Physician Compare (CMS)
  - Hospital Compare (CMS)
  - Private domain scoring systems (Insurance Companies, Joint Commission, etc.)
  - PEPPER report (Program for Evaluating Payment Patterns Electronic Report)

Pertinent example:

- CMS has created a new Quality Payment Program under MACRA called MIPS (Merit-based Incentive Payment System)
  - "Think about your MIPS score like a credit score. It will follow you wherever you practice in the future. Currently CMS is gathering information and forming your individual MIPS score based off data abstracted from charts during the billing/coding process. Therefore, the care you provide and document now will affect you in the future."
    - Miles Snowden, Chief Medical Officer, TeamHealth

Another example:

Overpayments and underpayments are a huge problem
The Recovery Audit Program resulted in more than $990 million in overpayments being returned to the Medicare Trust Fund and almost $38 million in underpayments returned to healthcare providers in just three years (2005-2008), according to the U.S. Centers for Medicare and Medicaid Services. Due to these astounding discrepancies, Congress instituted a permanent, nationwide Recovery Audit Program.

- Healthcare providers are trained to speak one language…coders speak another language.
- We invariably get frustrated because they don't understand what we are trying to communicate:
  - We think it's so obvious what we're trying to communicate
  - Or, we get frustrated because we think they are "picking" at minutia.
- The Clinical Documentation Integrity (CDI) department is comprised of Registered Nurses that are specially trained to identify opportunities where documentation can be further specified to accurately reflect the patient's condition in the coding language.
- The CDS will write queries to obtain specification, acuity, and etiology based on clinical indicators, treatment, and existing documentation. This is done concurrently (while the patient is an inpatient) and retrospectively (after discharge).

It is **NOT** US versus THEM…we play on the same team

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Physician documentation …in our eyes!

- A way to communicate between providers
- Describes the reasons why the patient is in the hospital
- Describes our thoughts and treatment plans
- Proves we were there so we can bill for our services

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Physician documentation
The bigger picture

- Our documentation is the KEY to accurately translating the patient's "story" into the language that the coders can use.
- Currently, the CDI department assists us with translating our language with queries.
- Ultimately, by learning the rules of the "game" we can drastically reduce the amount of queries received by documenting in a language that is translatable.
- They cannot translate the language.
- They cannot even infer or assume…even for what seems obvious to us.

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Physician documentation
The bigger picture

- It is my job to establish the Principal Diagnosis, helping to determine the Diagnosis Related Group (DRG)
- It is my job to document secondary diagnoses as they can contribute to a Complication/Comorbidity (CC) or Major Complication/Comorbidity (MCC) – these are VERY IMPORTANT!!
- My documentation supports Length of Stay (LOS)
- My documentation addresses the Severity of Illness (SOI) and Risk of Mortality (ROM) which are “scored” and used in multiple algorithms

Principal Diagnosis

- Defined as “the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”
- Determines the DRG for the hospital stay, which is the “base price” CMS (or insurer) pays for the entire hospital encounter

DRG (Diagnosis Related Group)

- The CMS system of classifying diagnoses into “groups” in which patients demonstrate similar resource consumption and length-of- stay patterns
- Think of this as the CMS version of “fair market value” of the hospital stay
- “Flat fee”

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…demonstrate similar resource consumption?

Patient in Room #1 with
“Pneumonia” – DRG 195

Patient in Room #2 with
“Pneumonia” – DRG 195

What, again, are CC and MCC's?

- CC and MCC's are basically secondary diagnoses, but they have BIG IMPACT and have to be documented correctly
- CC and MCC's impact:
  - the scoring of SOI and ROM for that hospital stay
  - determines the relative weight (RW) of the DRG
  - impacts the GLOS
- In short…it highlights the difference between the patient in Room #1 versus Room #2
  - Eye-ball test → Obvious difference
  - Documentation test → let's go to an example…

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Pneumonia, Unspecified without CC/MCC		Pneumonia, Unspecified w/CC		Pneumonia, Unspecified w/MCC	
DRG	195 RW-0.7099	**DRG**	194 RW-0.9332	**DRG**	193 RW-1.3731
LOS	2.7	**LOS**	3.4	**LOS**	4.5
SOI	1	**SOI**	3	**SOI**	3
ROM	2	**ROM**	2	**ROM**	3
Secondary Diagnoses	• Dehydration • Nausea/ emesis • Malaise and fatigue	**Secondary Diagnosis**	• COPD A/E • Morbid Obesity, BMI-43.5 • CHF, chronic combined or HFrEF • Chronic resp failure with hypercapnia	**Secondary Diagnosis**	• Add… acute on chronic resp failure with hypercapnia AND hypoxia

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Pneumonia, Gram negative Unspecified without CC/MCC		Pneumonia, Gram negative w/CC		Pneumonia, Gram negative w/MCC	
DRG	179 RW-0.9300	**DRG**	178 RW-1.2952	**DRG**	177 RW-1.8507
LOS	3.4	**LOS**	4.5	**LOS**	5.7
SOI	1	**SOI**	3	**SOI**	3
ROM	2	**ROM**	2	**ROM**	3
Secondary Diagnoses	• Dehydration • Nausea/emesis • Malaise and fatigue	**Secondary Diagnosis**	• COPD A/E • Morbid Obesity, BMI-43.5 • CHF, chronic combined or HFrEF • Chronic resp failure with hypercapnia	**Secondary Diagnosis**	• Add…acute on chronic resp failure with hypercapnia AND hypoxia

Important takeaway:

- Health-Care Associated Pneumonia (HCAP) describes a "setting"
- It does NOT code to a "complex" pneumonia and needs to be specified:
  - Gram Negative
  - Fungal
  - Aspiration
  - MRSA
- Remember: it is okay to use terminology such as suspect or probable

But what if I don't know for sure if it's gram negative?

- There are 3 must haves:
  - High risk host
  - High risk setting
  - Appropriate gram negative antibiotic coverage

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Important takeaway – what do I document when I suspect but am not 100% certain?

- Diagnoses can be described as: “suspected, probable, or likely”
  - They are code-able if described as such.
- It can be listed this way on a discharge summary
- Tip: you WILL be queried if the “suspected” diagnoses are not included in the discharge summary.

Good documentation drives SOI and ROM scores

- Used to calculate Case Mix Index (CMI)
- CMI is a numerical representation of what kind of patients you (and the hospital) manage.
- CMI is used in numerous calculations and algorithms to determine service needs, justify outcomes, negotiate reimbursement, score physician quality data, etc.

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So…let's look at an actual HOP query example:

Dr. _____:

86 yr old F patient with history of possible dementia was admitted with increased confusion and was found to have urinary tract infection. Per H&P, "Review of systems are unable to be obtained due to patient's confusion." Per progress note on 11/16, "She does not converse much today, very lethargic." Per 11/17 progress note, "She is now back to her baseline" and "altered mental status secondary to urinary tract infection." Treatment has included IV Rocephin, IV Invanz X 1 dose, serial labs and cultures. After study, can this be further specified as:

Acute metabolic encephalopathy due to UTI

Altered mental status secondary to urinary tract infection only

Other

Unable to be clinically determined

Let's define encephalopathy

- Acute encephalopathy: encompasses stupor, coma, delirium, and acute confusional states, is an acute condition of global cerebral dysfunction.
- S/Sxs: decreased LOC, altered mental status, delirium, confusion, obtunded, stupor, coma, agitated, lethargic, somnolent, drowsy, fluctuating alertness, delirious.
- Types: Metabolic, Toxic, Hypoglycemic, Hypoxic/anoxic, Ischemic, Hepatic, Septic, Uremic, Wernicke's
- Common conditions associated with: acute liver failure/cirrhosis, acute/chronic systolic heart failure, alcohol dependence and abuse, brain injury, brain malignancy (primary or metastatic), cirrhosis, electrolyte imbalance (hyponatremia), ESLD, ESRD, Infections (UTI), Poisonings, Sepsis, Shock (type)

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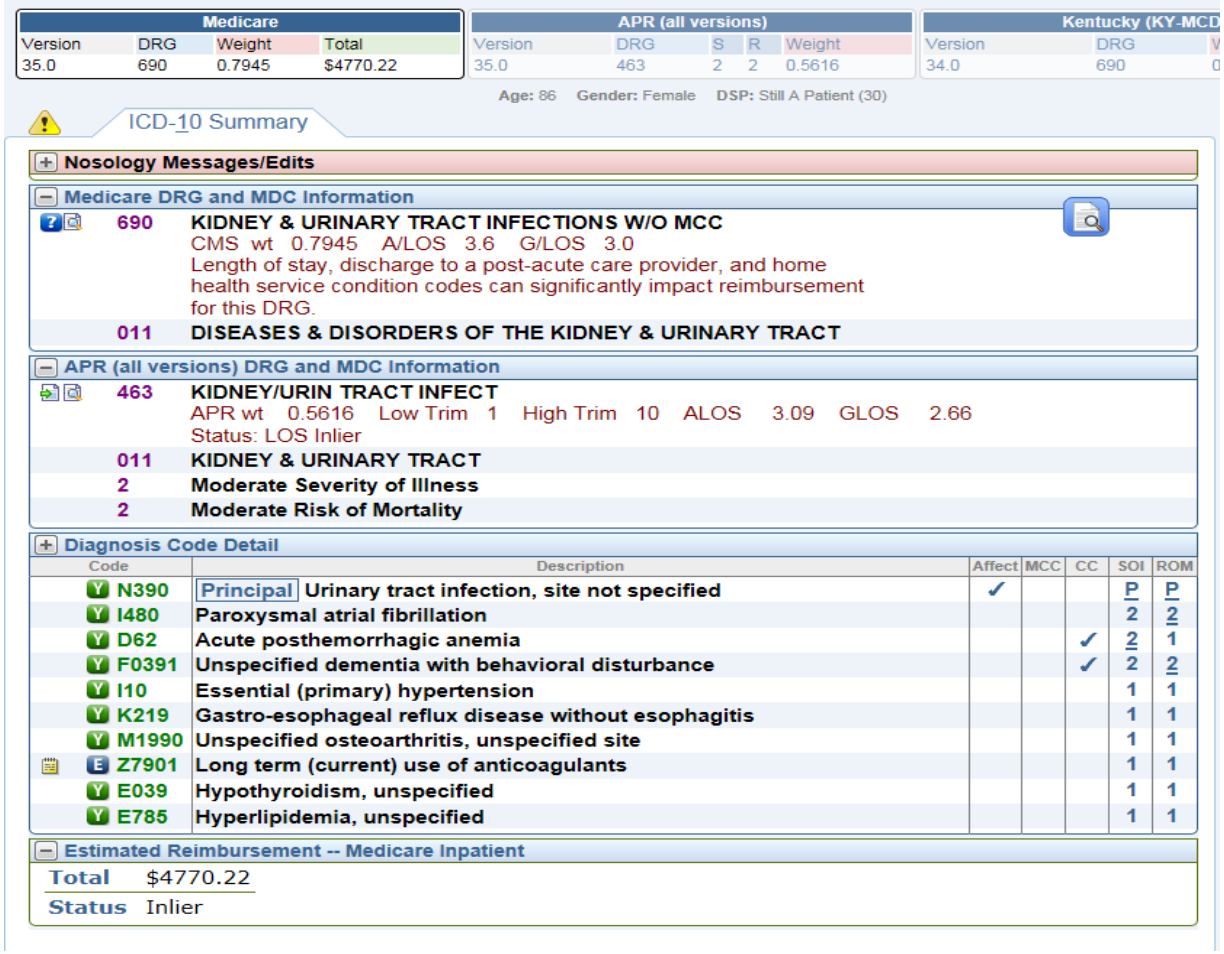
If documentation is:
UTI and altered mental status



Medicare			
Version	DRG	Weight	Total
35.0	690	0.7945	$4770.22

APR (all versions)				
Version	DRG	S	R	Weight
35.0	463	2	2	0.5616

Kentucky (KY-MCD	
Version	DRG
34.0	690

Age: 86 Gender: Female DSP: Still A Patient (30)

ICD-10 Summary

Nosology Messages/Edits

Medicare DRG and MDC Information

690 **KIDNEY & URINARY TRACT INFECTIONS W/O MCC**
CMS wt 0.7945 A/LOS 3.6 G/LOS 3.0
Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.

011 **DISEASES & DISORDERS OF THE KIDNEY & URINARY TRACT**

APR (all versions) DRG and MDC Information

463 **KIDNEY/URIN TRACT INFECT**
APR wt 0.5616 Low Trim 1 High Trim 10 ALOS 3.09 GLOS 2.66
Status: LOS Inlier

011 **KIDNEY & URINARY TRACT**

2 **Moderate Severity of Illness**

2 **Moderate Risk of Mortality**

Diagnosis Code Detail

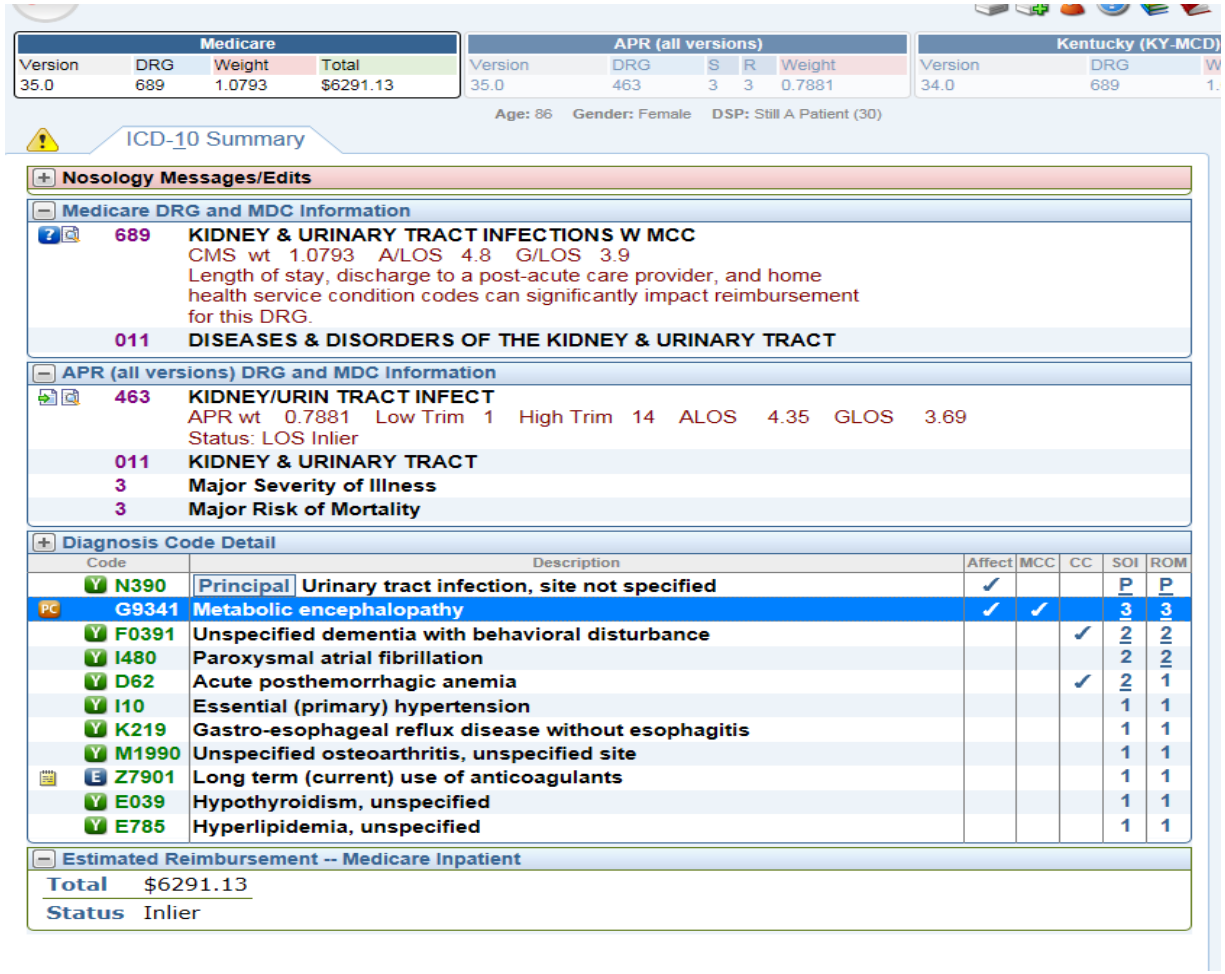
Code	Description	Affect	MCC	CC	SOI	ROM
Y N390	Principal Urinary tract infection, site not specified	✓			P	P
Y I480	Paroxysmal atrial fibrillation				2	2
Y D62	Acute posthemorrhagic anemia			✓	2	1
Y F0391	Unspecified dementia with behavioral disturbance			✓	2	2
Y I10	Essential (primary) hypertension				1	1
Y K219	Gastro-esophageal reflux disease without esophagitis				1	1
Y M1990	Unspecified osteoarthritis, unspecified site				1	1
E Z7901	Long term (current) use of anticoagulants				1	1
Y E039	Hypothyroidism, unspecified				1	1
Y E785	Hyperlipidemia, unspecified				1	1

Estimated Reimbursement -- Medicare Inpatient

Total $4770.22
Status Inlier

BAPTIST HEALTH®

If documentation is:
acute metabolic encephalopathy due to UTI



Medicare			
Version	DRG	Weight	Total
35.0	689	1.0793	$6291.13

APR (all versions)				
Version	DRG	S	R	Weight
35.0	463	3	3	0.7881

Kentucky (KY-MCD)	
Version	DRG
34.0	689

Age: 86 Gender: Female DSP: Still A Patient (30)

ICD-10 Summary

Nosology Messages/Edits

Medicare DRG and MDC Information

689 KIDNEY & URINARY TRACT INFECTIONS W MCC
CMS wt 1.0793 A/LOS 4.8 G/LOS 3.9
Length of stay, discharge to a post-acute care provider, and home health service condition codes can significantly impact reimbursement for this DRG.

011 DISEASES & DISORDERS OF THE KIDNEY & URINARY TRACT

APR (all versions) DRG and MDC Information

463 KIDNEY/URIN TRACT INFECT
APR wt 0.7881 Low Trim 1 High Trim 14 ALOS 4.35 GLOS 3.69
Status: LOS Inlier

011 KIDNEY & URINARY TRACT
3 Major Severity of Illness
3 Major Risk of Mortality

Diagnosis Code Detail

Code	Description	Affect	MCC	CC	SOI	ROM
Y N390	Principal Urinary tract infection, site not specified	✓			P	P
PC G9341	Metabolic encephalopathy	✓	✓		3	3
Y F0391	Unspecified dementia with behavioral disturbance			✓	2	2
Y I480	Paroxysmal atrial fibrillation				2	2
Y D62	Acute posthemorrhagic anemia			✓	2	1
Y I10	Essential (primary) hypertension				1	1
Y K219	Gastro-esophageal reflux disease without esophagitis				1	1
Y M1990	Unspecified osteoarthritis, unspecified site				1	1
E Z7901	Long term (current) use of anticoagulants				1	1
Y E039	Hypothyroidism, unspecified				1	1
Y E785	Hyperlipidemia, unspecified				1	1

Estimated Reimbursement -- Medicare Inpatient

Total $6291.13
Status Inlier

In Summary:

- Impact of Query IF healthcare provider had documented Metabolic Encephalopathy:
  - SOI/ROM increase from 2/2 to 3/3
  - DRG change from 690 to 689
  - GLOS increase from 3.0 to 3.9 days
  - Relative weight change from 0.7945 to 1.0793
  - Would have been the ONLY MCC on the chart.
    - What may seem insignificant to us with regard to documentation, really does make a big impact, and think about its cumulative effect long term with improved documentation!!

Did you know?

- Acute myocardial infarction within 4 weeks = MCC
- Acute/subacute PE (within 90 days) and on anticoagulation = MCC
- Acute coronary syndrome does NOT translate to AMI, but rather codes to just chest pain
- Morbid Obesity (BMI >40) = CC
- Other examples: chronic pancreatitis, history of CVA with hemiplegia, history of traumatic brain injury, history of PAD with BKA, chronic PE, tobacco dependence, hyponatremia, thiamine deficiency in alcoholics, opioid dependence, etc.

Remember our two guys?!?!

It is our responsibility to make sure the documentation reflects that even though both our guys presented with pneumonia…they are not the same patient…they are not going to have the same LOS…they are not going to consume the same amount of resources!!

Malnutrition

- Review and sign (if in agreement) the attestation note from the RD's Malnutrition Severity Assessment
- Once these are signed and attested they can be used for coding purposes (i.e. you should not receive queries!)
- Impact can be for a CC (mild to moderate) to MCC (for severe)
- May also increase SOI and ROM
- Our nutritionists/RDs are a very helpful resource – use them!

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Remember:

- If the BMI is <19 or >40 **this needs to be on your radar**!
  - The coders can pull the actual BMI documented in the nursing assessment; the docs do not have to calculate.
  - **But**, the docs do need to document accordingly and link a diagnosis to the BMI
    - Ex: Underweight, failure to thrive, cachexia, obese, morbidly obese
    - If not documented, don't be surprised if you receive a query (especially if it will impact the DRG, CC, SOI, ROM.

Congestive Heart Failure

- Must, must, must document:
  - Acuity (acute, chronic, acute on chronic) → everytime
  - Specificity (diastolic, systolic, combined, HFrEF, HFpEF)
  - Etiology

Congestive heart failure, unspecified = **"worthless term"**

Congestive Heart Failure

- Etiology….what….why?
  - If there is documentation of Hypertension and/or Chronic Kidney Disease, the coding **automatically** links diagnoses to include, for example, hypertensive heart disease as the primary diagnosis (as opposed to CHF).
  - Example:
    - Acute on chronic diastolic CHF ONLY = RW 0.67
    - Hypertensive heart disease complicated by acute diastolic congestive heart failure = RW 1.4 (HTN HD is primary diagnosis and CHF becomes a MCC)
  - If you are documenting CHF, coders **will be looking for the links**: Valvular heart disease, pulmonary hypertension, amyloid, etc.
  - If you don't link → expect the query as the impact may change the DRG, CC, MCC, SOI, ROM

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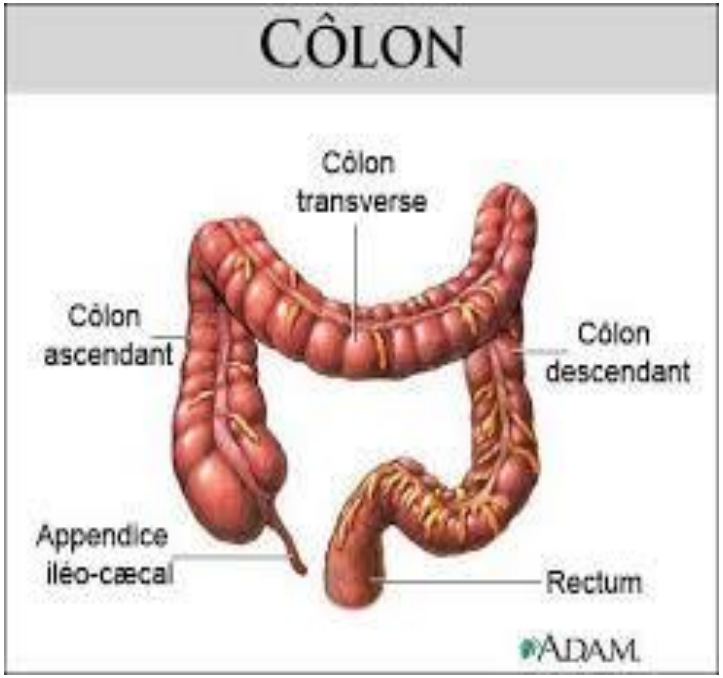
Infections a/w indwelling catheters (or other implanted devices)

- If the infection is related to the device, **it will change the DRG**.
  - Most common example: UTI in a patient with a chronic indwelling Foley catheter
- Coding guidelines dictate that this relationship gets clarified, so **expect a query if the documentation does not spell it out clearly to the coders**.

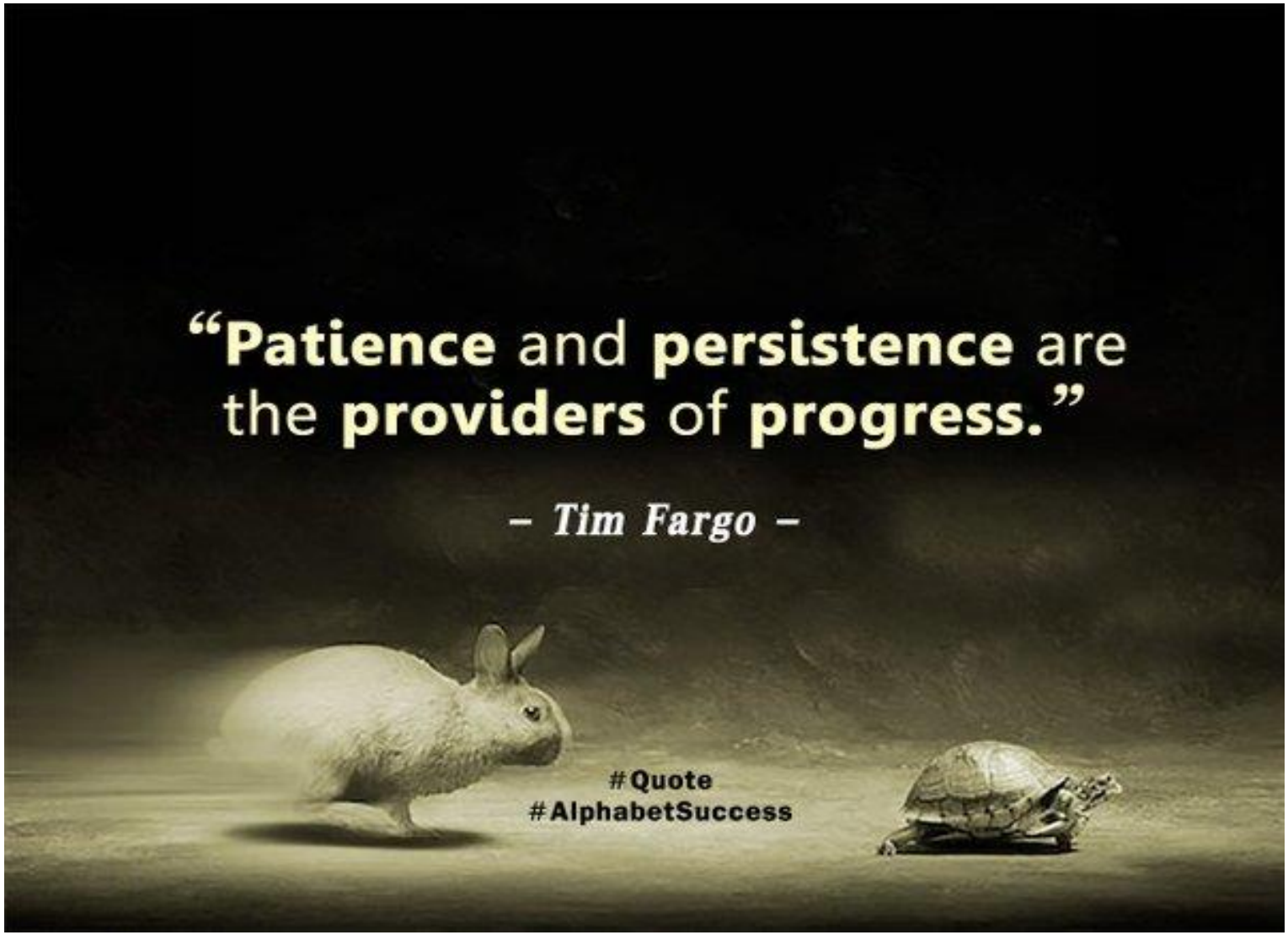
Acute colitis

- Expect a query if you document acute colitis and no other details are given
- Bacterial colitis treated with antibiotic therapy has a different DRG, higher weighted, etc.
- Coders cannot infer bacterial colitis even if antibiotics were given throughout the hospital course, including at discharge.
- Be specific!



Queries

- A few key points to remember:
  - Your answers to the queries are part of the medical record!
  - Timely answering of these queries and d/c summary clarifications have big impact on the coding/billing process.
  - Coders cannot infer or assume…even when it seems obvious what we are trying to communicate.
  - We are the master translators with the responsibility of making sure the documentation provides a thorough and complete summary of our patients' hospital stay….remember our two guys (the last time I'll say it!)
  - This information/data which is used to calculate case mix index (CMI), ROM, SOI, etc., will also be used to grade individual providers (and hospitals) as it reflects the type of patients you manage **"on paper".**


"Patience and persistence are the providers of progress."
– Tim Fargo –
#Quote
#AlphabetSuccess

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CLINICAL INFORMATICS

BAPTIST HEALTH®

INFORMATION MANAGEMENT

To schedule computer training

CLINICAL INFORMATICS

270.575-2730

wbhcit@bhsi.com

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COMPLIANCE

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COMPLIANCE

- Key takeaways:
  - A better understanding of HIPAA
  - A better understanding of Stark Law
  - A better understanding of Federal False Claim Act
  - Compliance Hotline/Contact Resources
  - EMTALA – Physician on call responsibilities

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Standards of Conduct

- The **business** of Baptist Health Care System **will be conducted according to all applicable federal, state, and local laws.**
- All individuals working within Baptist should perform their responsibilities in **ways to avoid conflicts of interests.**
- **All billing** by our hospital **will be for the services and items actually provided**, in keeping with the rules of government and other payers.
- When working with our medical staff, contractors, and other healthcare organizations, **all employees will conduct themselves in keeping with applicable laws, in particular, those laws that prohibit fraud and abuse, waste, restraint of trade and improper benefits.**
- All individuals within our Baptist Health Care System **will strive to maintain a cooperative relationship of mutual trust with all government agencies**.
- Baptist Health Care system will **vigorously pursue its Corporate Responsibility Program to achieve all Compliance Objectives and to develop a culture of compliance throughout the system.**

HIPAA

Covered entities are expected to have reasonable safeguards to protect patient information. Some examples include:

- Speaking quietly when discussing a patient's condition with family members in a waiting room, semi private room, or public area
- Obtain permission from patient before discussing condition in the presence of others
- Avoid using patients' names in public hallways and elevators
- Protect the paper or electronic medical record
- Never share your computer password

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HIPAA

Please discard any document that contains PHI in this type of BIN.
These BINS are located in all nursing stations and ancillary areas.

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Device and Medial Control Accountability

- All portable devices and media containing EPHI must be **registered** with the BHP information services department.
- Any portable device or media containing EPHI should be used only by the individual who registered the device/media.
- Access to data must be protected by the use of authentication such as a password.
- Any portable device or media carrying EPHI should protect the data with a method of encryption.
- All portable devices containing EPHI will be marked as confidential and indicate method of return if found. If the device is misplaced, then it must immediately be reported.
- Individuals are responsible for ensuring the device is free from all forms of malicious software
- Texting is not an improved method of communication

Physician Self-Referral Law (Stark Law)

- The Physician Self-Referral Law, often called the Stark Law, prohibits a physician from making a referral for certain designated health services payable by Medicare or Medicaid to an entity in which the physician (or an immediate family member) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.
- **Example:** A provider refers a beneficiary for a designated health service to a business in which the provider has an investment interest.

Stark Regulation

Every agreement with a physician who constitutes a referral source, or a potential referral source for the hospital must be in writing and reviewed in advance by hospital counsel or reviewed by administrator against criteria established by counsel.

Examples of these agreements, but are not limited to:

- Medical Directorship
- Employment Agreement
- Miscellaneous Physician Service Agreements

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Billing Accuracy

Baptist Health Paducah:

- will only bill for services rendered.
- must comply with special billing requirements for government sponsored programs or other payors.
- is committed to accurate billing to patients and or third party payors.

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Fast Facts about the False Claims Act

…… Any person who

- knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
- knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
- conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; or
- knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government is liable to the United States Government for a civil penalty ……..

Federal False Claims Act

The terms "knowing" and "knowingly" mean that a person, with respect to information:

- (1) has actual knowledge of the information;
- (2) acts in deliberate ignorance of the truth or falsity of the information; or
- (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

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Compliance Hotline **1-800-783-2318**

- In order to provide staff, physicians, patients, an avenue in which to raise concern or wrong doing, the hospital has established a hotline.

- Calls to the hotline will be treated confidentially and may, at the callers request, remain anonymous.

BAPTIST HEALTH®

EMTALA

- Baptist Hospital Paducah will comply with all federal and state regulations and laws regarding evaluation and treatment of patients with emergency medical conditions.
- Medical screening examinations are provided to all persons presenting to the emergency department for treatment.
- The Medical Staff approved policy provides an overview of the Emergency Department Physician Staffing and the On-Call Responsibilities of the Baptist Health Paducah Medical Staff member.

To review complete policy, please see *E13.45-MS Emergency Services and Physician On-Call Responsibilities*

Response Time

- Physicians on emergency call rotation should respond by telephone **within a timely manner** of being called and have the capability of responding physically, to the patient's bedside, within **30 minutes** of responding by telephone in the event of an emergency or as otherwise determined by the Emergency Department physician.

Failure to Respond:

After review by the MEC, failure of any Medical Staff member to meet the obligations of the emergency coverage is cause for disciplinary action.

- **First Offence:** noncompliance of call obligation may result in a 7-day suspension of admitting and clinical privileges.
- **Second Offence:** noncompliance of call obligation may result in a 30-day suspension of admitting and clinical privileges.
- **Third Offence:** termination of Medical Staff membership and privileges.

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Contact Resources

- Baptist Health Paducah Director of Compliance and HIPAA
  Missy Freeman (270) 415-7105
- Baptist Health Paducah HIPAA Security Officer
  Jay Orazine(270) 415-6990
- Compliance Hotline **1-800-783-2318**
- System Compliance and HIPAA Privacy Officer
  Don Riggs (502) 896-5056
- Baptist Health Legal Department **(502) 896-5048**

PATIENT / CUSTOMER RELATIONS

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Scope
to help resolve problems and support the care team

Team Members

Stacey Young, Patient Relations Director	270.575.2848	stacey.young@bhsi.com
Laken Leigh, Patient Relations Specialist	270.415.7726	laken.leigh@bhsi.com

Bottom Line

- HCAHPS surveys, designed and directed by Medicare, are mailed to 50% of our inpatients at BHP
- Results are publicly available on the Medicare website
- Hospital reimbursement is driven only through the answer of ***ALWAYS***
- Results used in many provider contract evaluations

HCAHPS

The HCAHPS *(Hospital Consumer Assessment of Healthcare Providers and Systems)* survey is a standardized survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience.

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HCAHPS Questions

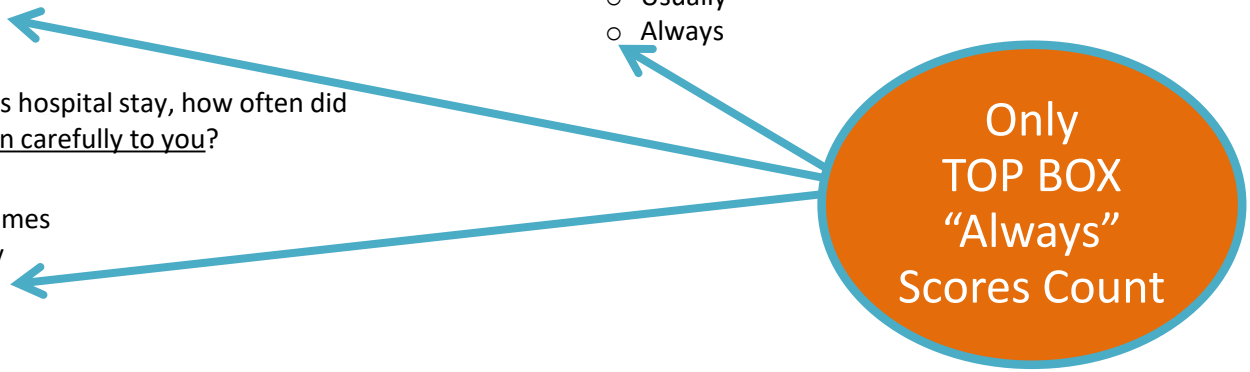
Three HCAHPS questions directly tied to you

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?
   - Never
   - Sometimes
   - Usually
   - Always

6. During this hospital stay, how often did doctors listen carefully to you?
   - Never
   - Sometimes
   - Usually
   - Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always



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Baptist Health Paducah Goals FY 23

		Percentile Rank by Received Date								
	Baseline (FY 22 final)	**Current FY TD**	**%tiles to go for 2024**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Market Patient Experience Impact	**55**	61	14	**57**	**61**	**62**	**62**	**59**	**61**	**61**
System Goal Inpatient: HCAHPS RN Comm	43	75	0	45	87	70	93	60	71	81
System Goal: ED Staff Worked Together	56	41	34	37	71	56	22	27	65	36
System Goal: MP Patient Experience Impact	62	74	1	64	66	63	68	73	74	75
Facility Goal Inpatient: HCAHPS Response of Staff	27	58	17	54	23	48	75	16	70	73
Facility Goal Inpatient: ED Staff Cared About You	61	48	27	53	76	57	29	30	74	40

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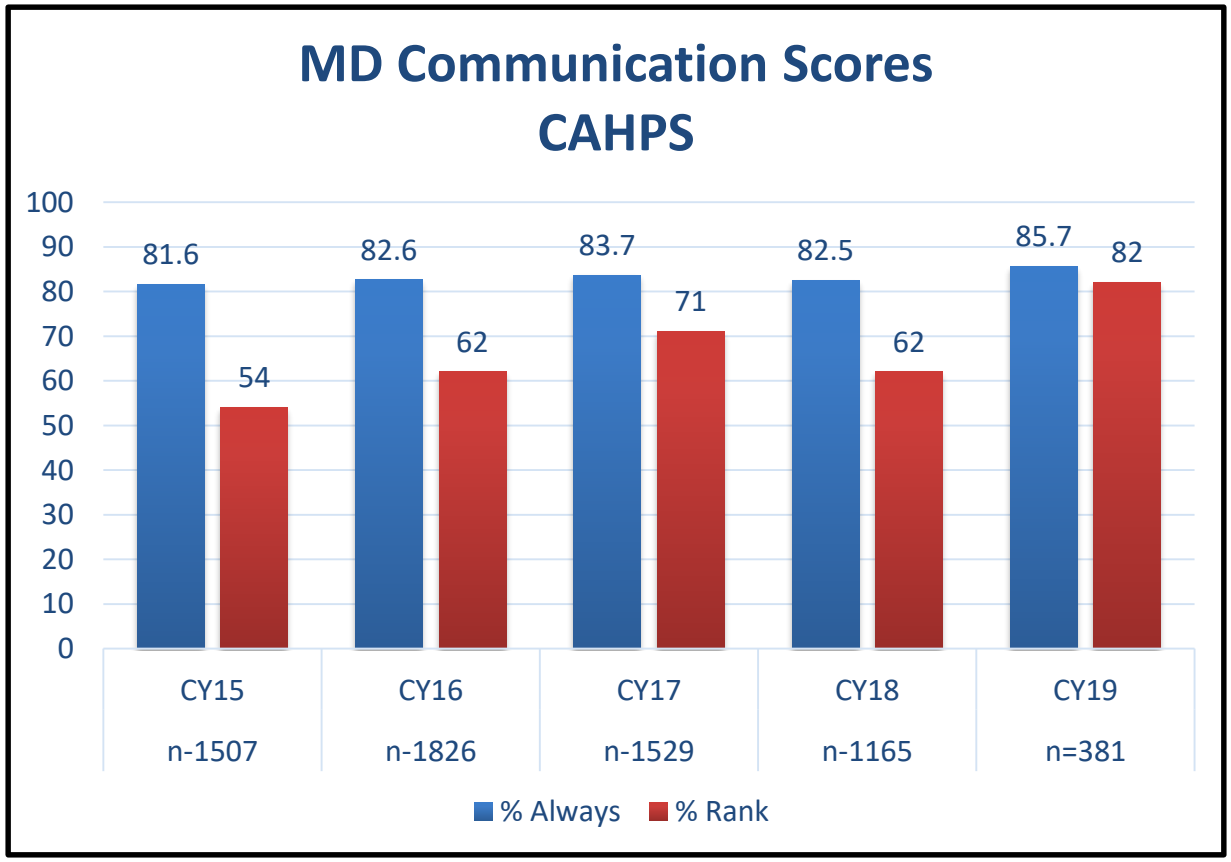
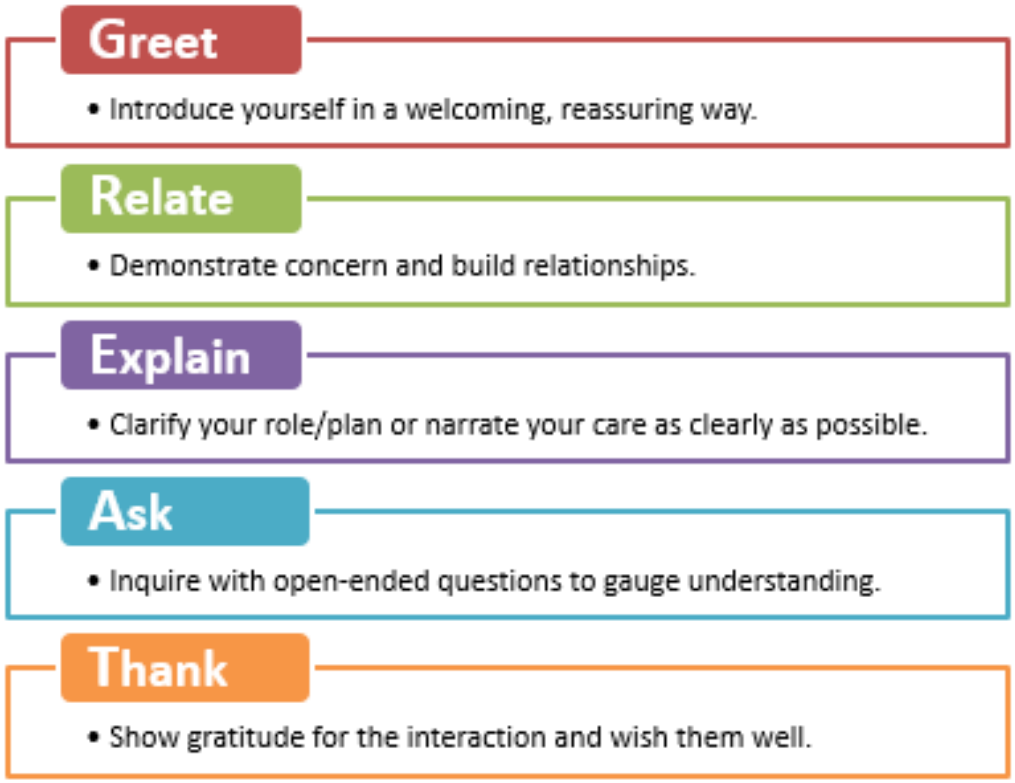
Most Current MD Scores



% Rank – Where you stand when compared with a database of more than 1200 hospitals in the nation

How to Improve Physician Communication



How does a physician make a positive impact on a patient?

By following the simple concepts outlined in the communication model below:

- GREAT communication components need to be used throughout the entire patient conversation.
- Non-verbal communication attributes that influence patient perception. These include:
  - Sit down if possible
  - Warm tone of voice and demeanor
  - Engaging body language
  - Consistent eye contact
  - Showing empathy and appropriate use of touch
  - Not coming across as rushed: demonstrating a relaxed bedside manor
  - Showing appropriate emotions such as enthusiasm, positive attitude, and warmth

What to do if your patient has a problem

- Acknowledgment is the most important step
- Inform the nurse on duty, the nurse informs the director of the unit, and if needed, the patient relations department.

BAPTIST HEALTH®

We are *ALL* part of the Patient Experience!

BAPTIST HEALTH®

EDUCATION & DEVELOPMENT

BAPTIST HEALTH®

Continuing Medical Education for Physicians

- Baptist Health Paducah is an accredited provider of AMA PRA *Category 1 Credit(s)*™.
- Live courses are offered throughout the year.
- Noon Tumor Conferences are offered each Thursday from 12:00 – 1:00 p.m. (except on/around some holidays).
- When available, self study courses are offered via posters in the physician lounges or via email.
- CME activities are marketed via postings near physician entrances and email.

  If you wish to be added to our e-mail distribution lists, please send information to maria.hayden@bhsi.com.
- Record of CME attendance at BHP is maintained in a database and provided annually or upon request.

CPR Training Center

- The American Heart Association has designated BHP as the CPR Training Center for 12 Western Kentucky counties.
- The Center provides direction, equipment, and supplies to over 300 BLS, ACLS and PALS instructors.
- Classroom offerings for Initial ACLS & Experienced Provider courses along with PALS are free to medical staff.
- Textbooks must be purchased.
- Call ext. 2723 for additional information.

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Medical Library Resources

- BHP provides access to online Medical Library resources through the following:
  - DynaMed Plus
  - Medline Complete, PubMed, and PubMed Central
  - National Cancer Institute
  - EBSCO e-books

- For more information regarding access, contact the Education Department at
  - Phone: (270) 575-2723
  - E-mail: Sjones@bhsi.com (Sherry Jones)

BAPTIST HEALTH®

DynaMed Plus®

Get answers to your clinical questions fast:

http://search.ebscohost.com/login.aspx?authtype=uid&profile=dmp&user=ns002541main&password=main

- With DynaMed Plus, you will get:
  - Content updated 24/7/365
  - Concise, evidence-based recommendations with supporting references
  - Clinically organized topics designed to get to the answer quickly
  - Key points on the background, evaluation & management of a condition presented at the top of each topic
  - Synthesized recommendations classified using GRADE
  - Internal medicine topics developed and maintained jointly by DynaMed Plus and American College of Physicians (ACP) clinical leadership
  - Drug and lab reference content provided by Micromedex®
  - Ability to sign up for alerts when a topic or specialty area is updated with new evidence and guidelines
  - Off-site access and free mobile app available on Android and iOS platforms.

BAPTIST HEALTH®

DynaMed Plus®

Medline Complete database access with more than 2,500 full text medical journals:
http://search.ebscohost.com/login.aspx?authtype=uid&user=ns002541main&password=main&profile=ehost&defaultdb=mdc

- DynaMed Plus, Medline Complete and EBSCO eBooks are available on BEN under the Training tab in the Reference section.
- DynaMed Plus access anywhere with a username/password or use the free mobile app on iPhone, iPad, & Android devices.
- DynaMed Plus is also available in EPIC.

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INFECTION CONTROL

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C.diff Testing

***C. diff* testing should only be performed on those patients that are clinically suspected of having *C. diff* infection**

Before ordering a test for *C. diff* please consider the following:

- Does that patient have clinically significant diarrhea defined as 3 or more unformed stool in 24 or fewer consecutive hours **AND**
- Have all other reason for diarrhea been excluded such as **recent laxatives use, stool softeners, tube feedings,** etc.?
- Does the patient have symptoms of *C. diff* infection?
- Leukocytosis (WBC $\geq$ 12,000)
- Fever (Temp > 100.4 F)
- Sustained, clinically significant diarrhea without other recognized cause
- abdominal pain and cramping
- Ileus without any other identifiable cause
- **Test only loose or liquid stool**. Specimen **must** conform to the shape of the vessel into which it is placed to be eligible for testing.
- Testing is restricted to one stool every 7 days (if previous test has been negative).
- **Do not order a test for cure**. Cured patients can carry and/or shed toxigenic *C. diff* for multiple weeks after diarrhea resolves.

BAPTIST HEALTH®

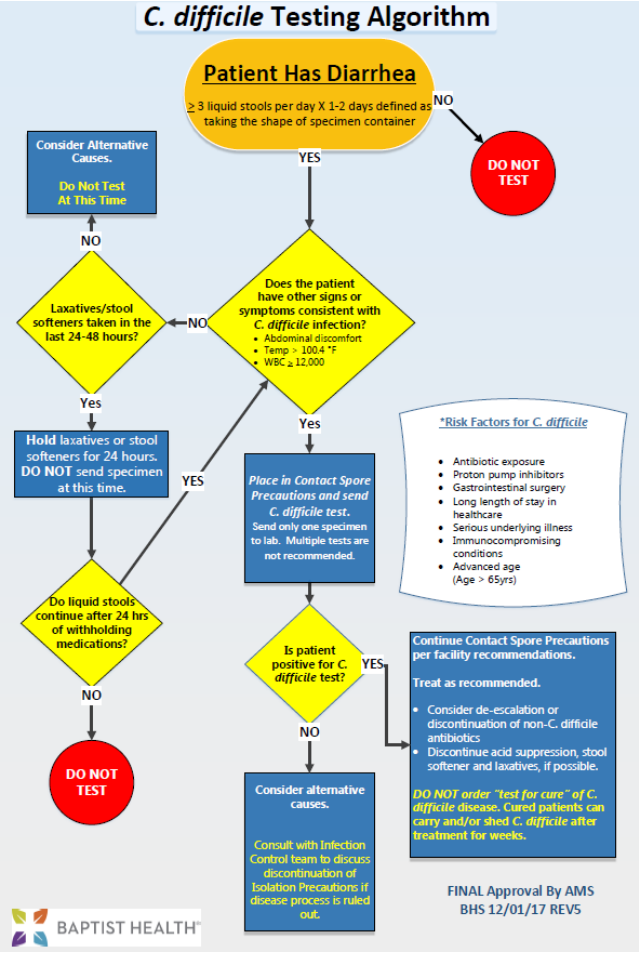
C.diff Testing

Use of Contact Spore Precautions, including wearing **gloves and gown** when treating patients with *C. diff*, is an important strategy in our control measures along with appropriate environmental cleaning and disinfection. Finally, our Antimicrobial Stewardship Committee is continuing to work to ensure that we are using antibiotics appropriately and sparingly. We would appreciate your input with suggestions about additional efforts and strategies to reduce *C. diff*. Please feel free to contact your local infection control department if you have any questions.

- Infection Control PI / QI Coordinator: Mary Lee Evers, RN
- Infection Control Specialist: Wanda Carnes, RN, MSN

C.diff Testing

Please review the following *C. difficile* Testing Algorithm (*located in your packet*) that should be used as a reference for diagnostic testing:



BAPTIST HEALTH®

LAB / PATHOLOGY

BAPTIST HEALTH®

Clinical Laboratory & Anatomic Pathology

- Laboratory is accredited by the following:
  - Joint Commission on Accreditation of Health Care Organization (JCAHO)
  - College of American Pathologists (CAP)
  - Laboratory Medical Director: Robert Haugh, M.D.
    - Pathologists include:
      - Carolyn Watson, M.D.
      - Dustin Woods, M.D.
      - Chris Green, M.D.
      - Crystal Rose, M.D.

BAPTIST HEALTH®

Clinical Laboratory & Anatomic Pathology

- Laboratory Director: Lorne Childress (270) 415-7699
- The Laboratory is divided into departments that are under the technical direction of a Pathologist. Additionally, each department has its own supervisor.
- List of departments and supervisors:

DEPARTMENT	TELEPHONE	SUPERVISOR
Blood Bank / Serology/ Immunology	(270) 575-2719	Alice Holder
Chemistry	(270) 575-2702	Trish Ward
Coag/Hematology/Urinalysis	(270) 575-2714	Jenny Wilson
Cytology Department	(270) 575-2711	Keith Smith
Outpatient Laboratory	(270) 575-2957	Chris Willett
LIS Manager	(270) 575-2804	Sherry Byrd
Pathology	(270) 575-2709	Keith Smith
Microbiology	(270) 575-2714	Nancy Shelton
Afternoon / Midnight Shifts	(270) 575-2700	Marlene Thorpe
Phlebotomy & Specimen Processing	(270) 575-2700	Chris Willett
Point of Care / QI	(270) 575-2703	Angie Parmer

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NEURODIAGNOSTICS / SLEEP LAB

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Neurodiagnostics

- Hours of operation: 8:00-4:30pm Mon-Fri
- Department Phone: (270) 575-2752
- EEG Technologists = 3
- Manager: Brian Carr, R.EEG.T, RPSGT, RST
- Director: Pam Lindeman, MA, RRT, NDHP-BC
- Medical Director: John Grubbs, M.D., D.AASM
- Neuro-Hospitalists:
    - Joseph Ashburn, M.D.
    - Clare Braun-Hashemi, M.D.
- Technician On-Call 24/7 – Neurologists must initiate on-call request.
- Procedures available:
    - EEG: Routine, Extended, Bedside Long Term Monitoring and Ambulatory
    - EP: Brainstem Auditory Evoked Response (BAER), Visual Evoked Potential (VEP) and Somatosensory Evoke Potentials (SSSEP)
    - Nerve Conduction Velocity Studies and Electromyograms (NCV/EMG)

MARKETING

BAPTIST HEALTH®

Corbin | La Grange | Lexington | Louisville

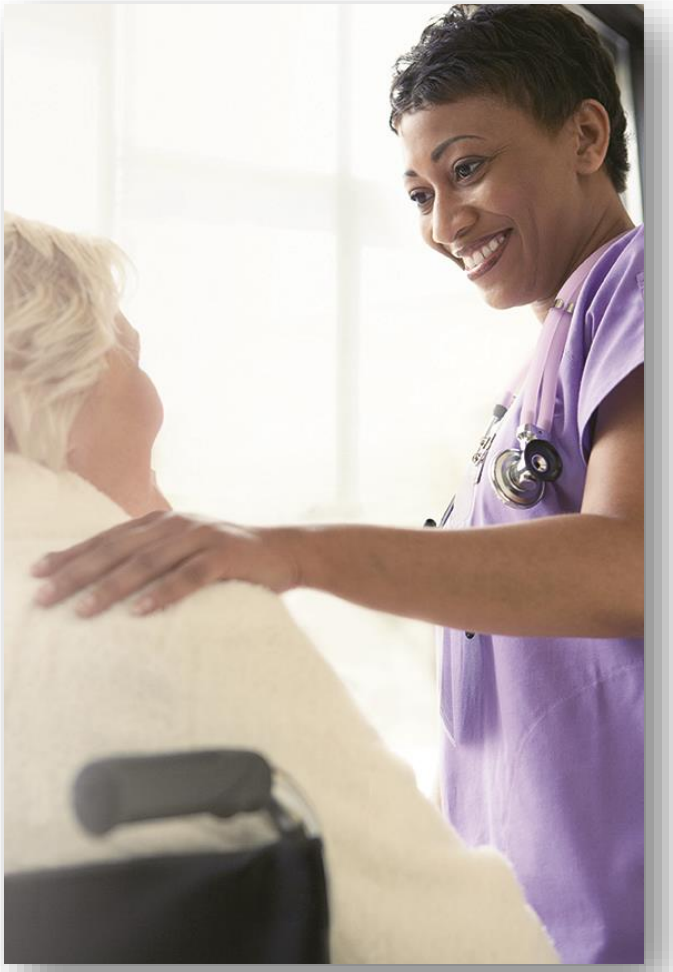
Madisonville | Paducah | Richmond

Managed hospitals in Elizabethtown and Russell Springs

BAPTIST HEALTH®

Mission: The mission of Baptist Health is to exemplify our Christian heritage of providing quality healthcare services by enhancing the health of the people and communities we serve.

Vision: The vision of Baptist Health is to be nationally recognized as the healthcare leader in Kentucky.



Baptist Health is one of the largest not-for-profit healthcare systems in Kentucky, with more than 2,100 total beds and more than 15,000 employees.

BAPTIST HEALTH®

Baptist Health Paducah

- Regional medical and referral center, serving about 200,000 patients a year from 3 states
- More than 1,700 employees and 260 physicians
- Full range of services: cardiac and cancer care, diagnostic imaging, women's and children's services, surgery, emergency treatment, rehabilitation and more
- Grown from 117 beds in 1953 to 349 beds on a campus covering eight square blocks

BAPTIST HEALTH®

Our Location

The main campus covers eight square blocks in the heart of Paducah, from 24th to 28th streets and Broadway to Kentucky Avenue. The hospital and adjacent structures, including three medical office buildings, a freestanding digital imaging center, an urgent care, a day care center and the area's only parking garage, occupy about 1 million square feet of space valued at more than $400 million. The hospital also operates a rehabilitation center off-campus.

Our Promise:

We treat you the way we would want to be treated, every time, at every Baptist Health location.

BAPTIST HEALTH®

In Kentucky, Baptist Health:

- Delivers **one of every four** babies
- Performs **one of every four** total joint replacement procedures
- Handles **one of five** surgical oncology (cancer) patients
- More than **2 million** patient encounters

BAPTIST HEALTH®

In Kentucky, Baptist Health:

- Cares for **one in six**
  - Heart patients
    - **One in five** open heart surgery patients
  - Inpatients
  - Outpatients
  - Inpatient surgical patients
  - Outpatient surgical patients
  - Medical oncology (cancer) patients
- Treats **one in 10** Emergency Department patients

BAPTIST HEALTH®

Marketing Services

PAID MEDIA

- HealthTalk, 90-second videos featuring physicians and patients
- Advertising

FREE MEDIA

- News media
- Social media
- Internal communications for staff and physicians
- Special events (lunch-and-learn, seminars, screenings, health fairs)
- Special projects (i.e. grand opening, anniversary, community events)

COMMUNITY OUTREACH

- Carson Center and Paducah symphony shows
- Many Baptist-sponsored events, such as 5Ks, fundraising dinners, etc.

MARKETING STAFF

E-mail or phone us with your request:

Laura Grumley, 415-7725,
laura.grumley@bhsi.com

Madelyn Chambers, 575.2797,
Madelyn.Chambers@bhsi.com

BAPTIST HEALTH®

BHMG PHYSICIAN RECRUITMENT & ALIGNMENT

BAPTIST HEALTH®

GOAL

Goal is to recruit physicians, both employed and independent, along with advanced care providers to Baptist Health Paducah to take care of patients in Paducah and the region we serve. Once physicians are recruited to Baptist, we work to integrate the physicians into the Baptist family and the community, while serving as a resource to all physicians simply helping to make it easier to practice at Baptist Health.

BAPTIST HEALTH®

RECRUITING

- Provide physician recruitment -including searching for candidates, coordinating telephone interviews and site visits of viable candidates, arranging luncheons and dinner for the physician candidates and post site visit evaluation surveys.
- Maintain recruiting pipeline for retaining top talent from the area.
- Provide recruitment assistance statewide.
- Provide weekly recruitment update to hospital and medical group administration.
- Assist in contract development during the recruitment process.
- Manage each physician's onboarding.
- Maintain the evaluations, references, W-9 and history questionnaire for each physician.
- Serve as a resource and assist in resolving physician concerns to employed and independent physicians to help make it easier to practice at Baptist Health
- Develop new programs to educate and promote Baptist Health to future physicians – example: Baptist Health Pre-Med Academy, AHEC dinners and residency dinners.
- Create or coordinate opportunities for physicians and families to learn more about our region while making them feel at home by participating in hospital and community events. For example, Symphony, BBQ on the River, Heats and Heels, Golf tournament, Coffee with Chris.

Recruitment Manager

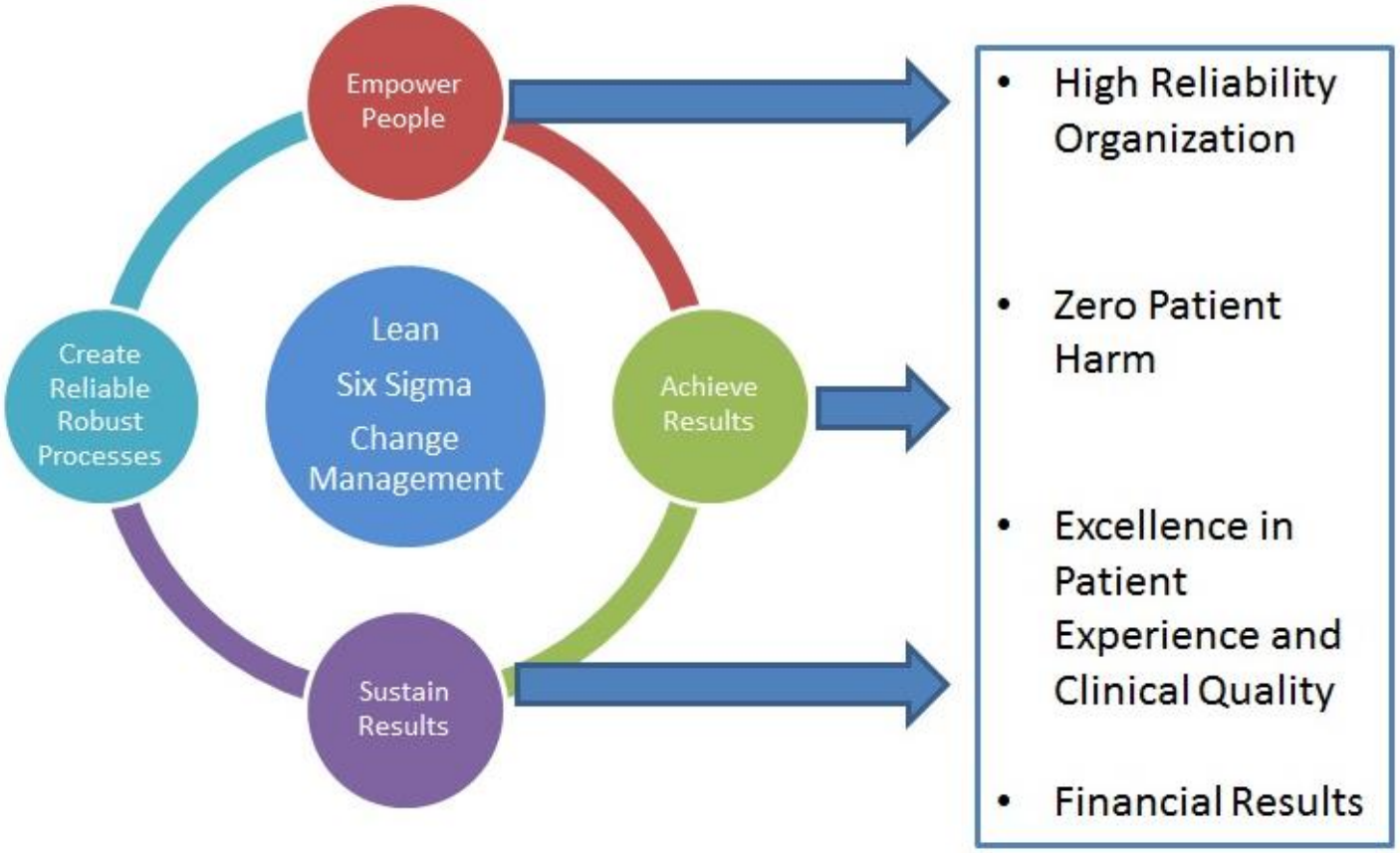
Connie Overstreet: Office - 270.415.7795, Cell - 270.559.7074

BAPTIST HEALTH®

QUALITY

BAPTIST HEALTH®

Process Excellence
aka Performance Improvement



Our vision is to advance high reliability within healthcare, enabling the transformation to healthier communities.

Our mission is to lead the BHS cultural and performance transformation to a high reliability organization through training, coaching, innovation, and project delivery.

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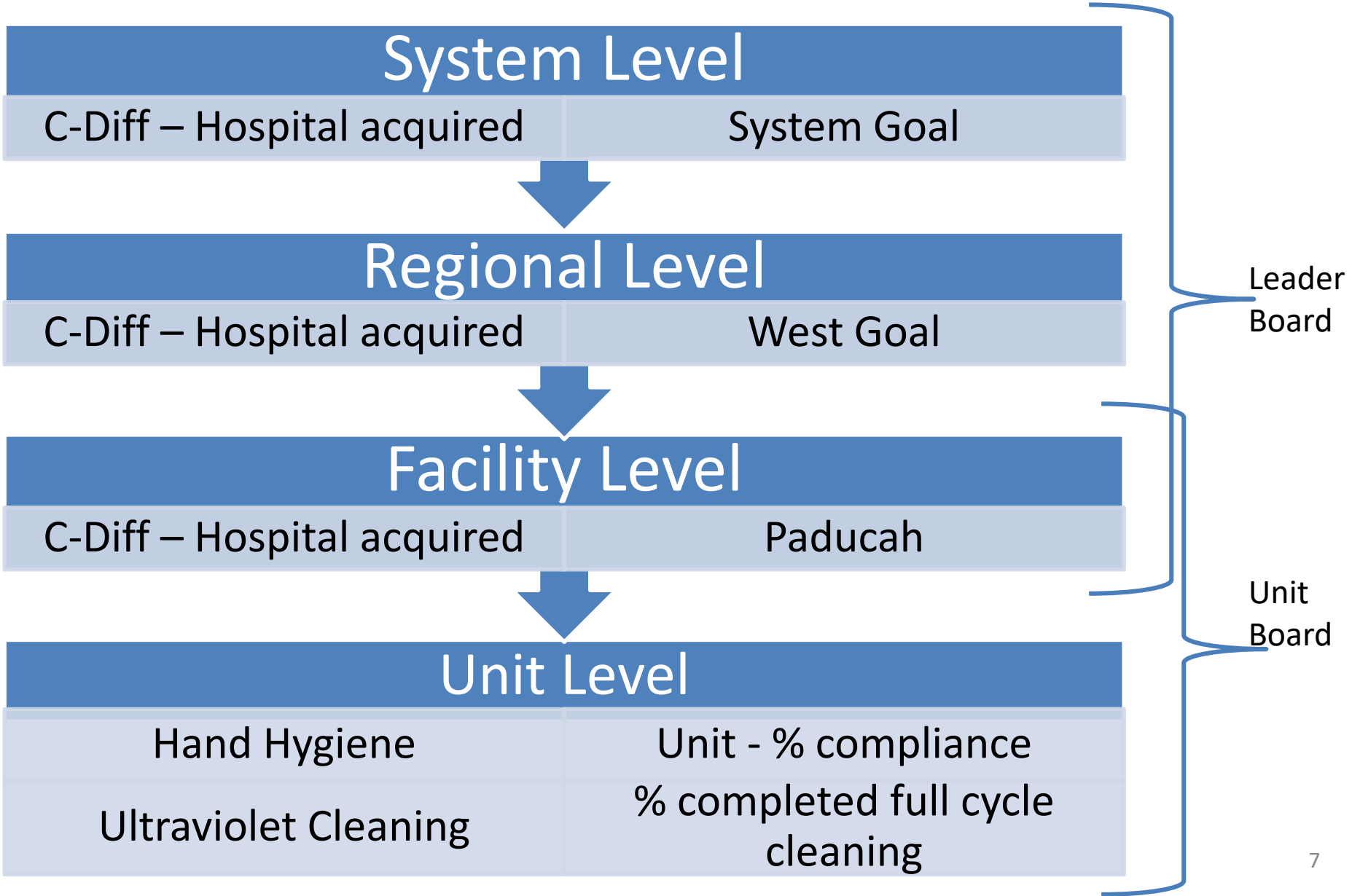
Baptist Health Goal Development

BAPTIST HEALTH®

Developing Metrics Example



BAPTIST HEALTH®

Quality

- Commitment we make to our patients, families, and each other
- Expectation from our patients
- True to our values
- Regulated by reimbursement agencies, CMS, accrediting bodies

Value Based Care

Report Card:

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- More Staff
- New Equipment

- Performance Improvement Data
- Identify Gaps

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Quality

https://www.youtube.com/watch?v=yUaTVF3ApWk

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MISSION: Baptist Health demonstrates the love of Christ by providing and coordinating care and improving health in our communities.

VISION: Baptist Health will lead the transformation to healthier communities.

FAITH-BASED VALUES: Integrity, Respect, Compassion, Excellence, Collaboration and Joy.

COMMITMENT TO PATIENT SAFETY:
Continuously improving patient outcomes by creating a highly reliable organization focused on a culture of safety, process excellence and zero patient harm.

High-Reliability Organizations

Journey to Zero….

Relentless Commitment, Undying perseverance to improvement
patient safety starts with transparency. We have to help each other “in the moment” to become a high reliable organization.

Five principles of HRO:

1. Sensitivity to operations
2. High reliability organizations are reluctant to accept "simple" explanations for problems.
3. Preoccupation with failure. Never satisfied with that they have not had an accident for months or years.
4. Deference to expertise
5. Commitment to resilience

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Regulatory Services

- Joint Commission
- Joint Commission Disease Specific Certification - Stroke
- Chest Pain
- Commission on Cancer
- CAP
- OIG
- American College Radiology
- ACE
- COEMIG
- COERS
- MSBAQIP

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The Joint Commission

2023 Hospital National Patient Safety Goals

(Easy-To-Read)

Identify patients correctly	
NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
Improve staff communication	
NPSG.02.03.01	Get important test results to the right staff person on time.
Use medicines safely	
NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
Use alarms safely	
NPSG.06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.
Prevent infection	
NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning.
Identify patient safety risks	
NPSG.15.01.01	Reduce the risk for suicide.
Improve health care equity	
NPSG.16.01.01	Improving health care equity is a quality and patient safety priority. For example, health care disparities in the patient population are identified and a written plan describes ways to improve health care equity.
Prevent mistakes in surgery	
UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

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A Just Culture is about …

- Recognizing that good people sometimes make mistakes …
- Designing safe systems and managing behavioral choices because no system nor any human is perfect …
- A collective commitment by individuals, leaders and the organization as a whole to create a culture of safety and honoring the shared responsibilities to support a Just Culture…

"People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right?

Wrong. ***The problem is seldom the fault of an individual; it is the fault of the system****. Change the people without changing the system and the problems will continue."*

~ Don Norman, Author, the Design of Everyday Things

BAPTIST HEALTH®

“People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right?

Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

Don Norman

The Design of Everyday Things

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Why is Just Culture Important?

FATAL MISTAKE AT THE MASSACHUSETTS GENERAL HOSPITAL.—The *Boston Traveller* contains a long document from Dr. J. C. WARREN, in relation to a death by chloroform, accidentally administered at the Massachusetts General Hospital. It appears that chloric or sulphuric ether is used in the hospital, in preference to chloroform. Three operations were performed on Saturday, Oct. 30. The first was for a contracted hand, and the patient was etherised with what was supposed to be chloric ether. The operation was performed, and the patient escaped without any other inconvenience than a slight soreness of the throat. The second case was for a tumor on the right side of the face. During the operation the patient came very near dying, but was saved. The third case, which proved fatal, was that of a young man, about twenty years old, a native of Ireland, who had his arm entangled in the machinery of a bark mill about five days before. He refused to have it amputated until mortification had taken place. On Saturday the operation was performed. Etherisation was carefully made, and the operation was accomplished in about two minutes. Just as it was finished it was perceived that his pulse was rapidly failing. Every effort was made to save him, but the patient breathed his last without an effort or convulsion. Dr. WARREN adds:

"On the following morning an examination of the body was proposed, but his friends arriving, objected, and although we urged the importance of ascertaining the immediate cause of his death, they continued to object decidedly.

"Immediately after the occurrence of alarming symptoms in this case, it was discovered that the substance which had been used was not chloric ether, but chloroform: and not till then did we understand the extraordinary phenomena which presented themselves in this and the preceding cases. This patient died with the usual phenomena of chloroform poison.

The New York Times

Published: November 23, 1852

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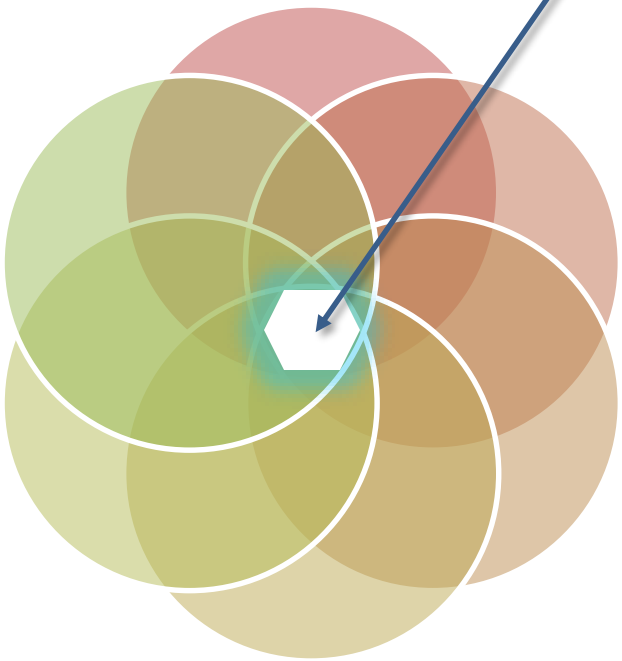
Leadership Commitment & Communication

Baptist Health Just Culture

Just Culture Culpability Decision Algorithm



Employee Competency (education & training) & Fitness for Duty

Patient Safety Event Reporting & Algorithm

Employee Coaching, Mentoring & Individual Ownership of Safety

Progressive Disciplinary Policy

Just Culture is the alignment of a number of key components …

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RISK MANAGEMENT / PATIENT SAFETY

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Contact Information

- Paducah Risk Management Offices:
  - Medical Park 2, Suite 301
  - Meet the Staff:
    - Patient Safety for Health Director
      - Tracy Phillips, RN (270) 575-2980
    - Patient Safety Officer
      - Karrie Williams (270) 415-7739
    - Associate Vice President, Risk Management
      - Tawana Shaffer, MBA, BSc, CRT, CPHRM
      (502) 805-4309

After hours/weekends, contact hospital operator and ask for Risk Management

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What to Report to Risk Management

- Incident: Any happening not consistent with the routine operation of the institution that may have caused or may have the potential for causing injury to patients, visitors or loss/damage to property
- Serious Safety Event: An event in which patient harm occurs due to a deviation in generally accepted practice standards which resulted in severe permanent or temporary harm or death.
- Sentinel Event: An incident not primarily related to the natural course of a patient's illness or underlying condition that reaches a patient and results in death, permanent harm, severe temporary harm or intervention required to sustain life.

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Reporting Examples

Incidents/Serious Safety Events include but are not limited to:

- Medication Errors
- Falls
- Adverse Drug Reactions
- Unprofessional Conduct
- Patient Misidentification
- Equipment Issues
- Procedure Deviations
- Hospital Acquired Conditions
- Blood Administration Events

Sentinel Events include but are not limited to:

- Suicide in hospital
- Unanticipated death of full term infant
- Rape on premises
- Invasive procedure on wrong patient, at wrong site or wrong procedure
- Unintended retention of foreign object
- Fire/heat during a procedure
- Intrapartum maternal death

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How to Report to Risk Management

- SAFE reports are available on EPIC for everyone to report incidents. Just pull up the patient involved and click on SAFE report tab in upper left corner of the screen and choose the icon of the event you are reporting. The * items are mandatory fields. When you click submit, a copy goes to the Director of the Department and also to Risk Management.

- You may also call any of the Risk Management staff listed on the #2 slide at any time to report a concern regarding a patient, visitor, practice, process or event.

Your concerns are very important to us – that is how we know about incidents and what needs improvement!

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Disclosure of Unexpected Events

- Baptist Health System supports disclosure of unexpected events to patients/families. Risk Management is happy to assist with any disclosure, however when it is a significant or sentinel event Risk Management and BHS attorneys (as needed) will meet with the physician prior to the disclosure to assist the physician. After a thorough investigation of all facts of the event has been completed Risk Management will schedule a meeting regarding the event. During this meeting a plan for disclosure will be formulated. This plan will include who will attend the disclosure (sometime the physician will want a witness – sometimes not, depending on the situation). Talking through the event and deciding the best way to relay the event to the patient will assist the physician with this often difficult task.

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What to Do if You Are Contacted by an Attorney or Receive a Letter

- If you receive a call from an attorney regarding a patient (yours or someone else's patient) asking for any information or your opinion on a matter, politely tell them they will need to contact the Risk Management Department to schedule a time to speak with you. They may tell you they just want to ask a simple question or have an informal conversation with you about the patient. Still refer them to Risk and we will talk with them to ascertain what information they are seeking and assist you if it is necessary for you to speak with them.
- Should you receive a letter from an attorney, a subpoena, a lawsuit or any correspondence from the judicial system related to your practice of medicine give us a call before you reply in any way. We will assist you with any correspondence or information they may require.

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Lawsuits

- How will I know I am involved? There are two ways:
  1. Receiving a subpoena
  2. Receiving a Complaint and Summons (a lawsuit)
- What if I receive either of these forms?
  - **DO** notify Risk Management – (an attorney will be appointed as needed)
  - **DO NOT** prepare an answer to the lawsuit – your attorney will
  - **DO NOT** discuss anything about the case with anyone else
  - **DO NOT** change anything in the medical record
  - **DO NOT** call the patient to discuss the lawsuit
  - **DO NOT** discuss the case with colleagues
  - **DO NOT** email ANYONE about the suit
  - **DO NOT** make any NOTES -- personal or otherwise
  - **DO NOT** prepare any written statements

Safety Tips

- Telephone orders: Nurses are required to enter the order in EPIC while on the phone with you in order to accurately respond to best practice advisories or warnings.
- Verbal orders: Only in emergency situations
- Critical test results: Should be reported to you within one hour of result availability.
- Test Results: When you order a test, you are responsible for informing the patient of the test results including incidental findings and document your conversation. (The patient may be instructed by you, if appropriate to follow up with another physician to further evaluate after you have informed them.)

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Surgeries / Procedures

- Informed consent: Documentation of the discussion between person performing the procedure using language they can understand regarding risks, benefits and alternatives is required prior to the procedure (emergencies excluded)
- Time out will be conducted for all procedures:
  - -Time out occurs immediately prior to procedure with all participants present including surgeon/physician/PA/APRN
  - -All staff present acknowledge information is correct
  - -All staff are empowered to stop the procedure as needed
- The surgical team debriefs with the surgeon following procedure.

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Allow Natural Death (A.N.D.) / Do Not Resuscitate (D.N.R.)

- Documenting code status: There are two decision points providers must document:
  - CPR
  - No CPR
    - If no CPR then level of Medical Intervention is required:
      - Full scope or treatment;
      - Limited additional intervention; or
      - Comfort measures only.

- See policy *Levels of Support Orders, Withholding/Withdrawing Treatment [code status] 12016.02*

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Pediatric Patients – Unsafe Discharge

- A hold may be placed on pediatric patients who would be discharged into an unsafe situation. If a child who is in the hospital or under the care of a physician appears to be in imminent danger if returned to the person(s) having custody of the child, the physician or hospital administrator may hold the child without court order, provided that a request is made to the court for an emergency custody order at the earliest practicable time, not to exceed 72 hours.

Should this situation arise call the hospital Social Worker for assistance and notify the Administrator on Call of the issue.

Chain of Command

- Chain of Command – Escalation of Patient Care Concerns: Any healthcare provider who identifies a concern with the quality of patient care or patient safety and is unable to directly resolve it with the involved healthcare professionals will present the concern to successively higher levels of authority until a resolution is achieved. Levels may be skipped depending upon the patient condition or the nature of the issue.
- Medical Staff Chain of Command is as follows:

Any MD / Provider

↓

William Titsworth, M.D. (Surgery Chair) **OR** Kyle Parish, M.D. (Medicine Chief)

↓

Lauren Jackson, M.D. (Chief of the Medical Staff)

↓

Bradley Housman, M.D. (Chief Medical Officer)

BHMG Providers may contact Dr. Blair Tolar (BHMG Medical Director) regarding other clinics or other BHMG employed providers

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72 Hour Holds

- Adult Emergency 72 hour hold: The hold order allows a physician who is a bona fide member of the hospital's medical staff to hold a patient who, in the physician's judgment, is a mentally ill person* for 72 hours [not including weekends (12:01 am Saturday until 12:01 a.m. Monday) and holidays] until a behavioral health assessment is conducted and appropriate disposition is provided. Patients on 72 hr hold are considered a flight risk and may not leave the unit unless medically necessary and they are accompanied by staff. Patient's on 72 hr hold have a right to refuse medical treatment unless an emergency exists or the treatment is necessary to prevent injury to the patient or others.

**A person with substantially impaired capacity to use self-control, judgment, or discretion in the conduct of their personal affairs and social relations, associated with maladaptive behavior or recognized emotional symptoms where impaired capacity, maladaptive behavior, or emotional symptoms can be related to physiological, psychological, or social factors. If the patient is under the age of 16 years contact hospital Social Services for information and assistance.*

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Medication Information

Pharmacy assists with medication reconciliation on Admission

- Pharmacy technicians will be staffed Mon-Fri 9a–9p and Sat-Sun 8a–6p to assist providers with the following:
  - Compile home med list on admit
  - Update allergy information
  - Offer Meds-to-Beds service at discharge
  - Consult Pharmacist for identified compliance or education needs
  - Consult Care Manager for financial assistance with medications
  - Run a KASPER report and place in Media Tab for reference
- Med Rec Status: A pharmacist will verify the technicians list. Completion will be noted as "Pharmacy Complete."

- Scope of Service: ED, and inpatients excluding Mother/Baby, TCU and LTACH.
- Off hours: Med Rec will be verified and any clarifications addressed with provider the following shift. Providers can access KASPER reports by their own personal account or wait until a technician returns.
- Collaborative Agreement: Physicians may authorize pharmacists to continue and discontinue home medications through a collaborative care agreement. Contact Director of Pharmacy at extension #2104 if you have an interest in this type of agreement.

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In Kentucky – You **are** Required to Report:

- Suspected Child abuse/neglect to Child Protective Services; a local law enforcement agency or the Department of Kentucky State Police; the Commonwealth's attorney or the county attorney; by telephone or otherwise. KRS 620.030
- Suspicion that a child is a victim of human trafficking as defined in KRS 529.010 shall immediately be reported to a local law enforcement agency or the Department of Kentucky State Police; or the cabinet or its designated representative; or the Commonwealth's attorney or the county attorney regardless of the suspect's relationship to the child.
- Suspected Adult abuse to Adult Protective Services:
  - Any vulnerable adult: "18 years of age or older who, because of mental or physical dysfunctioning, is unable to manage his or her own resources, carry out the activity of daily living, or protect himself or herself from neglect, exploitation, or a hazardous or abusive situation without assistance from others, and who may be in need of protective services;
- Rape to local Rape Crises Center if the victim wishes to have a Rape Crises Center advocate present for the exam or otherwise available for consultation per 502 KAR 12:010 (2)(1)(b)

Reporting to Child/Adult Protective Services is a duty in each of the above suspected abuse/neglect/ trafficking circumstances– the Service is then required to report to law enforcement if they feel it is necessary. There can be personal penalties for failure to report.

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In Kentucky – You **are not** Required to Report:

- Reporting law for victims of domestic violence has changed to a mandatory information and referral. Providers are required to provide educational material to victims of domestic and dating violence. Reporting is only required if requested by the victim. Revised law as of June 2017.
- Physical impairment such as history of seizure or stroke to Dept of Transportation (this includes visual impairment)– it is however physician discretion to report without being subject to civil or criminal liability- contact Risk Management if you need assistance. An affidavit may be required.
- Doctor shopping--however, it may be reported at the discretion of the physician. KRS 218A.280 states "Information communicated to a practitioner in an effort unlawfully to procure a controlled substance, or unlawfully to procure the administration of any controlled substance, shall not be deemed a privileged communication."
- In fact, **you may not report** the following (with exceptions)
  - Sexual crimes except as required in cases of suspected abuse in the last slide. (UNLESS– except in cases of child abuse, which must be reported, the patient has the final say regarding reporting to law enforcement)
  - Gunshot wounds (unless it is to avert a serious threat to health or safety--imminent)

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Call Coroner When Death is:

- Homicide/violence
- Suicide
- Drowning
- Fire/explosion
- Accident
- Suspected child abuse
- Drugs or poisons in the body
- Sudden/unexplained reasons
- Sudden Infant Death
- MVA when operator of vehicle left scene
- MVA when body found in/near roadway or railroad
- Potentially caused by something other than natural
- Less than 24 hours after hospitalization*
- In the Emergency Department *
- While patient is in police custody /jail
- MVA with no obvious lethal trauma
- Human under age of 40 and no past medical history to explain death
- Death occurs at worksite and no apparent cause of death
- Death at worksite when industrial toxins may have contributed to death
- Involving a body that is to be cremated and no past history to explain death
- When decedent is not receiving treatment by a licensed physician and medical history does not indicate cause of death

*McCracken County Coroner Required

Contact Number: 270-444-4732

Responding to Surveys and Investigations

You are required to notify Baptist Health Paducah Administration and Risk Management if a regulatory surveyor, governmental investigator or accrediting organization surveyor requests to conduct an inspection, review or perform an investigation of you and/or any Baptist entity.

Please note:

All Baptist employees are entitled to have a member of Administration present with them during any interviews and Baptist employees are strongly encouraged to do so.

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Workplace Violence Training

- If you are a non-employed provider, please watch the following video on Workplace Violence. All employed providers have learning modules to complete in their BHMG onboarding orientation. You will not have to complete both.

Workplace Violence Training for Healthcare Workers - YouTube

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MEDICAL STAFF ORIENTATION

- Complete the Provider Self-Study Orientation Acknowledgement form by signing, dating and presenting the form to the Medical Staff Office prior to appointment date.

- Failure to return the signed form to the Medical Staff Office will result in a delay in the appointment process which may include being unable to complete your application.

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MEDICAL STAFF SERVICES

Thank you for your participation.

Please contact the Medical Staff Office if you have any questions or problems accessing any of the links provided in this orientation.

Manager
Cara Lovell
270.575.2551 Office
270.889.4012 Cell
Cara.lovell@bhsi.com