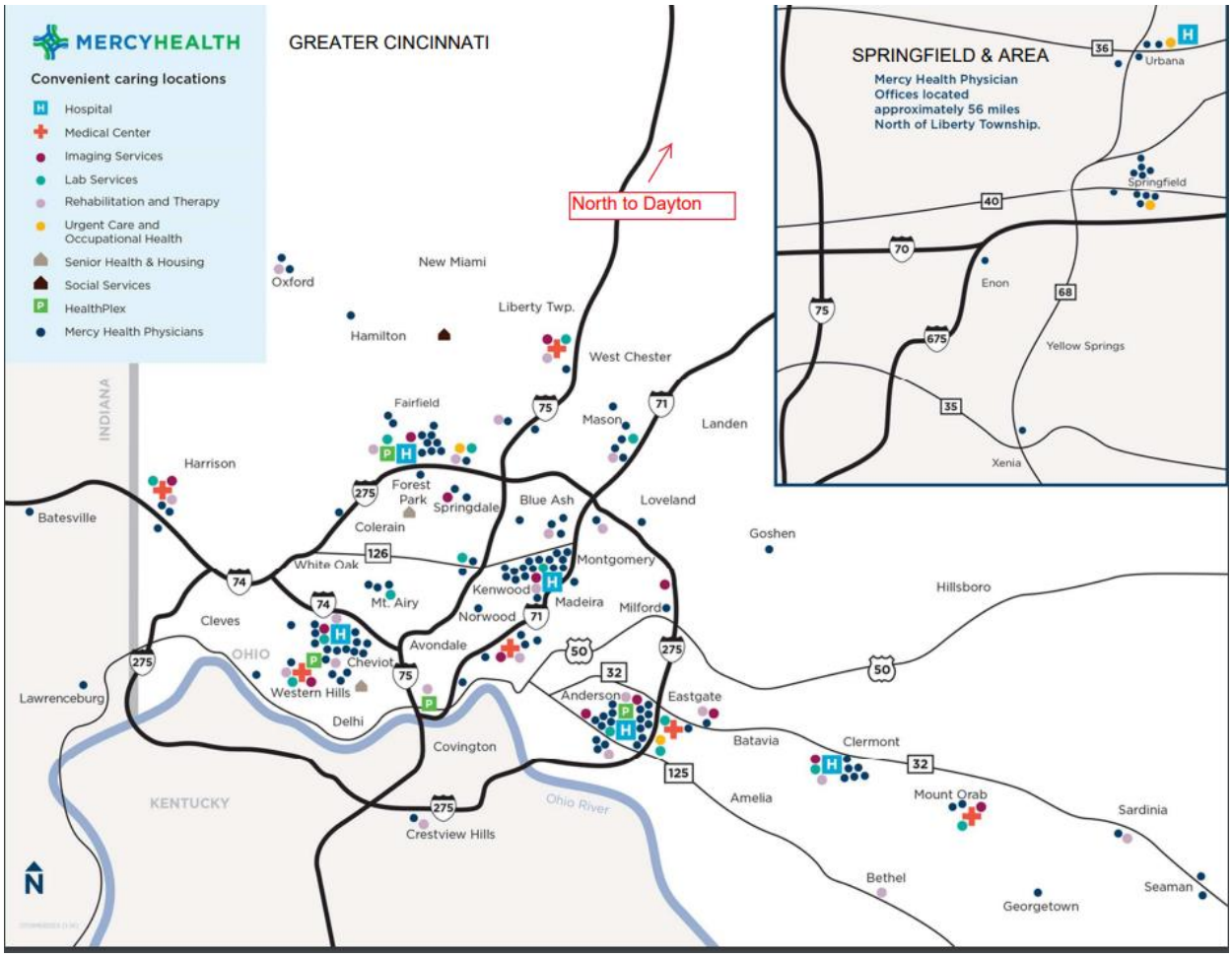
MERCYHEALTH
Anderson Hospital

Medical Staff Reference

Welcome to the Mercy Hospital Anderson Medical Staff

You are joining a medical staff of more than 800 with a hospital of 1200 employees. Opening in 1984, the current Mercy Anderson is licensed for **193 beds**; we admit an average of 35 patients per day or 1120 per month.

Mercy Anderson is an eleven-time *Thomson Reuters Top 100 Hospital*. Your colleagues and nursing staff welcome you. The hospital provides a fully electronic environment for physicians that includes the Epic electronic medical records, physician-order entry, digital radiology and remote access. You will need some basic training and orientation before receiving your Epic log-in. If you cannot find a specific number, call the main hospital number at 513-624-4500.



Bon Secours Mercy Health (formerly Mercy Health, merged in 2018)

We are a Catholic healthcare ministry serving Florida, Kentucky, Maryland, New York, Ohio, South Carolina, Virginia, and Ireland. Bon Secours Mercy Health is the largest health system in Ohio and fourth largest employer in Ohio with $5.1 billion in assets. Bon Secours Mercy Health employs nearly 34,000 associates in more than 100 organizations, including 24 hospitals in Ohio and Kentucky and is one of the largest healthcare systems in the country.

Physician Parking Available -- Requires Decal
Convenient covered “physician-only” parking is available in the MOB II garage on level 1 and 2 behind administration and the medical staff office. Get your vehicle decal from the Medical Staff Office. You will need this to avoid ticketing from Security.

Medical Staff Members Photo Identification Badge
Obtain a photo identification badge from the Medical Staff Office during business hours. This must be worn at all times in the hospital. An extra tab identifies you as a physician. The badge contains a magnetic strip that allows entrance to the physician lounge across from the Medical Staff Office, the library, and the external door after hours.

Medical Staff Support and Structure

Medical Staff Office (513-624-4058) 8:00 a.m.– 4:30 p.m. weekdays
You must report in person with a government issued photo ID (driver license) to the Medical Staff Office for a hospital photo identification badge before your credentials’ application can be approved. Medical students and residents must report on their first day at the hospital and fill out a brief information form.

An updated event and meeting calendar is located on the door. **Kitty Jones** is your coordinator for medical staff services. **Nissa Walker** is the manager; her direct number is **513-624-4391**. Direct any questions you may have for committee chairs or medical staff governance to the office at **513-624-4058** and we will see that the message is immediately transferred.

Categories of Medical Staff Membership:

Associate Members who have clinical privileges may regularly admit patients without limitation within the scope of granted clinical privileges. Associate Members may attend Medical Staff meetings but may not vote, hold office or be a Department/Committee Chair. An Associate Staff member is not required to hold clinical privileges.

Active Members must complete a minimum of two years as an Associate member of the Medical Staff. Members of this category shall regularly provide evaluation and management services to inpatients or outpatients at the Hospital or actively participate in Medical Staff Affairs. In order to advance to or remain a Member of this category, Members must be clinically active or must actively participate in Medical Staff affairs at the site at which member seeks Active membership. Members of the Active category who do not meet this clinical/participation requirement will be moved to the Associate Staff at reappointment.

Active Members may admit patients without limitation within the scope of granted Clinical Privileges; attend and vote at all Department, Section, committee, and general Medical Staff meetings; hold office; and chair committees. Active members are required to take emergency call, unless excused for good cause by the Department Chair

Affiliate Medical Staff consist of Practitioners affiliated with the Hospital who do not hold Clinical Privileges. Affiliate Members may visit their patients who are in the Hospital and review their patients’ Hospital medical records but may not make entries; order outpatient diagnostic tests but NOT therapeutic procedures and attend Medical Staff meetings as non-voting members. Affiliate Members may have “view only” Epic access to medical records. Each appointee to the Affiliate Medical Staff may: order outpatient diagnostic tests but NOT order therapeutic procedures and may NOT attend Medical Staff meetings or functions.

Emeritus Medical Staff are nominated by the MEC and approved by the Board for distinguished service. They must have been active in the Hospital community. The Emeritus staff shall consist of Physicians and Surgeons, and psychologists recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long-standing service to the Hospital or the community.

Medical Staff Membership and Clinical Privileges

Medical Staff Membership by itself confers no Clinical Privileges. Each Practitioner must request Clinical Privileges and may only practice within the scope of the Privileges

Expectations of Medical Staff Membership

1. Compliance with Medical Staff bylaws, rules, and regulations
    - Maintain current evidence of licensure, DEA, and liability coverage.
    - Complete medical records documentation.
    - Participate in the Emergency Department call schedule.
    - Payment of medical staff dues.
2. Participate in medical staff committees
3. Adherence to National Patient Safety Goals, including Core Measures.
4. Compliance with approved patient care protocols.
5. Participate in Medical Staff Committees if requested
6. Adherence to national patient safety Goals
7. Participation in and compliance with clinical practice guidelines.

Credentialed Medical Staff Required to Follow Ethical and Religious Directives (ERD)

Catholic health care is premised on the human dignity of all persons and the sacredness of human life. Our Bylaws require that all medical staff abide by the Ethical and Religious Directives (ERDs) for Catholic Health Care Services. Compliance with these ERDs is a condition for medical staff privileges.

When you accept hospital privileges, you are agreeing to practice in a manner consistent with the ERD when rounding and performing procedures at any Mercy facility. “Consistent” neither implies not suggests that the physician personally espouses the Directives or adheres to the Catholic faith. “Consistent” does imply that the physician will participate in the healing mission of the hospital and will not provide a limited set of prohibited services – direct abortion, direct sterilization, active euthanasia or some means of contraception.

A full copy of the ERDs is available https://www.usccb.org/resources/ethical-and-religious-directives-catholic-healthcare-services.

Hospital Operations

Joint Commission Standard - Antimicrobial Stewardship

A Joint Commission standard effective Jan 1, 2017 requires hospitals to have antimicrobial stewardship as an organizational priority including a multi-disciplinary team. Epic CarePATH pharmacy intervention triggers have been in place since fall 2015 for the Cincinnati Bon Secours Mercy Health hospitals. In 2021, Anderson based pharmacists documented 3419 interventions – common triggers include duration of therapy, de-escalation of therapy, regimen review and IV to PO.

Mercy Hospital Anderson Antibiogram 2021

Mercy Hospital - Anderson

Antibiogram - January 1, 2021 - December 31, 2021

(% Susceptible)	#	%	Penicillin	Ampicillin	Tetracycline	Oxacillin	Vancomycin	Clindamycin	Amoxicillian-Clavulanic Acid	Ampicillin-Sulbactam	Aztreonam	Ertapenem	Meropenem	Trimethoprim-Sulfamethoxazole	Piperacillin-Tazobactam	Cefazolin 1st Gen (CFZ)	Cefuroxime (CRM) 2nd Gen	Cefoxitin (CFX) 2nd Gen	Cefotaxime (CFT) 3rd Gen	Ceftriaxone (CAX) 3rd Gen	Cefepime (CPE)	Amikacin	Gentamicin	Tobramycin	Ciprofloxacin	Levofloxacin	Nitrofurantoin	Erythromycin	Linezolid
ALL GRAM-POSITIVE BACTERIA		-																											
Staphylococcus aureus (all)	358				85	48	100	73						92		47							98		62		96	41	100
-Methicillin-susceptible (MSSA)	171	48%			93	100	100	85						97		100							100		92		100	71	100
-Methicillin-Resistant (MRSA)	187	52%			79	0	100	61						87		0							96		36		92	13	100
Staphylococcus epidermidis	71				81	38	100	57						65		45							95		75		100	39	100
Staphylococcus lugdunensis- SWOH DATA USED					95	85	100	77						99		89							99		97		100	76	100
Staphylococcus coagulase negative-SWOH DATA USED					81	82	100	64						88		74							89		75		98	38	100
Enterococcus faecalis (not VRE)	171			100			100																				99		100
Enterococcus faecalis (VRE) SWOH DATA USED				88			0																				100		100
Enterococcus faecium (not VRE) SWOH DATA USED				59			100																				34		100
Enterococcus faecium (VRE) SWOH DATA USED				2			0																				52		98
Streptococus pneumoniae SWOH DATA USED			64				100		93				83							92						100			
ALL GRAM-NEGATIVE BACTERIA		-																											
Escherichia coli (not ESBL)	830	94%							85	69	100	100	100	83	98	91	91	92	100	98	100	100	94	92	85	83	97		
Klebsiella pneumoniae (not ESBL)	200	92%							97	86	100	100	100	95	98	94	91	95	100	100	100	100	99	97	98	98	38		
Klebsiella aerogenes	27								0	70	100	100	100	96	89	0	0	0	90	89	96	100	100	100	100	100	37		
Klebsiella oxytoca (not ESBL)	47								94	81	100	100	100	98	96	53	88	100	100	98	100	100	100	98	100	100	86		
Enterobacter cloacae	63								0	20	60	95	100	86	90	0	20	0	70	83	89	100	95	95	93	97	31		
Citrobacter freundii	18								0	0	100	100	100	83	94	0	0	0	75	78	100	100	94	92	100	100	92		
Proteus mirabilis (not ESBL)	120								99	94	99	100	100	87	100	77	97	97	100	98	99	100	92	97	82		0		
Morganella morganii	17								0	0	78	100	100	88	94	0	0	78	89	93	87	100	88	0	94	100	100		
Serratia marcescens	43								0	0	71	100	100	98	80	0	0	14	71	84	93	100	100	97	98	100	0		
Stenotrophomonas maltophilia	18													100												93			
Pseudomonas aeruginosa	154										82		98		94						92	95	80	99	89				
Acinetobacter baumannii -SWOH DATA USED										49			58	57						33		66	70	76	45				
Escherichia coli - ESBL	55	6%							50	33	0	100	100	44							4	83	75	67	22	21	90		
Klebsiella pneumoniae - ESBL	18	8%							25	0	0	94	88	17							0	100	61	29	17	40	0		
Klebsiella oxytoca-ESBL-SWOH DATA USED									21	12	0	100	100	50							21	100	71	71	83	85	100		
Proteus mirabilis-ESBL-SWOH DATA USED									91	76	0	100	98	53							11	97	87	77	2		0		
Acid Fast Bacilli			*Statistical validity of estimates of percent susceptibility for organisms with fewer than 30 isolates reported is limited.																										
Mycobacterium turberculosis	1	3%	Take this into consideration when interpreting the reported results.																										
Other Acid Fast Organisms	29	97%	*Beta-hemolytic streptococci are considedred susceptible to penicillin since resistant stains have not been identified.																										

One estimate shows almost half of antimicrobials prescribed in US hospitals are either unnecessary or inappropriate. Antimicrobial resistance is a serious public health concern. The rise in resistant microorganisms and the slow development of new antimicrobial drugs has prompted the Joint Commission to require antibiotic stewardship programs. Hospital based “Antibiotic Stewardship Programs” can optimize the treatment of infections and reduce adverse events associated with antibiotic use. Antibiotic use is measured as “days of therapy” (DOT) per 1000 patient days or “defined daily dose” per 1000 patient days. In 2021 the average DOB/1000 patient days at Anderson was 51

Modified Early Warning System (MEWS) – Early Detection of Patient Deterioration

A nurse may call and mention the MEWS score, which is a scoring system that identifies high risk patients. The score is calculated based on heart rate, blood pressure, respiratory rate, temperature, and neurological status. The score is calculated in Epic to enable nurses to identify patients who are deteriorating and need urgent intervention such as a call for a Rapid Response Team.

Code Blue

The operator overhead pages "Code Blue" and location three times. Clinical Administrator and ICU nurse assume leadership role and follow ACLS protocol until physician present. Any physician in the area is expected to respond until relieved by responding hospitalist. The Critical Care Committee will review Code Blues quarterly.

Code Pink

The operator overhead pages "Code Pink" and location three times. Clinical Administrator and NICU nurse assume leadership role and follow PALS protocol until physician present. Neonatology, anesthesia, NICU/ED nurse and chaplain should respond.

Rapid Response Team

The Operator overhead pages “Rapid Response Team” and location three times. Respondents include the Hospitalist, Clinical Administrator, respiratory therapist, and nursing. Others like radiology or EKG tech may be called. This is intended for “pre-codes” or significant change in status requiring an immediate evaluation.

Code Violet

The Operator overhead pages “Code Violet” and location three times. Respondents include security, the Clinical Administrator, and nursing. Others like the hospitalist may be called. This is intended for violent or unruly patients.

Code	Respondents
Code Blue	Hospitalist (First responder) Emergency physician (back-up) Clinical Administrator Respiratory therapy Nurses (ICU, ED, A2) Laboratory EKG Chaplain Attending physician (if available)
Code Pink (neonatal or pediatric patients)	Neonatology (first responder if in house) Emergency physician (back-up) Clinical Administrator Anesthesia NICU/ED nurse Chaplain

Rapid Response	Hospitalist (First responder) Clinical Administrator Respiratory therapy Nurses (ICU, ED, A2) Chaplain Attending physician (if available)
Code Violet	Clinical Administrator Security Nursing Hospitalist (if needed) Attending physician (if available)

The Clinical Administrator (CA)

Shifts: 6a-6p and 6p-6a. They cover the hospital 24/7
Location: their office is located within Nursing Administration on the second floor across from the lab.
Contact Information: **Phone 513-233-6561**

Clinical Administrator primary responsibilities:

- Throughput
- Coordinate patient bed placement using EPIC
- Quick register direct admits in EPIC
- Staffing and staffing readjustment every 4 hours to meet needs
- Primary nursing responder for Codes and Rapid Responses
- Critical care trained, able to manage patients
- Update SurgeNet when hospital is at or over capacity
- Fill out CA report twice daily for administration
- Initiate chain of command
- Call in OR and cath lab teams for acute issues

Translating service is available both for languages and ASL

Stratus is the interpretation system. They have ASL available as well through the green iPads. Verbal translation services can be obtained through the iPad or by calling **833-787-2205** and using speakerphone.

Bilingual employees or employees with knowledge of ASL cannot be used as staff interpreters unless they have undergone the process to become a qualified interpreter. Services of a qualified foreign language interpreter must be offered, at no additional cost, to all patients and/or relatives identified as Limited English Proficient. To preserve patient confidentiality, family and friends should not be asked to interpret for a patient unless there is an emergency situation (until an interpreter can be arranged and arrives), or the patient expressly requests to use that person. Document this in the medical record.

Language Services Extended Instructions - for BSMH.pdf

Utilization Review Management Committee

The utilization review committee meets quarterly. Utilization review reports through the Quality and Patient Safety Committee to the Medical Executive Committee. The function is to establish, implement and evaluate a program of admission certification and continued stay reviews for patients in accordance to applicable state or federal law, regulations, or third-party contractual requirements.

1. Review and discuss data from our outside utilization reviewers – Ensemble – including inpatient vs observations and denials
2. Assist in the selection and ongoing modification of criteria and standards
3. Address over-utilization or underutilization issues identified through utilization review activities:
    - medical necessity of admissions
    - extended length of stay and high-cost cases (data provided from Long LOS committee)
    - cases of non-covered stays
    - short stay inpatient stays
    - observation cases
    - professional services furnished including drugs and biologicals
4. Recommend changes in hospital procedures, medical staff practices, and continuing education programs based on analysis of review findings and regulatory changes
5. Act on issues referred to the Committee by medical staff, administration, or other hospital committee
6. Antibiotic stewardship
7. Refer potential or actual quality or patient safety events through incident reporting system or directly to appropriate quality committee

Long LOS Committee

This committee meets weekly via Zoom (Tuesday at 1:30pm) to review all cases with an LOS of 8 days or longer. The committee consists of the Vice President of Medical Affairs, palliative care, case management manager and the hospitalist clinical performance nurse. A weekly review of high length of stay cases. This will be clinically and financially focused to look for opportunities to advance toward discharge and current status. Typically, 3-4 minutes on each case. The format will be case summary, current clinical updates, current LOS and GMLOS, discharge planning (insurance, next site of care, denials, etc.), CDI opportunities. Depending on the number of cases, it may not last the whole hour, or we may need to discuss more in depth offline.

Care Plan Committee

The care plan committee typically meets every 2-3 weeks. The committee consists of the director of risk management, the manager of case management, the Vice President of Medical Affairs, an ED and hospitalist representative. An emergent care plan may be created for an urgent situation. Contact the Clinical Administrator or Kelly Raschke (KRaschke@mercy.com) if you wish to attend.

Epic CarePATH Electronic Medical Records and Physician Order Entry

All credentialed providers are required to complete EHR Training or Epic proficiency verification. Please register providers early in the application process for a class to be held three days to two weeks prior to their anticipated rotation start date. Provider should not be scheduled to a training session if they are working or on call. All trainings are held virtually on Zoom. Providers will need to join the zoom training from a laptop or desktop computer, and not from a phone or tablet. Registration closes two business days prior to the class time. Classes are scheduled between 4-6 hours for those who are not Epic proficient or have not actively used Epic within the last six months at either a BSMH Hospital or other outside healthcare organization.

Epic (CarePATH) Inpatient Provider new hire training and test out sessions are available for registration at: https://www.signupgenius.com/tabs/43072d907aecdecc17-inpatient

2022 IP CarePATH Provider Training Registration Step by Step (003)1-6-2022.pdf

Please contact BSMHProviderTraining@mercy.com if you have issues with scheduling. You may also contact the Medical Staff Office at 513-624-4058.

Epic Tips and Tricks

Orders Management – Inpatient Preference List

Customized order sets are key for admissions or transfers. For an individual order, use the minimum number of letters to "find" the order. Expand the search by clicking on the Facility List (F6). When you've got what you want, add it to your preference list by clicking on the STAR to the right of the order. Organize your preference list into sections.

Discharge Navigator – Prescription Preference List

Follow through with the discharge navigator and Med Reconciliation to (1) Reconcile the Meds for Discharge (2) Complete the discharge order and write prescriptions, and (3) Review and Sign. There is no other way to get to the discharge order except through Med Reconciliation. This preference list is for discharge prescriptions or post-discharge orders (like labs or X-ray). Remember to specify if going to SNF or home.

Surgical Navigator – Phases of Care

Be sure to place your orders in the correct phase of care. Pre-op orders are placed in Pre-Op Consult and Post-op orders are placed in either *Inpt Post Op* (staying in the hospital) or *Post-op Discharge* (home from the PACU). Both Post-op phases of care require you to go through Med Reconciliation to get to the transfer order. Otherwise, they are not going where you intend. Before your surgical patient is admitted, if the patient is in Epic, you can go directly to Direct Admit Orders under the Epic button and the orders can be released by the nurse under the correct account number.

In Basket – How Things Get There

Click on "sign" for orders. You can highlight multiple orders by using the SHIFT and the mouse. Anything with the letters "hpf" can be completed in DocView. CC'd Results are just that – copies for you as a courtesy. Just click Done to remove them. Refresh takes away the Signed and Done tasks.

SmartPhrases Speed Up Documentation
Colleagues can share their documentation templates with you as a starter document. Colleagues can share their documentation templates with you as a starter document. Email Michael Weller, the Anderson/Clermont Site specialist, at EHR-Site-Specialists@bsmhealth.orgEHR-Site-Specialists at bsmhealth.org or call 1-855-214-3027 for basic templates and smart phrases to help you get started. If you are joining a specific group or subspecialty, they may already have templates to share. The @phrases@ are SmartLinks to data somewhere in Epic.
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Guard Your Epic Password Closely and Do Not Give to Anyone Else
Be careful with your password. Anyone who logs in under your ID and password becomes you for all practical purposes. Access can be monitored throughout Epic. Avoid opening and viewing charts for which you do not have a clinical or administrative reason. Do not give your log-in information to anyone else. Mid-level providers and ED scribes have their own log-in that is appropriate for their level of access. Passwords must be reset every six months. This is a one-sign on, meaning that the same password will access other items on the Mercy Hub.

Epic Access From Home or Office
The website for OUTSIDE the hospital is https://chpEconnect.health-partners.org Best to use Windows *Explorer* or *Firefox*. Only works with *Firefox* on Mac (not *Safari*). Works with limited capabilities on an iPad (you may order certain simpler items or medications and cosign documents). You will need to download Citrix the first time you use this site. Click Accept. This may take some time. Enter your Epic Username and password to enter the Citrix site. It is *very important* to scroll down to **MSWO** in the third box. Citrix will load, call **513-981-5050** for guidance and help.

Click on the **Epic Hyperspace PRD South Central** icon. At the Epic Hyperspace log-in screen put in your username and password, just like in the hospital

Incident Reporting and Patient Complaints

Incident Reporting for Physicians Available Through SafeCARE

SafeCARE is an electronic reporting system available on all hospital computers. But if you need an alternative, the Medical Staff Office has established a voicemail SafeCARE Reporting Line at **513-624 - 4390**. Report the facts in a brief narrative and risk management will enter the issue and follow up with you. Remember to specify the patient name and medical record number, location or department, and your contact information or you may also enter anonymously.

Patient Complaints and Grievance Management

Hospitals are required to formally address any complaint by a patient or family member.
CMS Definitions

- Complaint: any expression of dissatisfaction with staff or service, which can be resolved quickly by staff present
    - Receive immediate response to avoid escalation to formal grievance
    - Acronym “HEART” helps manage complaints
        Hear
        Empathize
        Apologize
        Respond
        Thank
- Grievance: a formal or informal written or verbal complaint that cannot be resolved at the time of the complaint by staff present
    - Includes any allegations of patient abuse or neglect, violation of patient rights, patient harm, or compliance with CMS requirements
    - Grievances require a written response within 7 days
    - Require formal investigation and address each concern specifically

The patient advocate and appropriate administrator follow up with the patient and family the next day to assure resolution. If asked for your input, please respond in a timely manner.
Our Patient Representative is here to listen to patients, families and others regarding concerns and complaints relating to their care and treatment. She will investigate and direct inquiries to appropriate staff to help resolve their issues. Most of the time these issues can be resolved, but at times the physician’s assistance may be needed.

Most complaints are communication issues. Some common physician-related complaints are:

a) Lack of adequate information to patient/families,
b) Not allowing enough time for patient/ family input,
c) Patient confusion regarding care/treatment/diagnosis from various physicians on the case,
d) Who is coordinating care? Many patients have numerous physicians on their case. This is very often a source of frustration with patients and their families. They aren’t sure who is coordinating their care or which physician can answer their questions.

Contact the patient representative if your patients/families have any complaints or if you are sensing frustration or dissatisfaction from the patient. Sometimes, just having a person take the time to listen to them and look into their concerns can make all the difference between a Good or Bad hospital stay

Clinical Practice Guidelines – Inpatient Rounding and Communication

Importance of the Treatment Team

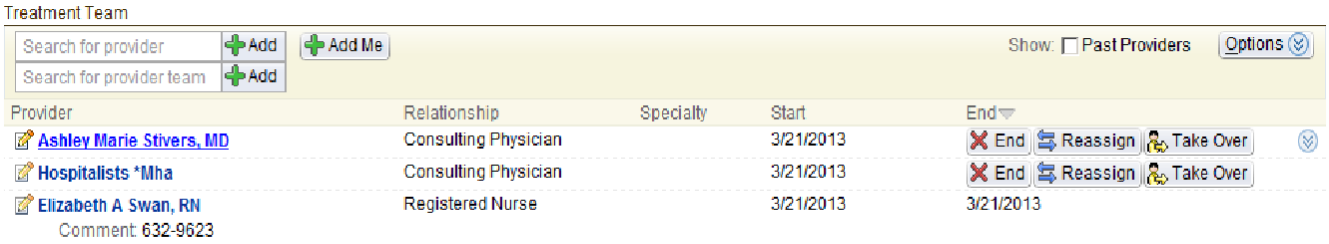
Attending physician, attending nurse, advance practice clinicians, consulting specialists, and patient care assistants with contact numbers are under the Treatment Team. If a nurse practitioner or physician's assistant is serving as the "attending" they will be listed under the treatment team. If a resident physician is on the case they are also listed as "resident" on the treatment team and should be messaged for routine issues until 1700.

Attending Hospitalist: Update Treatment Team 0700

The hospitalist attending physician for every patient is updated by 0700 each morning. Attending hospitalist is responsible for all *Perfectserve* messaging calls from 0700 until 1700. From 1700 to 0700 the next day, a covering designated hospitalist provider will answer.

Nursing: Update Treatment Team within One Hour of Shift Start

The Treatment team must be updated within an hour of starting every shift (no later than 0800 or 2000). Delete all prior names listed on the Treatment Team that are not currently involved in the patient's care. Be sure that your full number is listed i.e., 632-9620. If you are orienting include a comment with the preceptor's name and number. Use the Sign In function and do NOT set a start and stop time. This is to be done for every patient, every shift.



Attending Physician and Nurse Should Make a Reasonable Attempt to Co-Round

The treatment team is the source of accurate attending and nurse patient assignment at any time. Co-rounding is encouraged for all providers. This is crucial for effective communication. The attending physician and nurse make a reasonable attempt to co-round at the bedside daily. If that is unable to occur, then the physician should call or have face to face contact with every RN about every patient. There are Nurse/Case Manager Discharge rounds which occur on each unit at 11am. These rounds were designed for discharge planning and do not take the place of attending/nurse communication.

Typical Co-Rounding Questions

To facilitate co-rounding at the bedside, nursing can ask the following questions.

1) Is there a continued need for IV therapy? Is a PICC indicated?
2) Is there a need for a Foley catheter? Can it be removed?
3) Is telemetry monitoring still indicated? Can it be removed?
4) Is PT/OT indicated?
5) Medication Review (Sleep aides, pain medication, laxatives, Insulin)
6) Review of oxygen therapy and titration
7) DVT prophylaxis
8) Discharge planning needs, including PCP appointment, precerts for nursing home or rehab placement.

Discharge Medication Reconciliation

This is an important clinical function that is shared by members of the treatment and the ultimate responsibility of the discharging physician or advanced practice provider.

Medication Reconciliation for Non-Orthopedic Medications

Hospitalists complete the medication reconciliation (and sign new scripts) on the day before anticipated discharge for all medications other than analgesics and DVT prophylaxis.

Nursing: Consults are Called in Real Time – Documented in a Progress Note

All consults are to be called at the time they are ordered, or upon admission to the floor for regular consults ordered on ED admissions. Staff (unit clerk or nursing staff) should document using "Progress Note", not "Consult Note". The nursing smart phrase ".consult" may be utilized. Include the provider that was contacted, date and time.

Discontinue Telemetry When Not Indicated

American College of Cardiology Class III Recommended Guidelines: Cardiac monitoring is not indicated because the patient's risk of a serious arrhythmia or the likelihood of therapeutic benefit is low.

- Postoperative patients who are at low risk
- Patients with terminal illness and who are not candidates for treatment of arrhythmias that may be detected
- Patients who have undergone routine, uncomplicated coronary angiography
- Cardiac ruled out by normal EKG and enzymes
- Chronic stable atrial fibrillation
- Stable asymptomatic PVC's or non- sustained ventricular tachycardia who are hospitalized for reasons other than cardiac or hemodynamic compromise
- Patients whose underlying cardiac disease has been stabilized and who have had no arrhythmias on 3 consecutive days of monitoring

Providers place a *nursing communication* order to discontinue telemetry.
Telemetry is now a time-limited orderset.

PerfectServe Messaging Guidelines for Hospital Medicine

PerfectServe Messaging

The PerfectServe Messaging link can be accessed via the Mercy Health Hub from any workstation within the facility and it is also now embedded in EPIC. There are 3 ways to contact Hospital Medicine:

1. Individual Provider Message - to message an individual provider, search by name or locate under the "favorites" list.
2. "MHA Admitting/Consult Hospitalist" – Used for ED admissions, Transfer Center, Direct Admissions, and Consults.
3. "MHA Cross Cover Hospitalist" – Used for afterhours cross cover messages only.
4. PerfectServe messages should include: Call back number, your name, room number (or Date of Birth if no room), patient name, message with desired outcome (FYI, URGENT, expected orders, etc.).
5. PerfectServe for providers may also be accessed through the phone app.

Routine messaging (0700-1700)

All Hospitalist messages during daytime hours should be directed to the current Hospitalist assigned to the patient, as listed on the Epic Treatment Team (Physician, Nurse Practitioner or Resident Physician), which is not necessarily the Attending Physician.

After hours messaging (1700 – 0700)

All Hospitalist messages should be directed to the "MHA Cross Cover Hospitalist" in PerfectServe. In rare circumstances, the daytime Hospitalist may be contacted after 1700 if requested by the provider for a specific reason (i.e., awaiting test results or late discharge arrangements).

Troubleshooting Unanswered Messages

Messages are expected to be answered within 30 minutes. If you do not receive a call back within 30 minutes for a routine issue, a second page should be sent through *PerfectServe*. Urgent issues should be indicated in the message and may warrant a second message in <30 minutes if necessary. FYI messages should be indicated as such and do not necessarily require a call back. If you are unable to reach the Hospitalist, you should contact the Sound Physicians Answering Service #513-244-9070.

Direct admission notification

A PerfectServe message should be sent to "MHA Admitting/Consult Hospitalist" and NOT the attending listed on the chart (if any). Either the RN or Unit Clerk should add "*MHA Hospitalist" to the Epic treatment team to ensure the patient is included in the Hospital Medicine census

Consulting Hospital Medicine

A PerfectServe message should be sent to "MHA Admitting/Consult Hospitalist". Either the RN or Unit Clerk should add "*MHA Hospitalist" to the Epic treatment team to ensure the patient is included in the Hospital Medicine census.

Paging Guidelines when Hospitalist is the Consultant (i.e., Surgical patients)

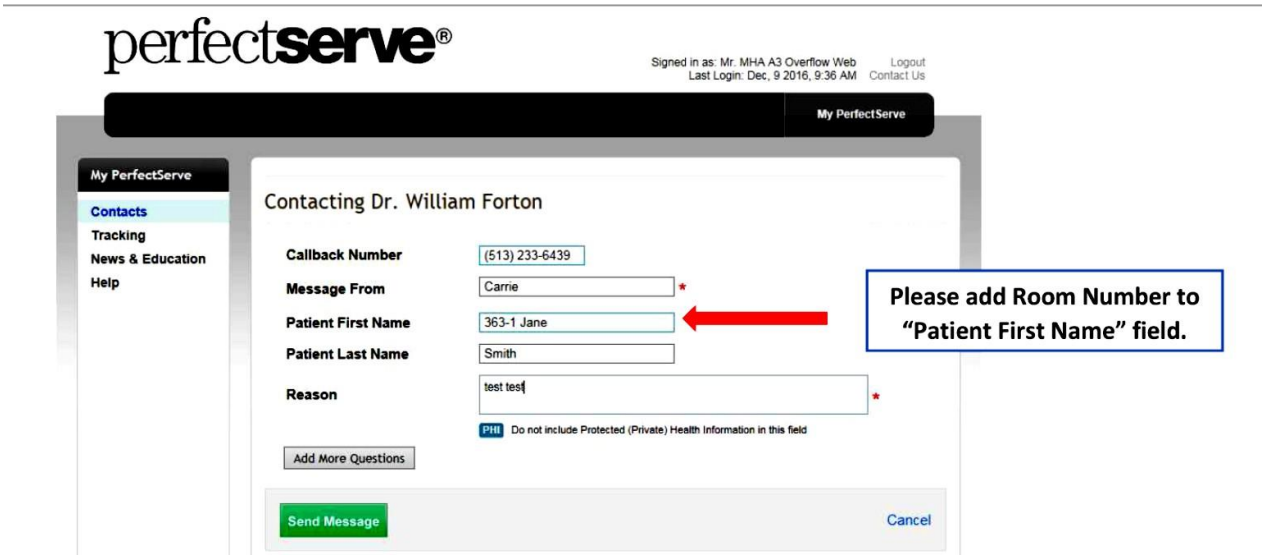
Hospital Medicine is typically first call for all patient clinical issues with the following EXCEPTIONS:

- The proceduralist (surgeon, interventional cardiology) is first call for all issues for the first 24 hours following a procedure (STEMI with PCI or surgery).
- The proceduralist should always be first call for: Diet (including TPN), pain management, DVT prophylaxis, and transfusion orders.

Any significant change in patient condition/status, including transferring of patient to higher level of care or another facility, must be communicated to the attending service. Either the nurse or the Hospitalist may contact the primary service attending.

Paging Guidelines for Hospitalist patients that had a procedure:

- The proceduralist (surgeon, interventional cardiology) is first call for all issues for the first 24 hours following a procedure (STEMI with PCI or surgery).
- The proceduralist should always be first call for: Diet (including TPN), pain management, DVT prophylaxis, and transfusion orders.



Addressing Routine Overnight Clinical Issues with Nocturnist Physician or APP (1900 – 0700)

Unit Charge Nurse keeps a running log of routine questions, concerns, and needs for the nocturnist. Around 2200 -2330 (this can be flexible) the Charge RN will touch base with the nocturnist via phone call or face to face visit from the physician to review the list. The nocturnist will provide the appropriate orders and address needs. Some examples of things that might be on the list include: sleeping medication, stool softeners, access problems, pain medication adjustments, parameters for blood pressure medications, and renewal of restraints. This does not replace urgent pages as above.

Hospitalist coverage of non-Hospitalist patients without an existing consult

The Hospitalist may be asked to respond to and provide emergent care to any hospitalized adult patient in an emergency setting, typically during a Rapid Response, Code Violet or Code Blue, without requiring a pre-existing consultation. ICU patients may occasionally require "emergency" care without formally being called as a Rapid Response due to unit policy. Typically, ICU's do not call rapid response since the patient is located already in the highest level of care.

The primary service attending should be notified by the nursing staff of the patient's condition and the involvement of the Hospitalist as soon as possible. The Hospitalist will initiate a physician-to-physician conversation with the primary attending when warranted.

The hospitalist is otherwise not authorized to provide care without a specific consultation request from the primary attending. For any non-emergent issue, the primary service attending should be contacted first.

Consulting Pulmonary Critical Care

Pulmonary Critical Care Messaging Guidelines

Contact the physician on Call through PerfectServe "MHA Intensivist Pulmonary," which is covered by the Pulmonary Critical Care physician from 0700-1900, and the on-call Hospitalist/Nocturnist from 1900-0700.

All new ICU admits from the ED should be called first to Hospital Medicine. A second call may be placed to Pulmonary Critical Care during daytime hours (0700-1900), if clinically indicated. However, no second call to Pulmonary Critical Care is necessary at night (1900-0700)

Consulting Pulmonary Critical Care

A PerfectServe message should be sent to "MHA Intensivist Pulmonary". Either the RN or Unit Clerk should add "*Pulmonary Critical Care" to the Epic treatment team to ensure the patient is included in the Pulmonary Critical Care census.

Mercy Anderson- Age-Appropriate Admissions

All specialties other than Anesthesia, Emergency Medicine, Family Medicine, OB and surgery are limited by credentials from admitting and consulting on patients based on nursing, malpractice coverage and/or group decision. Use caution when admitting patients under age 18 since pulmonary/critical care services 18 and above only.

Specialty	Age	Exceptions
Nursing	16 and up	OB/ED/MAASC
Pulmonary/Critical Care	18 and up	
Cardiology	18 and up	
Nephrology	18 and up	
Urology	18 and up	
GI*	16 and up	
Hospitalists** and ***	16 and up	
Surgery****	16 and up	
OB	All ages	
ED	All ages	

Appendix

*GI – can see 15 and up, however nursing care limits to 16 and up unless in MAASC
** hospitalists can see 14 and up, however nursing care limits to 16 and up
*** hospitalists can admit pregnant patients ages 18 and up for non-OP medical issues up to 20 weeks, under age 18 would need OB primary regardless of weeks, under age 16 will be admitted to OB unit with OB primary
****surgery can see 14 and up, however nursing care limits to 16 and up unless in MAASC
***** there is legal precedent to protect a provider when giving emergency stabilizing treatment until able to transfer to a different facility (i.e., pregnant 13-year-old with ICU level postpartum complications)
If a patient under the age of 18 has a high level of acuity and has the potential to require ICU level of care, then the hospitalists may decline admission.

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Note Types That Require Co-sign in CarePATH

Progress notes and brief op notes do not require a “co-sign” when entered by a resident physician or advanced practice provider (NP/PA).

Note Type	Resident	Medical Student	NP/PA
H&P	Yes	Yes	Yes
ED Provider Note	Yes	Yes	Yes
Progress Note	Yes	Yes	No
Initial Consult Note	Yes	Yes	Yes
Op Note	Yes	Yes	Yes
Procedure Note	No	Yes	Yes
Discharge Summary	Yes	Yes	Yes
Brief Op Note	No	Yes	No

SBAR Communication Format

When discussing patients, nurses follow the “SBAR” format for team members to effectively communicate information to one another. The **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation (SBAR) format is used for patient discussion over the phone or in person.

SBAR: Communicate the following information:

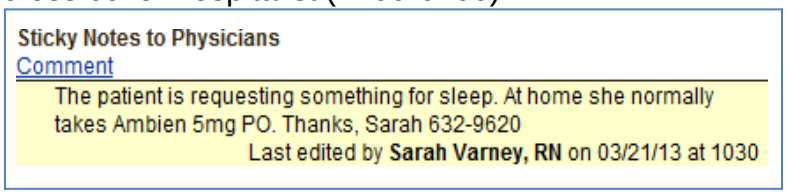
- **Situation**—What is going on with the patient?
- **Background**—What is the clinical background or context?
- **Assessment**—What do I think the problem is?
- **Recommendation**—What would I recommend?

Reference information may include

1. Why the patient is here
2. Pertinent past medical history (CAD if patient with chest pain)
3. Pertinent medications (patient on cardiac meds with chest pain)
4. Pertinent tests and procedures (chest pain patient had a cath last week)

Sticky Notes for the Physician Section

Routine non-urgent communication may be placed in a “sticky note” prior to the physician rounding. These include family issues, needs, and requests (unless emergent) that would not be in a progress note. If the physician has already rounded, the sticky note may not be seen until the following day. Urgent issues should always be sent through *PerfectServe* to the attending provider (0700-1700) or cross cover hospitalist (1700-0700).



Physician Addressing Sticky Note and Then Delete

When the physician addresses a sticky note request (like an order for a sleep aid), they will delete the specific text – thereby signaling that it has been addressed and eliminating another physician from also addressing.

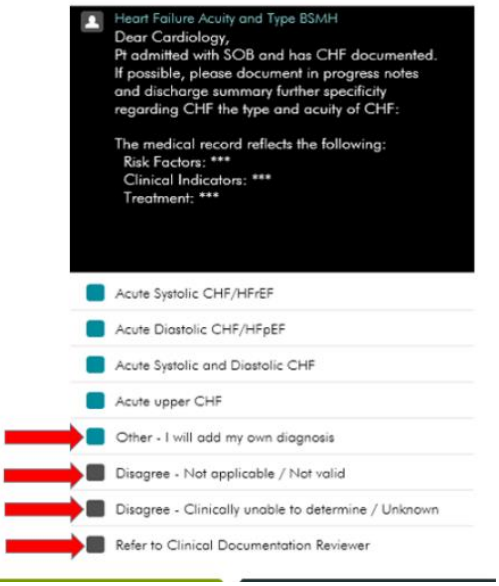
Clinical Documentation Information (CDI)

3M 360 Encompass MD enables effective communication in real time between Clinical Documentation Specialists and Providers via a notification in Epic. This will allow you to immediately address any documentation queries with little to no interruption in your daily workflow. Once a Provider logs into Epic, a notification or "toast" will populate in the bottom right-hand corner of your screen signaling a clinical documentation request. The notification will also appear when you enter an individual patient's chart.

CDI Queries – Responding appropriately

- Please answer the query by selecting one of the provided options that is clinically supported.
- Do not answer the query if you are still working the patient up.

- Other - If you believe something else is being treated besides the options provided to you, please add your own "diagnosis".
- Avoid using options – Disagree – N/A or Disagree – unable to determine. If selected, please explain why in the text box.
- Refer to Clinical Documentation is the only option that will not generate a progress note.



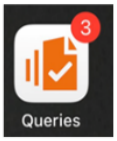
CDI 3M Advanced Query Messenger

<u>An alternative way to answer your queries via smartphone.</u>

CDI 3M Advanced Query Messenger (AQM)

3M Advanced Query Messenger is a new alternative way to answer your queries via a smartphone. The application is HIPAA compliant – where no patient info is stored on your smartphone. AQM Uses two factor authentication to sign in/secure network.

1) Download the Advanced Query Messenger 3M App from your app store. Search for "3M Queries".



2) Open app and you will be prompted for a mercy email. Type in your specific Epic ID + @mercy.com
Ex: Coch223@mercy.com

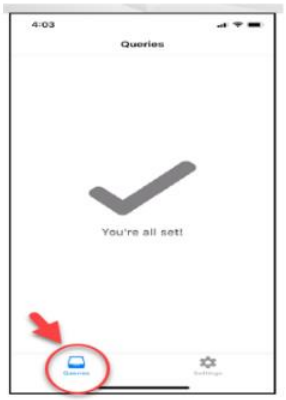
3) You will then be prompted to login to the BSMH network with same login and password as above.

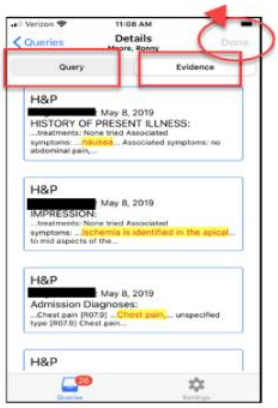
4) VIP 2 factor authentication will be prompted to ensure application is secure. Once Verified, you will return to the 3M Advanced Query Messenger App.

CDI 3M Advanced Query Messenger (AQM) - continued

5) Once you are logged in, you can click on the queries in the left bottom corner.

6) Your queries will now be listed. You then can review a query, the associated evidence and then select your answer and hit done in the right upper corner to complete the query.





Incident Report through SafeCARE

Incident reports are necessary and desired to improve patient care and safety. Writing a good incident report is a valuable skill that has a direct effect on patient safety and improvement in care. Perhaps the hardest part of writing an incident report is separating facts from opinions and assumptions. Doing so requires reflection and rewriting, which is why it is important not to rush the process. Approach the incident as a reporter would, focusing on who, what, when, where, why and how.

Clear, dispassionate language that accurately depicts events is sufficient for the most effective incident reports. You may want to compose the text in Word (with spell checker and grammar check) and copy into the SafeCARE report.

Although writing a thorough incident report requires time, it is essential that the investigation and writing process begin as soon after the incident as possible. It is in the short space of time after an incident that memories will be clearest and less likely to contain embellishment.

Determination of Legal Next of Kin (Ohio)

If no prior determination of DPOA for Healthcare, the legal next of kin should be determined in the following order:

1) Spouse
2) Adult Child of the patient or, if there is more than one adult child, a majority of the patient's adult children who are available within a reasonable period of time for consultation with the patient's attending physician.
3) The patient's parents
4) An adult sibling of the patient or, if there is more than one adult sibling, a majority of the patient's adult siblings who are available within a reasonable period of time for that consultation with the attending physician.
5) The nearest adult who is related to the patient by blood or adoption, and who is available within a reasonable period of time for that consultation with the attending physician.

Medical Decision-Making Policy for “Unfriended” Patients

Medical Decision-Making for Patients Who Lack Decisional Capacity and No Surrogate. This policy provides a mechanism for providers to make medical decisions for patients who do not possess decision-making capacity and who do not have a surrogate decision-maker. This is approved by the Ethics Committee in consultation with the Medical Executive Committee. Consistent with the Ethical and Religious Directives for Catholic Health Care Services as they relate to surrogate decision-making and the withholding or withdrawing of life-sustaining medical treatments.

Mercy Health will take reasonable steps to locate (a) an advance directive from the patient, or (b) a surrogate decision-maker. If no advance directive or surrogate decision-maker can be located, Mercy Health will make medical decisions on behalf of the patient utilizing the best interests standard. Decisions will be made by physicians in consultation with case management, social work, ethics and other relevant parties.

C2 Intensive Care Unit

ICU Multi-disciplinary Rounds

Multi-disciplinary rounds begin promptly at 8:30 am seven days per week. Core participants include the Intensivist, ICU charge nurse, ICU based pharmacist, ICU based dietician, and respiratory therapist and nurse for each patient. The nurse documents the plan for the day in a brief progress note.

Overnight Hospitalist Coverage of non-Hospitalist Patients without an existing consult

The Hospitalist may be asked to respond to and provide emergent care to any hospitalized adult patient in an emergency setting, typically during a Rapid Response or Code Blue, without requiring a pre-existing consultation. ICU patients may occasionally require "emergency" care without formally being called as a Rapid Response due to unit policy. Typically, ICU’s do not call rapid response since the patient is located already in the highest level of care.

The primary service attending should be notified of the patient's condition and the involvement of the Hospitalist as soon as possible. The Hospitalist will initiate a physician-to-physician conversation with the primary attending regarding their involvement.

The hospitalist is otherwise not authorized to provide care without a specific consultation request from the primary attending. For any non-emergent issue, the primary service attending should be contacted first.

Nocturnist Rounds in the ICU

The Nocturnist will do brief “walk rounds” overnight, typically around/after midnight. Charge nurse and Nocturnist will visit each room and discuss with bedside nurse any issues/needs.

Emergency Department

Place a Note in the Progress Notes when Consultant is Called

Designate when and who answered the call when calling consultant. This prevents the consultant from being called twice when patient arrives on the inpatient unit.

Direct Admission to Hospital Medicine

Some patients may be safely admitted directly to a hospital room due to a known diagnosis and to bypass the emergency department. Coordinate through the Transfer Center by calling 513-981-BEDS (2337). Bed availability should be determined by the Transfer Center prior to a physician-to-physician discussion. Direct admission will be at the discretion of the accepting Hospitalist based on physician-to-physician discussion and bed availability.

Direct Admit Criteria

1) Patient is being evaluated by a physician (not on the phone).
2) Primary care physician is able to provide a diagnosis (like pneumonia).
3) Patient is stable for waiting up to 4 hours after hospital admission for laboratory exam and physician exam.

Activating the UC Stroke Team at 513-844-7686

Call UC Stroke Team for any stroke or TIA with symptoms presenting within **12 hours**, regardless of severity or NIH stroke scale. Please activate the team as soon as you hear about a stroke case in order to avoid potential delays in treatment. This includes emergency department patients or a patient who develops symptoms as an inpatient.

Thrombolytics for Stroke

When thrombolytics are given for stroke, the UC stroke team attending is first call at **513-844-7686** for the initial 24 hours. The “Admit CVA thrombolytic” orderset is used for the admission by the hospitalist. Currently Cincinnati is using Tenecteplase, TNK, for acute CVA treatment.

Medical Emergency in a Non-patient outside a Patient Care Area

When a rapid response or code blue is called on a “non-patient” (family or visitor), the responding team should move the victim to the emergency department as quickly as possible for appropriate evaluation and management to begin. There is no “patient relationship” with non-patients and so any intervention is considered “Good Samaritan” until patient in the emergency department and effectively “registered”.

Emergency Department Security

A uniformed sheriff’s deputy is stationed in the emergency department from 7 p.m. to 3 a.m. seven days a week. This provides another layer of security and protection to patients and staff

Radiology Guidelines

To discuss any imaging with a reading radiologist, call **513-891-7231** from outside the facility or **5-7231** from inside the hospital which will connect you to a radiologist who can go over the study. Typical daily hours are 7 am to 4 pm with "after hours" defined as 4 pm to 7 am.

Interventional Radiology (IR) Guidelines

1. Typical IR procedures, such as biopsies, tunneled dialysis catheters, ports, vertebral augmentations, IVC filters, etc., to be requested and performed during normal working hours, are ordered and scheduled in the usual fashion.
2. Atypical or complex IR procedures, such as cancer interventions, nephrostomies, biliary procedures, TIPS, mesenteric angiograms, etc., to be requested and performed during normal working hours, should be ordered and scheduled in the usual fashion after a physician-to-physician discussion.
3. All after-hours IR procedures should be requested by the ordering physician after a physician-to-physician discussion with the interventional radiologist to ascertain the appropriateness of the procedure and to agree upon an appropriate time and day to complete the requested procedure. The on-call interventional radiologist can be reached via the radiology Results Communication Center: 513-891-7231.

Radiology Critical Values – Reported within an Hour

- Inpatient and Emergency Department – reading radiologist informs ordering or covering provider within 1 hour.
- Outpatient – radiologist calls/pages ordering or covering provider a minimum of two times during a one-hour timeframe.

Metformin and Contrast

In patients with no evidence of AKI and with eGFR ≥30, there is no need to discontinue metformin either prior to or following the intravenous administration of iodinated contrast media, nor is there an obligatory need to reassess the patient's renal function following the test or procedure.

Cardiology Guidelines

Post Procedure Hospitalist Admission

- Cath Lab or PACU sends message to "MHA Admitting/Consult Hospitalist" for call back and discussion for admission
- Proceduralist / surgeon completes post-op orders, hospitalist admission orders

Code STEMI Process Guidelines

Emergency Department registration to bring back all chest pain patients over the age of 20 immediately for ECG and evaluation. ECG performed within 10 minutes and shown to physician immediately. IF the ECG shows STEMI, RN to IMMEDIATELY begin following process-DO NOT wait for ED doc to indicate each of these interventions:

1. Place 2 large bore IV's
2. Apply monitors
3. Place call to interventionalist on call for **MMA-** unless Dr specifically indicated it should be another group

Clermont or Mt. Orab Emergency Departments

Call to AirCare for transport (if there is an ETA given by AirCare of more than 15 min, call to alternate air ambulance service i.e., AirEvac). Order the following in Epic: CBC, CMP, troponin, pro-BNP, PT/INR. Portable chest-x-ray (stat).

STEMI from Outlying Hospital or Emergency Department

Call the Mercy Heart Institute answering service at 513-751-4222 to connect with the Interventional Cardiologist on call. Once STEMI is established, the interventional cardiologist arranges for cath lab, and the site arranges for transport.

Medical Care of the Pregnant Patient

Admission and Consultation for Pregnant Patients

Family Birth Center is consulted for any pregnant patient who presents to the emergency department with gestational age greater than 16 weeks, regardless of presenting symptom or complaint. Based on the consult, the patient may go to FBC triage or stay in the ER.

Pregnant Patients over the age of 18 with gestational age **less than 20 weeks with a primary medical diagnosis** may be admitted by Hospital Medicine with an Obstetrics consultation or just call to the Obstetrics House Officer for any questions. All pregnant patients with a primary obstetric diagnosis are admitted by Obstetrics. Hospital Medicine may be consulted for management of any medical co-morbidities.

When Patient is Unable to Leave Emergency Department

Occasionally, a pregnant patient does not appear to meet usual admission criteria, but the attending ER physician is unwilling or unable to discharge from the emergency department – due to follow up issues, multiple visits without diagnosis, or even patient and family demands.

Each specialty addresses their area of expertise – PCP, hospital medicine, obstetrics. For a primary obstetric issue, patients with an existing OB relationship, that physician is called and may need to talk or directly reassure the patient. For patients without an existing relationship, their PCP and/or House Officer may be called.

Code Blue Responsibilities on Family Birth Center

Hospital Medicine has responsibility for running inpatient code blue responses. In some cases, they are assisted by Emergency Medicine on an as needed basis (usually at the request of the responding hospitalist). In house obstetrics and CRNA will also respond to any code blue on FBC. The responding hospitalist is responsible for ACLS and any medical issues including cardiopulmonary arrest. The CRNA may assist with an intubation if needed. Obstetrics is responsible for issues that are unique to pregnancy and the baby. As with any code blue, it is important for all responders to identify their specialty.

Rapid Response Teams on Family Birth Center

Similar to code blue, Hospital Medicine addresses any medical issues, and all responders identify their specialty and function to the responding hospitalist. The majority of rapid response calls from FBC involve a family member rather than a patient – and are handled in the same way as the rest of the hospital.

Code Pink Responsibilities

Any code pink (pediatric emergency) is responded by an emergency medicine physician. Hospital Medicine is credentialed for age 15 and above.

Discharge Process

Discharge to Home

Discharging hospitalist reconciles medications at bedside with nurse co-rounding whenever possible. A1 is our discharge unit. It is typically open Monday through Friday from 6am to 6pm. Patients are typically identified the day prior. The nurses are initially trained on our step-down unit and have a focus not only on continued patient care, but discharge teaching and instructions. This unit helps to open up acute beds, decrease LOS and improve patient satisfaction.

Discharge Prescriptions

Providers may e-prescribe discharge prescriptions to the patient's pharmacy or the Mercy Anderson pharmacy for "meds to beds". Printed prescriptions should be signed by the prescribing provider before leaving the unit. Most nursing facilities require printed, signed copies of narcotics, benzodiazepines and schedule 4 and above medications

Discharge PCP Appointments

Hospital follow-up appointments should be arranged prior to discharge whenever possible. Appointments should be discussed during Co-rounding at discharge. The provider should place an order for "*Inpatient consult to Primary Care Provider*". Unit Secretary or staff member should call the office to schedule an appointment, with reasonable effort to accommodate patient/family schedule. Document appointment time, date, office location and phone number in Discharge Instructions and give patient an appointment reminder card. Patients with no PCP or "Unattached Patient" may utilize the medical staff "Doc of the Day" schedule to find an available new PCP. Mercy Care Clinic can also be used when appropriate.

Post-Acute Discharge

Discharging hospitalist signs continuity of care form, prints and signs any scripts for scheduled medications (seven-day supply), signs an Ohio DNR Form (if applicable). Consider changing sliding scale insulin back to oral medications the day before discharge when possible. Oral pain regimen should be trialed the day prior to discharge to ensure adequate pain control prior to transfer. DVT prophylaxis (when appropriate) should be ordered at discharge with recommended stop date. Foley catheter indications or plans for removal should be documented. Paper prescriptions should be provided for all controlled substances with 3–7-day supply – including Narcotics, Benzodiazepines, Lyrica, Ambien, etc.

Documentation after death of hospitalized patient

Notification to attending physician and appropriate consultants. Either one physician or APC or two nurses will confirm, and document patient expired if the physician is unavailable. The Progress Note should include reference to exam findings and Time of Death.

Electronic Continuity of Care Form

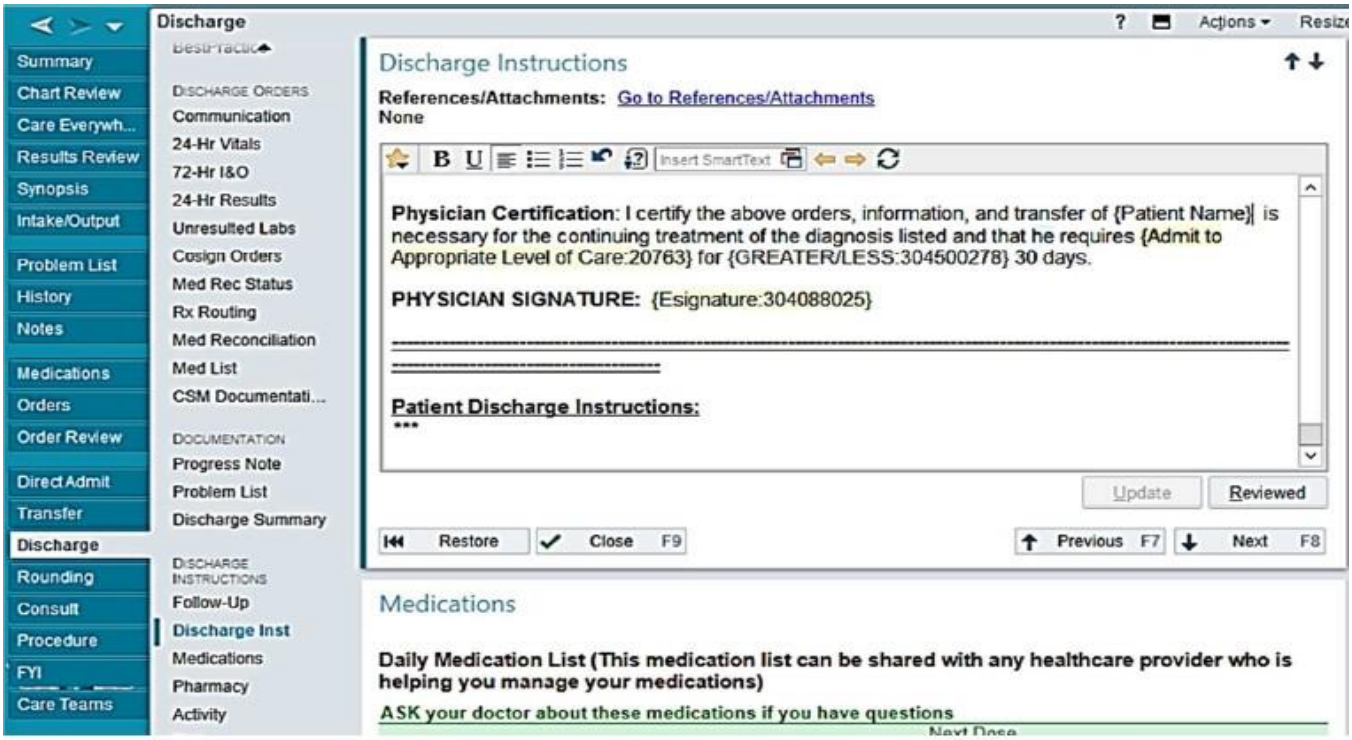
The SmartPhrase *.mhacoc* is placed in the "Discharge Instructions" section (usually by case management) and may be edited by the entire multi-disciplinary team (nursing, case management, physicians and other providers). It is used for all discharges to a post-acute facility (skilled nursing, extended care, LTAC, rehabilitation) and home health care.

Physician Responsibilities for Completing the Electronic Continuity of Care

Physicians or Advance Practice Clinicians (APC) are responsible for the “Physician Section”. Verify accuracy of discharge diagnoses (default will pull in Active Problem List), comment on Prognosis and Condition at Discharge, and answer if any changes to H&P. Similar to paper COC, fill out the “box” with any recommended follow-up, labs or other treatments (like IV antibiotics or fluids). This is the “box” for wound care, infectious disease, or other specialists to add their specific instructions. Finally, complete the electronic signature (*left to click, right to stick*) . If you need to update the physician signature, delete the current time stamp and use the smartphrase “.esign”.

Discharge Instructions Come After the Continuity of Care

As the COC and the “box” are intended for the receiving facility providers, any Discharge Instructions directed at the patient and family should be entered into the "Patient Discharge Instructions" section AFTER the eCOC.



Located in the **Discharge Navigator** under the **Discharge Instructions**.
Patient Discharge Instruction after the continuity of care.

Nursing responsibilities

- Responsible for completing "Nursing Section", which includes topics such as vital signs, IV access, wound care, ADLs, toileting, safety needs, nutrition, respiratory needs, etc.
- Section may be started by nursing in the days preceding discharge, however, should be reviewed, and updated by the discharging nurse at time of discharge.
- Electronic Signature (left to click, right to stick)
- Any Patient Discharge Instructions directed at the patient/family should be entered into the "Patient Discharge Instructions" section AFTER the eCOC.
- Any post-procedure patient discharge instructions
- Any patient education material (CHF teaching, Warfarin teaching, etc.)

Home Care:

- An order must be placed in EPIC (active orders) for Home Health care
    - Search “home care” to find the order - *Inpatient consult to Home Care needs*
- Complete an Electronic COC
- Provider must document medical necessity for Home Care in either a progress note or discharge summary.
    - Smartphrase - .HOMECAREMEDNEC

DME:

- An order must be placed in EPIC (active orders) for each DME item such as Home Oxygen, Hospital Bed, etc.).
- Provider must document medical necessity for each DME item in either a progress note or discharge summary.
    - Smartphrase - .DME### (example .DMEOXYGEN)
    - An Electronic COC is not required if DME is ordered without any Home Care

Mercy Care Clinic Referral

Patients discharged who need immediate follow up within one week and who do not have a primary care physician may be referred to the Mercy Care Clinic. This is a “free” clinic staffed by volunteer physicians located in MOB I, Suite 213. Mercy Care Clinic is intended for uninsured, but patients with insurance may be seen until they can be referred to a Mercy Health primary care physician by clinic coordinator Kim Miller.

1. Attending sends *PerfectServe* Message to Dr. Steve Feagins, clinical medical director with details.
2. Dr. Feagins will “accept” the patient for the clinic and an appointment can be made prior to discharge at 513-233-6096 (Monday through Thursday, 9 am to 4 pm) or the patient may call 513-233-6096 to schedule an appointment.

Patient criteria

- Upcoming surgical procedure in the next few days/weeks
- No existing PCP or PCP unable to schedule during the limited interval prior to planned procedure time (time restraint)
- Patients who would otherwise be seeking pre-op evaluation at an Urgent Care.
- Patients may be referred by subspecialties such as Orthopedic Surgery, Urology, General Surgery, Interventional Radiology, and Podiatry.

Workflow

- Patients will be scheduled by Pre-Admission Testing (PAT), Monday through Friday (excluding usual holidays), with appointment times typically at 7 am.
- Updated appointment schedule should be faxed to Hospital Medicine office (513-624-3284) every morning by 7 am.
- Patients will be instructed to come to the Diagnostic Center at 7am for any lab testing, EKG, vital signs,

and if necessary, signing consent for outside records (Care Everywhere). All facilitated by the PAT RN.

- Initial testing (labs/EKG) will be ordered by the PAT RN per protocol, using the facilities pre-anesthesia testing protocol.
- After initial testing is completed and the patient is ready to be seen the PAT RN will page the Hospitalist consult pager (513-329-0166). The patient will then be assigned to one of the rounding Hospitalists.
- A pre-operative H&P will be entered into EPIC under the upcoming surgical encounter.
- Any recommendations to delay or cancel the upcoming procedure due to patient condition or need for further testing will be communicated back to the requesting surgical provider and/or the provider's office

Procedure ordering

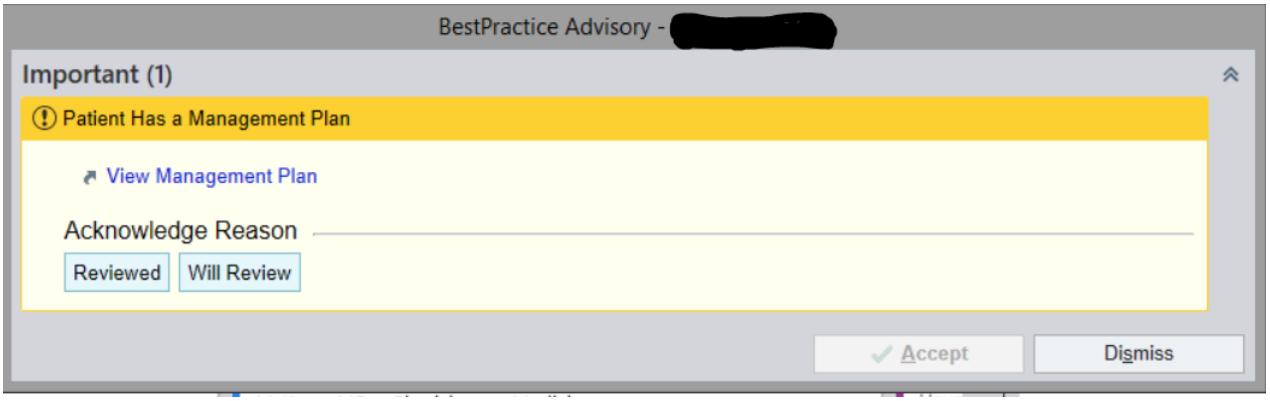
Please place an order for any procedure that you may be doing or asking for in EPIC. Without the order, proper consents and preparation may not be obtained in a timely fashion and the patient may not be placed on the schedule. It is important to place the order if you intend to do a procedure (i.e., EGD, colonoscopy, cardiac catheterization, TEE, stress testing).

Universal Time Out

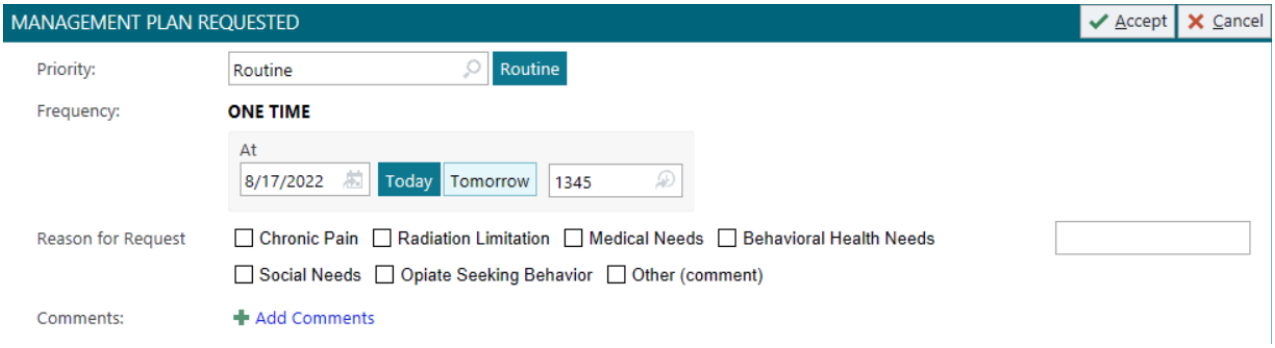
We are a “universal time out” hospital before any procedure or surgery – large or small. The “time out” is called and led by the surgeon (prior to incision) or proceduralist (prior to initiation) with acknowledgement from all in the room including the patient, prior to procedural sedation or anesthesia if possible. The checklist includes the patient’s name and identifier, procedure, specific location, and confirmation of ancillary information from labs and imaging that match the patient and the procedure. This includes everything from major joint replacements to central lines and interventional radiology – all procedures require a “time out.”

(Care) Management Plans

Predetermined plans for frequently admitted patients with consideration of special health care needs (frequent ED visits, frequent admissions, patients with individual issues – psychiatric, violent, complicated). This will automatically fire when opening the patient’s chart.



You may request that a care plan be created for your patient by ordering MANAGEMENT PLAN REQUESTED in CarePATH.



Additional Opportunities for Physicians at Mercy Health – Anderson Hospital

Mercy Care Clinic

Opened in July 2009, in partnership with the Muslim Clinics of Ohio, the clinic operates in the Medical Arts Building (MOB I). Patients are typically referred by the emergency department or hospitalists and must meet financial requirements. All members of the medical staff are encouraged to volunteer. Clinic sessions operate Monday through Thursday and typically see up to 4 patients per hour. Dr. Stephen Feagins, Mercy Cincinnati CMO, is the medical director and can be reached by pager at sfeagins@mercy.com.

Physicians Charitable Foundation (PCF)

The Physicians' Charitable Foundation is the charitable arm of the medical staff of Mercy Hospital Anderson. 2022 marks the 28th year of scholarships awarded. The Mission of PCF is to promote, sponsor, and provide physician leadership in community health issues and provide support for education programs in the community. PCF is a 501(C)3 (tax deductible) legal entity that serves as the charitable arm of the medical staff.

The purpose of the scholarship program is to financially assist and reward deserving students. Students must be pursuing a career in medicine, nursing or allied health. A number of scholarships ranging from $500 to $2000 will be awarded at the close of the school year to students graduating from high schools in the extended Anderson Township area. Children of MHA hospital employees, nursing staff, and other associates are encouraged to apply -- even if they live outside the Anderson area. Children of current Medical Staff members are not eligible for the scholarship to avoid conflict of interest. Guidance counselors are involved in recommending financially and academically deserving individuals.

Medical Explorer Scouting

You may be approached for brief assistance with our Medical Explorers. This is a part of the Boy Scouts, although males and females are welcome. Weekly sessions involve several areas of the hospital with 30 minutes of discussion from specialist physicians this fall. This is a great opportunity for these explorers to have a few minutes with a physician. We will work with your schedule.

Appendix

Anderson Committee Meetings 2022

MEETING	DAY & TIME	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
ADVISORY COMMITTEE **MOB Conf. Rm B**	7:00 a.m. 2nd Friday	14	11	11	8	13	10	8	12	9	14	11	9
BLOOD UTLIZATION **Administration Conference Room**	8:00 a.m. 2nd Fri	14	11	11	8	13	10	8	12	9	14	11	9
CREDENTIALS COMMITTEE **Zoom**	7:30 a.m. 1st Wed.	5	2	2	6	4	1	No Mtg	3	7	5	2	7
CRITICAL CARE COMMITTEE **Zoom**	7:00 a.m. 3rd Fri		18		15		17		19		21		16
DEPARTMENT OF OB/GYN **Zoom/MOB Conf. Rm D**	7:30 a.m. 3rd Tues		15		19		21		16		18		20
ETHICS **Zoom**	7:30 a.m. 2nd Thurs		10		14		9		11		13		8
EXECUTIVE COMMITTEE **MOB Conf. Rm C**	6:00 p.m. 3rd Mon	10	14	14	18	16	13	No Mtg	15	19	17	14	TBD
GENERAL MEDICAL STAFF **MOB Conf. Rm B&C**	6:30 p.m.									20			
QUALITY/PATIENT SAFETY **MOB Conf. Rm D** **Healing Garden Rm/Zoom**	7:00 a.m. 3rd Wed	19	16	16	20	18	15	20	17	21	19	16	21
PERIOPERATIVE SERVICES **ICU Conference Room**	7:00 a.m. 4th Thurs	27	24	24	28	26	23	28	25	22	27	~~24~~	22
SECTION OF EMERG. MED **ZOOM 10:00 to 12:00**	10:00 a.m. 2nd Tues	11	8	8	12	10	14	12	9	13	11	8	13
SECTION OF CARDIOLOGY **Administration Conference Room**	7:00 a.m. 1st Thurs.		3		7		2		4		6		1
SECTION OF PEDIATRICS **(agenda)** **MOB Conf. Rm. C**	8:30 a.m. 1st Wed			2			1			7			7
THORACIC CANCER CONFERENCE **ICU Conf Rm**	7:00 am 3rd Thur	20	17	17	21	19	16	21	18	15	20	17	15
BREAST CANCER CONFERENCE **Eastgate Group Room**	7:30 am 1st Fri	7	4	4	1								
BREAST CANCER CONFERENCE **Eastgate Group Room**	7:00 am or 7:30am 3rd Fri	21	18	18									
GENERAL CANCER CONFERENCE **2nd Wed – 7:00am** **ICU Conf. Rm**	7:00am 2nd Wed	12	9	9	13	11	8	13	10	14	12	9	14
OMEN CONFERENCE **MOB Conf. Rm. C**	12:30 pm every Wed	5 12 19 26	2 9 16 23	2 9 16 23	6 13 20 27	4 11 18 25	1 8 15 22 29	No Mtg	No Mtg	7 14 21 28	5 12 19 26	2 9 16 ~~23~~ 30	7 14 ~~21~~ ~~28~~
PED. MORT/MORB CONFERENCE **MOB Conf. Rm. C**	7:30am 1st Wed			2			1			7			7

Anderson Medical Staff Officers 2022-2023

Medical Staff Officers

Chief of Staff	Dr. Anthony Asher (radiology)
Chief of Staff Elect	Dr. William Lee (ED)
Past Chief of Staff	Dr. David Ward (surgery)
Medicine Department Chair	Dr. Jeff Hausfeld (internal medicine)
Surgery Department Chair	Dr. Aaron Bey (urology)
OB/GYN Department Chair	Dr. Michael Fesenmeier (OB/GYN)

Mercy Health Anderson Hospital 2022 Medical Staff Governance

Members of Regional Physician Council

Chief of Staff – Anthony Asher, MD (chairs MEC and Practitioner Effectiveness committee)
Chief of Staff Elect – William Lee, MD (chairs Quality committee)
Past Chief of Staff – David Ward, MD
Vice President Medical Affairs – Jamelle Bowers, MD

Medical Executive Committee Members

William Forton, MD (internal medicine)
Todd Bayer, MD (vascular surgery)
Betsy Drake, MD (internal medicine, primary care representative)

Chair, Department of Surgery – Aaron Bey, MD
Chair, Department of Medicine – Jeff Hausfeld, MD
Chair, Department of Ob/Gyn – Michael Fesenmeier, MD
Section Chief, Orthopedics – Ankit Bansal, MD
Section Chief, Pediatrics - John Furby, MD

MEC Representatives

Anesthesia Representative – Mark Ziegler, MD
Pathology Representative – Jonathon Rock, MD
Radiology Representative - Tony Asher, MD
Hospitalist Service Representative – William Forton, MD
Emergency Representative/Chief, Section of Emergency Medicine – Devin Patchell, MD

Committee Chairs

Credentials Committee – Matt Roberts, MD (emergency medicine)
Advisory (peer review) Committee – Laura Kenny, MD (internal medicine)
Ethics Committee – Peter Ruehlman, MD (Heme/Onc)
Oncology Committee – David Drosick, MD (Hem/Onc)

MEC Administrative Ex-Officio Non-Voting Members

Anderson President and CEO – Ken James
Anderson Chief Nursing Officer / Anderson Hospital Site Administrator – Nicole Barnett, DNP
Anderson Vice President of Medical Affairs – Jamelle Bowers, MD
Anderson Chief Operating Officer - Teresa Ash
Anderson Chief Financial Officer – Timothy Prestridge
Regional Chief Medical Officer – Steve Feagins, MD
Market and Anderson Director Medical Staff Services and Mercy Care Clinic – Nissa Walker

Anderson Hospital Executive Leadership

Ken James – Anderson President and CEO
Office: 513-624-4054 Email: KJJames@mercy.com

Nicole Barnett – Anderson Chief Nursing Officer, Anderson Site Administrator
Office: 513-624-4505 Email: NABarnett@mercy.com

Teresa Ash – Anderson Chief Operating Officer
Office: 513-624-4812 Email: TKAsh@mercy.com

Dr. Jamelle Bowers (Internal Medicine) – Anderson Vice President Medical Affairs
Office: 513-624-4503 Email: JRBowers@mercy.com

Tim Prestridge – Anderson Chief Finance Officer
Office: 513-624-4059 Email: TLPrestridge@mercy.com

Melissa Tillery - Interim Anderson Director of Quality
Office: Email: MTillery@mercy.com