

Practitioner Orientation



WASHINGTON REGIONAL MEDICAL CENTER
3215 N North Hills Boulevard
Fayetteville, Arkansas 72703
(479) 463-1000
www.wregional.com

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Welcome

Dear Practitioner,

It is my pleasure to welcome you to the Washington Regional Medical Staff. This orientation packet has been designated to help you become familiar with Washington Regional and includes information you will want to know before your first day in the hospital.



We have put together a simple but relevant Provider Orientation program for you to acquaint you with the information we believe you need for a successful onboarding experience. The materials allow you to ‘orient’ at your convenience.

Please make some time to review the enclosed information. For further questions, please feel free to contact Medical Staff Services at medstaff@wregional.com or (479) 463-7981.

Best regards,



David G. Ratcliff, MD
Chief Medical Officer

About Washington Regional

Washington Regional opened its doors on August 28, 1950 as “Washington County Hospital” with 50 beds, 27 physicians, and 65 employees.

Today, Washington Regional is a non-profit acute care facility licensed for 366 beds with the areas largest and most diversified medical staff of 433 physicians representing almost every specialty, 154 Allied Health Professionals, and 2,700 employees. We’ve been consistently named the area’s healthcare provider of choice by the nation’s largest and most comprehensive independent study measuring hospital performance and consumer preferences.

Washington Regional Medical System is a network of a hospital and clinics serving 5 counties across Northwest Arkansas. More people in Northwest Arkansas turn to Washington Regional for maternity care, emergency services, inpatient, and outpatient hospital services than any other hospital or health system in the region.

National Ranking: Washington Regional Medical Center has been named one of the nation’s Best Regional Hospitals by U.S. News & World Report. Washington Regional is the only hospital in Northwest Arkansas to be recognized by the publication.

Mission - Washington Regional is committed to improving the health of the people in communities we serve through compassionate, high quality care, prevention and wellness education.

Vision - To be the leading healthcare system in Northwest Arkansas – the best place to receive care and the best place to give care.

Values - To treat others – patients and their families, visitors, physicians, and each other – like we would want to be treated.

[Click here for a list of all the Washington Regional Clinics & Facilities](#)



Quality and Recognition at Washington Regional



Washington Regional is committed to providing high-quality, safe and effective care throughout the communities we serve, and our achievements have consistently garnered national recognition.

General Information:

- Accredited by the Joint Commission
 - Gold Seal of Approval
- Certified Total Joint Center
- Cancer Support Home
- Hospitalist Program
- Walker Heart Institute
- Willard Walker Hospice Home
- Arkansas SAVES Stroke Center
- Accredited Chest Pain Center
- Level II Trauma Center
- Region's only Hybrid Operating Suite
- Advanced certification as a Primary Stroke Center



Washington Regional Medical Center became the first healthcare provider in its primary service area – Benton, Boone, Carroll, Madison and Washington counties – to earn The Joint Commission's Gold Seal of Approval® and the American Heart Association/American Stroke Association's Heart-Check mark for Advanced Certification for Primary Stroke Centers. The Gold Seal of Approval® and the Heart-Check mark represent symbols of quality from their respective organizations.

"Simply put, Washington Regional offers comprehensive care at the highest level of quality and safety. The breadth and depth of our hospital and physician services make Washington Regional the leader in Northwest Arkansas."

Dr. David Ratcliff
Chief Medical Officer





Information for the New Member

Your Medical Staff is governed by the Medical Executive Committee which is made up of two departments; Medicine Control Committee and Surgery Control Committee. The Control Committees are chaired by Departmental Chairman and the Executive Committee by the Chief of Staff. Medical Executive Committee has final authority in all Medical Staff matters.

Your Service is chaired by your Service Chairman who sits on a Departmental Control Committee. You may bring issues to your Service Chairman who will decide where the issues will be heard.





MEDICAL STAFF LEADERSHIP

2016-2017



MEDICAL STAFF OFFICERS

CHIEF OF STAFF

Sam Turner, MD (Emergency Medicine)

VICE CHIEF OF STAFF

Larry Armstrong, DO (Neurosurgery)

IMMEDIATE PAST CHIEF OF STAFF

Randall Hightower, MD (Gynecology)

MEDICAL EXECUTIVE COMMITTEE

Sammy Turner, MD -Emergency Medicine

Larry Armstrong, DO -Neurosurgery

Randall Hightower, MD -Obstetrics/Gynecology

Michael Moulton, MD -Nephrology

Susan Ferguson, MD -Family Practice

Mark Moss, MD -Radiology

Kris Hanby, MD -General Surgery

Mary Pat Hardman, MD -Obstetrics/Gynecology

Richard McWhorter, MD -Urology

Chief of Staff, Chair

Chief of Staff-Elect, Vice Chief of Staff

Immediate Past Chief of Staff

Medicine Department Chair

Medicine Department Member-at-Large

Medicine Department Member-at-Large

Surgery Department Chair

Surgery Department - Member-at-Large

Surgery Department - Member-at-Large

MEDICINE DEPARTMENT CONTROL COMMITTEE

Michael Moulton, MD -Nephrology

Michael Bolding, DO -Hospitalist

Alan Diamond, MD -Neurology

Eric Sale, MD -Radiology

Chad Paschall, MD -Internal Medicine

Elizabeth Sharp, MD -Emergency Medicine

Meredith Denton, MD -Pediatrics

William Burt, MD -Hospitalist

Department Chair, Medicine Control Committee Chair

Department Vice Chair

Service Chair -Neurology

Service Chair -Imaging Services

Service Chair -Internal Medicine

Service Chair -Emergency Department

Service Chair -Pediatrics

Service Chair -Family Medicine

SURGERY DEPARTMENT CONTROL COMMITTEE

Kris Hanby, MD -Orthopedics

Paul Farris, MD -Otolaryngology

Stanley Strickland, MD

Kellye Smith, MD

Laura Collins, MD

Larry Armstrong, DO

Stephen Cashman, MD

Lucas Campbell, MD

Adam Childs, MD

Hollis Rogers, III, MD

Tom P. Coker, MD

Aneet Sharma, MD

Jon Berry, MD

Department Chair, Surgery Control Committee Chair

Department Vice Chair

Service Chair -Anesthesiology

Service Chair -Ophthalmology

Service Chair -Obstetrics/Gynecology

Service Chair -Neurosurgery

Service Chair -Otolaryngology

Service Chair -Pathology

Service Chair -Urology

Service Chair -General Surgery

Service Chair -Orthopedics

Service Chair -Oral Maxillofacial Surgery

Service Chair -Trauma Services



Medical Staff Meetings



Medical Executive Committee

3rd Monday of Each Month

(Except the months where the 1st falls on a Tuesday)

Surgery Control Committee

1st Tuesday of Each Month

Medicine Control Committee

1st Wednesday of Each Month

Physician Peer Review Committee

2nd Wednesday of Each Month

Credentials Committee

4th Tuesday of Each Month

Medical Ethics Committee

3rd Tuesday – once a quarter

Bylaws Committee

Twice a year and as needed

Critical Care Committe

4th Thursday – once a quarter

CME Committee

Once a year and as needed

Infection, Prevention, & Control

4th Tuesday – once a quarter

Pharmacy & Therapeutics

4th Tuesday – once a quarter

Physician Health Committee

As needed

Trauma Services Operations Committee

3rd Wednesday – once a quarter

Annual General Medical Staff Meeting

1st Monday of November Each Year

Trauma Services PI Committee

3rd Wednesday – once a quarter

Washington Regional Executive Team



Bill Bradley
President/CEO



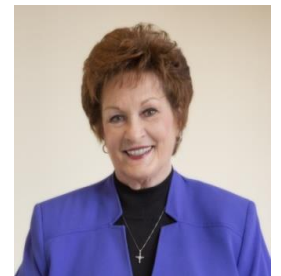
Tom Olmstead
Senior VP
General Counsel



David Ratcliff, MD
Chief Medical
Officer



Dan Eckels
Senior VP / Chief
Financial Officer



Beverly Winney
Senior VP / Chief
Nursing Officer



Mark Bever
EVP / Administrator



Becky Magee
Chief Information
Officer



Steve Percival
VP Human
Resources



Kristy Spruell
Corporate
Compliance Officer



Larry Shackelford
Senior VP
Outreach Services



Rob Bomstad
VP Physician
Enterprise



Tim Hudson
Executive Director
of Foundation

“No matter how much we grow, we will keep focusing on growth that meets the community’s needs.”



Keeping pace with our rapidly growing region can sometimes be a challenge. But Washington Regional has been able to respond effectively to the changing healthcare needs of area residents by listening carefully and paying attention to their concerns.

That kind of focus is why Washington Regional Medical Center is experiencing growth at an unprecedented level. Counting projects currently underway, the size of Washington Regional's North Hills campus will have doubled from 2002 to the beginning of 2017.

Yes, as the Northwest Arkansas population grew, Washington Regional grew along with it, but there's more than just an influx of new residents fueling this expansion. Through the years, as the need for advanced healthcare services became evident, Washington Regional invested in skilled staff and innovative technology to provide them. As more people chose Washington Regional for their care, we increased our capacity to accommodate them. An illustration on page 5 of this report outlines the services and facilities we have added to provide care that focuses on meeting the unique needs of this community.

Everyone on the Washington Regional team is focused on meeting those needs. Throughout this report, you will learn about physicians who are pioneering new lifesaving treatments, nurses who have studied and trained to earn advanced certifications, and countless support staff members who are committed to ensuring excellent patient care.

No matter how much we grow, we will keep focusing on growth that meets the community's needs. Before we decide to expand our square footage or add new services, we will always consider how the growth will help us fulfill our mission of improving the health of the communities we serve.

And because Washington Regional is focusing on what the community needs, you can be sure that we're not only growing with you, but also growing for you.

A stylized, handwritten signature in dark blue ink that reads "WLB".

William L. Bradley
Chief Executive Officer

Medical Staff Services



medstaff@wregional.com

463-7981 Phone

463-5345 Fax



Normal Hours of Operation: Monday – Friday 8:00AM – 4:30PM

Medical Staff Services Manager

(MSS Department Management and Meeting Management)

Sheilah Cornwell

463-1075

scornwell@wregional.com

Senior Credentialing Specialist

(Credentialing, Privileging Applications, and Meeting Management)

Joy Frick

463-1704

ddemars@wregional.com

Credentialing Specialist

(Credentialing, Privileging Applications, and Meeting Management)

Deanna DeMars

463-5077

ddemars@wregional.com

Credentialing Analyst

(Office Management, Database Management, Students, and Observers)

Patricia “Trisha” Holt

463-6520

pholt@wregional.com

Clerical Coordinator

(CME Program Management, Assist Administrative Assistant)

Maria Grace

463-1568

mgrace@wregional.com



General Information



MEDICAL STAFF SERVICES

We're located on the garden level of the hospital, just past the Physician Dining Room / Lounge.

Please notify Medical Staff Services regarding any of the following matters:

- changes to your office such as address, office manager, phone number, etc.
- changes to your home address, email address / telephone numbers, etc.
- requests to change category status or to terminate membership, request for leave of absence, and return from leave.

REFERENCE DOCUMENTS

The Medical Staff Bylaws, Rules and Regulations, and Policies are available on the Washington Regional Medical Center internet website, bottom of the page:

<http://www.wregional.com/main/medical-staff-services.aspx>

Please be sure to review the following documents:

- Medical Staff Bylaws
- Medical Staff Rules and Regulations
- Medical Staff Policies
- Allied Health Professional Policy

CONTINUING MEDICAL EDUCATION (CME) CREDITS

The Arkansas State Medical Board requires 20 CME hours annually as a condition of renewal. Conferences are offered at the hospital on an on-going basis. You may find a schedule on the Washington Regional internet; look for "CME Opportunities".

<http://www.wregional.com/main/medical-staff-services.aspx>

For questions please contact the CME Coordinator at 463-6520 for any questions.





General Information



OBTAINING A BADGE

ID badges are to be worn at all times while on duty and must be worn facing forward at or above the waist with the photo, name, and department clearly visible. There are many uses for the ID badge, such as access into the hospital, various work areas, practitioner lounge, Health Information Services (Medical Records), as well as designated practitioner parking.

Once the online orientation has been completed, you will be able to obtain an identification badge from Medical Staff Services. For questions, you can call the office at 463-7981. Please note that in order to be obtain your badge form, you will need to present your driver's license, passport, military or government issued identification (if not performed during the credentialing process), so that your identity can be validated. (TJC Standard MS 4.10).

REPLACEMENT BADGE

If your ID badge is lost or stolen, please contact Medical Staff Services for a replacement as soon as possible. It is very important to report when your badge is missing so that Medical Staff Services or Security can inactivate the badge.

**If after hours, please contact Security at 463-1170.*

MAIL

Does Medical Staff Services we have *your* correct email address?
All correspondence from the hospital is primarily **electronic**. Please verify your email address with Medical Staff Services and provide an alternate email such as an Office Manager to ensure you receive timely notices and pertinent information.



Email Us!



General Information

DOCTORS DINING / LOUNGE

- Available to all Medical Staff, Residents, Allied Health Professionals, and Students.
- Located on the garden level of the Hospital, adjacent to the cafeteria through the double doors, on your right.
- Workspace and computers are available at your convenience.
- Lunch is served Monday – Friday 11:00AM – 1:30PM



Meals are available in the cafeteria as follows:
6:30AM – 10:00AM and 10:30AM – 7:30PM

Important Contact Numbers

From any hospital phone, dial the extension below. From an outside phone, dial 463 and then the 4 digit extension below.

- | | | |
|--------------------------------|------|--------------|
| • House Supervisor | 7777 | |
| • Bed Control (available 24/7) | 7111 | Fax 463-7112 |
| | | |
| • Administration | 5000 | |
| • Business Office | 6000 | |
| • Case Management | 1194 | |
| • Central Scheduling | 5555 | |
| • Clinic Administration | 1400 | |
| • Compliance | 7640 | |
| • Health Information Services | 1076 | |
| • Health Partners | 2597 | |
| • Medical Staff Services | 7981 | |
| • Security | 1170 | |
| • PBX Operators | 1000 | |



Hospital Codes & Emergency Numbers

EMERGENCY PHONE LINE # 1234

This # tells operators it's an emergency

TREX

#3333

Red-----Fire

White-----Hazmat/Bio-Terror Emergency

Yellow-----Internal/External Disaster

Green-----Missing/Escaped Patient (16 years & older)

Purple-----Combative Patient

Gray-----Tornado approaching hospital

Silver-----Active Shooter on hospital grounds

(Code Silver: Run, Hide, Fight)

Pink----- Infant/Child Abduction (Under 16 years)

Black----- Bomb Threat/Suspicious Letter

Cardiac Conference----Cardiac/Respiratory Emergency

Using Fire Extinguishers(PASS)

P-Pull safety pin

A-Aim at the base of fire

S-Squeeze the handle

S-Sweep side to side

Hazardous Waste Spill (CLEAN)

C-Contain the spill

L-Leave the Area

E-Emergency Care

A-Access the MSDS

N-Notify Supervisors

Fire Safety (RACE)

R-Rescue

A-Alarm

C-Contain

E-Extinguish/Evacuate



Employee Health

463-1593 Phone

463-5438 Fax

Normal Hours of Operation: Monday – Friday 7:00AM – 3:30PM

The following Employee Health services are available for practitioners credentialed with Washington Regional:

- PPD (TB Skin Test)
- TB Mask Fit Test
- Flu Vaccine

INFLUENZA VACCINATION POLICY

Medical Staff , Allied Health, Students, and House staff at Washington Regional Medical Center, must have the influenza vaccine annually at the beginning of the flu season, as defined by the CDC, and no later than the first Friday in December. The vaccine is available free of charge to anyone with a valid Washington Regional ID badge thru the Employee Health office, or the practitioner may provide documentation to Medical Staff Services of vaccination performed at another site.





Compliance

7 Elements of an Effective Compliance Program

- Policies & Procedures
- Internal monitoring & auditing
- Compliance Office
- Training and Education
- Communication
- Responses & Remediation
- Enforcement & Discipline



Your Role in Compliance

- The Washington Regional Code of Conduct tells us to ask ourselves some of these questions when the “right” thing is unclear:
 - Is it inconsistent with our mission or values?
 - Is it illegal?
 - Could it harm government programs?
 - Could it harm our financial health?
 - Would it be uncomfortable reading about it in the paper?
 - Could it harm my co-workers?
 - Is it unethical?
 - Could it harm patients?
 - Is it fair?
- **Trust your “gut”**
 - If something feels wrong, it probably is
 - When in doubt, ask
- **Know how to ask questions**
 - There is no such thing as a stupid compliance question
 - If you see something, say something.

Washington Regional non-retaliation policy

- Protects you from retaliation or retribution, meaning you will not be penalized, for reporting what **honestly** believe to be a compliance program problem or for **honestly** participating in a compliance investigation.

Kristy Spruell, JD, Corporate Compliance Officer

ksprell@wregional.com

463-7640

Compliance Hotline

compliance@wregional.com

463-7641



WRMC Clinical Informatics

David Ratcliff, MD
Chief Medical Officer
463-6004

Terri Church, MSN, APN, ACNS-BC, CPPS
Director of Quality and Clinical Informatics
463-1826

Merri Roy, BSN, RN-C
Clinical Informaticist
463-4246



Washington Regional Medical Center uses Cerner PowerChart for our Electronic Medical Records System (EHR). We provide a webpage with links to the applications needed to access our network and our EHR from your location.

Please visit this site for the latest instructions and applications for accessing our network: <http://www.wregional.com/vpnclient/>

Our Help Desk can provide assistance in installing the necessary software on your system, most password resets, excluding Cerner Support Accounts, and generate tickets for our technicians to call you back if you are experiencing difficulties.

Physician Help Line
463-2222



Cerner

IS Physician Help Desk: from any hospital phone, dial 2222 or 463-2222.

REMOTE ACCESS TO CERNER

To access the Cerner CPOE system remotely, visit this link for information on installing the VPN client on your laptop: www.wregional.com/vpnclient for instructions for Windows or Mac.



Questions can be answered by calling the IS Physician Help Desk.

Password Requirements

The first time you login to your VPN or Cerner account, your password will need to change. Please note that changing your Cerner password **DOES NOT** change your network password.

The Washington Regional password requirements are:

- Minimum of 8 characters in length that do not form a word or name, or is part of your login ID
- Must contain at least one uppercase character of European languages (A through Z, with diacritic marks, Greek and Cyrillic characters)
- Must contain at least one lowercase character of European languages (a through z, sharp-s, with diacritic marks, Greek and Cyrillic characters)
- Must contain at least one digit (0 through 9)
- Special characters can be used in your password: ~!@#\$\$%&* _ - +='\|(){}[]:;'"<>.,?/
- Password cannot be reused until 4 change cycles have occurred
- The Washington Regional systems will force the password to change every 90 days



Admissions / Bed Control



Available 24/7

463-7111 Phone

463-7112 Fax



Contact Bed Control for hospital admission, including direct admits. They must receive an order for admission. Make sure to include the patient status on all orders; the choices are Inpatient, Observation, or Outpatient in a Bed. Once orders are received, Bed Control will assist with bed arrangements.

CPOE ORDERS FOR DIRECT ADMITS

Call Bed Control to make bed arrangements for direct admits. State that you will be entering orders via CPOE. **Ask Bed Control to create a CPOE encounter.**

Bed Control will need the following:

- Patient Name (accurate spelling of patient's name)
- Date of Birth
- SSN
- Gender
- Phone #



Bed Control will create the CPOE encounter *or* give the information to the Admitting staff to create an encounter. Please allow 15 minutes for encounter to be added into Cerner.

The patient will still need to check in with Admitting to provide ID, insurance cards, and sign admission papers upon arrival.

CPOE ORDERS FOR SCHEDULED SERVICES

When a physician/office calls to schedule an appointment and they wish to enter CPOE orders, they must provide the following information:

- Patient Name, Date of Birth, and SSN
- Insurance ID
- Pre-Cert information if required by payer – **this must be given at the time scheduling or appointment may not be scheduled**
- Exam name
- Diagnosis – ensures medical necessity is met

Scheduling will create the encounter and enter all the above data to obtain a slot on the schedule. The diagnosis given by the physician will be entered by Scheduling at the time of encounter creation, which will be retained on the CPOE order. The order type will be entered as Phone with read back, which will cause the order to flow to the physician's list in CERNER for a signature.



Scheduling

Routine Scheduling Encounter

- Physician will call Central Scheduling and request that an encounter be created.
- Provide the required scheduling information listed above.
- Scheduling will create the encounter and schedule the appointment in CERNER.
- Physician will log into CERNER after the scheduled appointment has been created and will electronically sign the order.
- Physicians will not enter the order again because it will already be entered by Scheduling during the phone call.

Emergent Imaging Add on cases today (during Scheduling hours)

- Physician will call Central Scheduling and request that an encounter be created.
- Provide the required scheduling information listed above.
- Scheduling will inform physician if pre-cert is required. Office staff must obtain pre-cert or patient sign a waiver for full responsibility before exam can be performed
- Scheduling will create the encounter and obtain a work in slot in CERNER.
- Physician will log into CERNER after the scheduled appointment has been created and will electronically sign the order.
- Physicians will not enter the order again because it will already be entered by Scheduling during the phone call.

Surgery Cases (Routine and Add On)

- Physician will call Surgery Scheduling and request that an encounter be created.
- Once the encounter has been added the physician should log into CPOE to enter the orders on the scheduled FIN.

Hours & Contact Numbers

Scheduling		
Central Scheduling	Mon - Fri 0800 - 1730	Ph 463-5555 Fax 463-5559
Walker Heart	Mon - Fri 0800 - 1630	Ph 463-1128 Fax 463-5559
Surgery	Mon - Fri 0800 - 1630	Ph 463-1117 Fax 463-1118
Admissions		
Main Admissions	Mon - Fri 0700 - 1900	Ph 463-1086
ER	24/7	Ph 463-1044
West Springdale	Mon-Fri	Ph 463-5660
Wound Care	Mon-Fri	Ph 463-4346
Walker Heart	Mon - Fri	Ph 463-1244
PASS	Mon - Fri 0500 - 1630	Ph 463-5930
OP CT	Mon - Fri 0730 - 1500	Ph 463-2600
Surgery	Mon - Fri 0400 - 1700	Ph 463-1038
Pre-Registration		
Surgery	Mon - Fri 0800-1830	463-5081 or 463-5080
Imaging	Mon - Fri 0800 - 1730	463-5082 or 463-5085
Cardiology	Mon - Fri 0800 - 1630	463-1254 or 463-5052

Health Information Services

463-1076 Phone

463-1239 Fax

HOURS OF OPERATION

- **Release of Information:** 8:00AM - 4:00PM Monday – Friday
- **HIS weekday hours:** 7:00AM - 12:00AM (midnight) Monday - Friday
- **HIS weekend hours:** 7:00AM - 3:30PM Sunday and Saturday

SERVICES PROVIDED

HIS is responsible for: Maintaining the medical record received from the units. The department abides by Medical Staff Bylaws and JCAHO requirements, ensuring the records are completed by physicians. Completion includes signatures and required dictated reports including:

- Transcribing reports dictated by the physicians.
- Coding of charts which starts the process for billing and reimbursement of hospital provided services.
- Release of information. Any requests for copies of medical records for continuing care, insurance payment, attorney request etc. are processed in our department by a contract service, ChartOne. All request for records required a signed HIPAA compliant authorization. A copy of an authorization can be obtained in HIS.
- HIS also supports the medical units by providing copies of records or printed portions of records for patient admissions. HealthMedx is available on all floors to view and print any documentation needed immediately from transcribed reports to radiology reports.





WRMC Dictation Number



463-2500 Phone

1 Pause	2 Dictate	3 Rewind
4 Fast Forward	5 Go to End	6 End Report – Begin a new Report
7 Listen	8 Disconnect	9 Go to Beginning
* Main Menu	0 Speak Job Info	#

CONNECT

1. When prompted, Enter your 4-digit User ID use a leading zero if only 3-digits. Example: 0123
2. Enter the 2 digit Work Type

01 – Pre-surgical History & Physical

02 – History & Physical

03 – Consultation

04 – Cardiology Progress Note

05 – Operative Note

07 – Critical Care Note

08 – Discharge Summary

09 – Sleep Study HP

11 – EKG

12 – Letters

13 – ER Notes

51 – Procedure Note

64 – Phys. Progress Note

91 – Sleep Progress Note

93 – Nocturnal Poly Sleep

3. Enter the 10 digit Account Number

RECORD

Begin dictating after the tone

1. To PAUSE: Press 1
2. To RESUME: Press
3. When you are finished with the report and ready to dictate another:
Press {6} to end the first report.

4. The system will speak JOB NUMBER to write on the chart.

5. Enter next 2-digit Work Type

6. Enter next 10-digit Account Number

7. Repeat for each report

8. When finished with session, Press {8} then {1}

9. The system will speak JOB NUMBER to write on chart

10. Then hang up phone

**Ask Medical Staff Services or Health
Information Services for a details
Dictation Instructions Card!**



Case Management



Department Overview

Karen McIntosh, Case Management Director

The utilization review process encompasses all clinical areas of the hospital, including inpatient, outpatient observation, emergency department and pre-admission reviews. All admissions to the facility are screened for appropriateness of admission, level of care, appropriate utilization of resources and discharge planning based pre-determined screening criteria. The utilization review process and discharge screens are discussed with the attending physician and if resolution has not occurred, are referred to a Physician Advisor for review. The Utilization Review Committee also reviews cases and as needed. Appropriate referrals are made to Risk Management, Quality Management, Infection Control, Rehabilitation, Dietary, Pharmacy, Skin Care Program, and other ancillary departments as needs and/or questions are identified through case review.

Performance Objectives

- Maintain Medicare ALOS at or below budget target
- Maintain Overall LOS at or below budget target
- Maintain Medicaid ALOS at or below budget target
- Maintain Self Pay ALOS at or below budget target
- Reduce denial rate by payers
- Reduce Focus DRG LOS to GMLOS
- Maintain Observation Visits and LOS below budget targets
- Maintain 30 day readmission rates consistent with benchmarks
- Assessment within 24 hours of Discharge Planning Consult request



Organizational Structure and Staff Resources

Case Management Department Director – Provides Organization and management of the function, policies, procedures, budget and staff of the Case Management Department in accordance with the philosophy, goals and mission of Washington Regional Medical Center, standards of care, regulatory requirements and accreditation guidelines.

Manager of Case Management and Social Work- Provides direct supervision of the Case Managers, Social Workers, and Utilization Review team members.

Case Management Continued...

Case Manager - Performs review of documentation and resource management in accordance with state, federal guidelines and hospital/department Policy and Procedures. Conducts medical necessity reviews to determine appropriate status assignment, level of care and continuing care needs.

Social Worker – Performs psychosocial assessment, and reassessment, develops and implements the patient's discharge plan in accordance with the standards of care and makes appropriate community referrals.

How to Contact the Case Manager

You may contact the *Case Manager or Social Worker assigned to your unit* for questions about medical necessity or discharge planning services. If you need assistance locating the Case Manager or Social Worker, please call 463-1194.

- *Admission Case Managers* are available 7 days a week during business hours (0800-1830) to assist in the process of ensuring that patients are admitted to the correct status. Admission Case Managers can be reached at 463-7183.

Monday through Friday: every two units have a Social Worker and Case Manager team. Follow-up with patients and families on continuing discharge planning needs may be best coordinated by the Unit-based Case Manager, Monday through Friday. Requests for new post-acute provider referrals or DME may not be readily coordinated after-hours and on weekends as payor authorization and service provider admissions personnel are not available to finalize decisions. Please help to facilitate timely discharge planning by obtaining orders during normal business hours, whenever possible.

Weekend Coverage: Case Management and Social Work are in house and available to assist with discharge needs. Please page through the operator.

Holiday Coverage: Case Managers and Social Worker are in house and available to assist with discharge needs. Please page through the operator.

Emergency Department: has both a Social Worker and a Case Manager to assist with placement of Emergency Department patients. The Social Worker is primarily focused on arranging for psychiatric patient placement.



Laboratory Services

WRMC laboratory is accredited by the College of American Pathologists.



Laboratory personnel for contact:

- Lucas Campbell, MD, Laboratory Medical Director 463-1126
- Kathryn Miller, BSMT (ASCP), Administrative Director 463-5059
- Karen Jarlos, BSMT (ASCP), Assistant Director 463-5757
- Paula Dodd, BSMT (ASCP), Core Lab Supervisor 463-5250
- Stacy McCaslin, BSMT (ASCP), Blood Bank Supervisor 463-5257
- Stephanie Frink, BSMT (ASCP), Microbiology/Serology Supervisor 463-1157
- Cathy Johnson, Office Manager, 463-5259 or 463-5226

Outreach Services

The laboratory has partnered with Quest Diagnostics. WRMS clinic computer systems are interfaced with Quest so orders flow to Quest and laboratory results flow back to the clinic information systems. WRMC laboratory performs non-esoteric testing for Quest, including Stat orders and microbiology cultures.

- Quest has a Patient Service Center for specimen collection at the following local locations:
- 3271 N. Wimberley Drive, Suite 2 in Fayetteville.
- 1200 SE 28th Street in Bentonville.
- The Har-Ber clinic at 813 Founders Park Drive in Springdale.

There must be an order in a Washington Regional Medical System clinic software, the Quest computer system or an order provided to the patient for laboratory testing to be performed.

Outpatient specimen collection is also performed in the admissions area at Washington Regional. An order must be submitted to the Washington Regional Scheduling office, the Admissions office or provided to the patient for laboratory testing to be performed.

Washington Regional Laboratory does provide collection services for special testing: These collections should be scheduled with the laboratory office at 463-5226.

- Semen analysis (fertility and post vasectomy). Form and instructions available through laboratory office.
- We collect and send out specimens to other laboratories for transplant follow-up testing.

Therapeutic phlebotomy – should be scheduled through Washington Regional Medical Center Scheduling, as it requires a bed and a nurse.



Laboratory Services Continued...

Laboratory Testing Services

The WRMC laboratory has a large in-house menu and strives to add additional assays to meet the needs of the providers. An example of uncommon tests on the menu includes:

Hematology/Coagulation

- Thromboelastograph (TEG, TEG platelet mapping and Rapid TEG)
- Verify Now (p2y12 and aspirin assays)
- Anti Xa heparin assay

Serology

- Procalcitonin

Chemistry

- Beta hydroxybutyrate

Microbiology

- Rapid microbial identification via MALDI (mass spectrometry) provides organism identification 24 hours faster than conventional identification methods.

Transfusion Medicine

- Antibody identification
- DNA antigen typing is sent to the Community Blood Center of the Ozarks for patients with multiple and challenging antibody profiles to provide blood products specific for the patient. This is determined by the blood bank staff.



Imaging

Radiologists

Eric Sale, MD

Barry Wetsell, DO

Ralph Panek, MD

Jong Park, MD

Mark Moss, MD

Kremer Nicholas, MD

Jarrett Sanders, MD

Imaging Leadership

Amy Jetton, Director of Imaging and Cardiovascular Services

Joanna Taylor, Imaging Administrative Manager

Jason Tice, RIS / PACS Coordinator

Doug Chambers, RIS / PACS Coordinator

Tonia McKinnie, Diagnostic Imaging Coordinator

Alison Wilson, CNMT, Radiation Safety Officer





Imaging



Diagnostic Imaging

- 6 Radiography and / or Fluoroscopy Units
- 4 C-Arms
- 4 Portables
- Bone Density

Computerized Tomography - CT

- Emergency Department (320-slice scanner)
- Inpatient (128-slice scanner)
- Outpatient (64-slice scanner)

Magnetic Resonance Imaging - MRI

- MRI Scanner
 - HDx 23 1.5 Tesla
 - Siemens Skyra 3T (4th Quarter 2016)

Nuclear Medicine

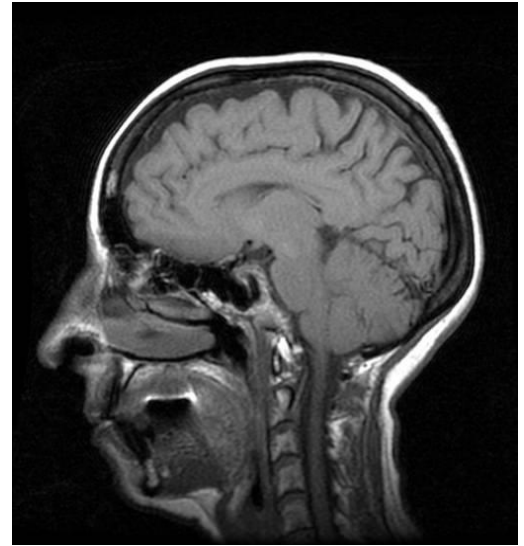
- 3 Nuclear Medicine Gamma Cameras
 - Dedicated Cardiac
 - Cardiac Stress Testing Monday - Friday

Ultrasound

- 5 Portable Units
- 3 Procedure Rooms

Interventional Radiology

- Interventional Radiology Suite
- Interventional Procedures Performed
 - Angiography: Balloon angioplasty / stent
 - Embolization (Chemo, Y90 Radioactive, Uterine Fibroid, etc)
 - Line insertions (PICC, Central, etc)
 - IVC filters
 - Nephrostomy Placement
 - TIPS
 - Thoracentesis, Paracentesis
 - Thrombolysis
 - Biopsy
 - Vertebroplasty / Kyphoplasty
 - Dialysis access
 - Biliary interventions
 - Drainages, Aspirations, Injections
 - Drain insertions





Infection, Prevention, and Control



GENERAL INFORMATION

Urinary catheters should be inserted *only* when medically necessary and should be evaluated *daily* for medical necessity. Urinary catheters should never be used solely for the convenience of healthcare workers.

Urinary Catheter (aka Foley) should be removed as soon as possible in the post-op period, and unless a contraindication is documented by the physician within 48 hours of completion of surgery. Any contraindication for removal or reason for Foley must be documented each day. Hourly monitoring of urine output outside of the critical care area is not an approved reason for Foley catheter use on wards.

HAND HYGIENE

Hand hygiene shall be used prior to insertion, removal, Foley care and anytime the catheter is manipulated (examples include specimen collection, patient transfer and ambulation). Hand hygiene shall consist of hand washing with soap and water or the use of a waterless alcohol-based hand rub. Educate the patient on hand hygiene at the bedside.





Infection, Prevention, and Control



DAILY REVIEW OF FOLEY NECESSITY

Daily review of Foley necessity is crucial to prompt removal. It shall be the responsibility of medical staff, and nursing staff, to evaluate catheter necessity on a daily basis.

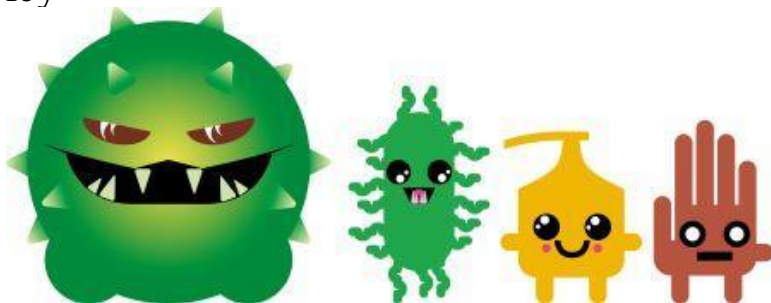
SITE MANAGEMENT

- Routine perineal care with soap, clean water and clean washcloth daily and PRN.
- Sheeting Clip used to prevent dependent loop
- Drainage tubing and bag below bladder
- Bag/Meter not touching floor (floor placement only with Foleys designed for floor placement such as CritiCore)
- Separate clean container for each patient for urine measurement

MONITORING

Nursing personnel shall monitor the patient at least daily for and document signs of infection, such as (but not limited to):

- Fever (>38 C/100.4 F)
- Suprapubic tenderness
- Costovertebral angle pain or tenderness (with no other recognized cause)
- Dysuria, urgency, painful urination, or frequency that occurs >24hr after removal of Foley



Antibiotic Stewardship Program (ASP)

The Antibiotic Stewardship (ASP) is a program or series of interventions to monitor and direct antimicrobial use at a health care institution, thus providing a standard, **evidence-based** approach to judicious antimicrobial use. In other words..."Right drug at the right dose for the right duration".

- 30%-50% of all hospitalized patients receive a course of Antibiotic
- 50%-99% of antimicrobial use is inappropriate
- The most common reasons for inappropriate antibiotic use are that the duration of therapy is too long or the antibiotic dose is suboptimal.



Antibiotic Stewardship standards are monitored by The Joint Commission (TJC) and by the Committee for Medicare and Medicaid Services (CMS). Regulatory standards are in place and it is critical that WRMC maintains these standards. A multidisciplinary committee consisting of Infectious Diseases, Pharmacy, Infection Prevention and Control, Laboratory / Microbiology Services, Information Systems, representatives of the Medical Staff and Nursing staff, and Hospital Administration guide the ASP activities at Washington Regional.

The ASP provides unsolicited review by a board-certified Infectious Diseases physician of all inpatients who have any cultures obtained. All restricted or expensive antibiotic are reviewed and we also review for antibiotic redundancies. Recommendations are given via e-mail (Cerner Messaging Center) and placement of a note in the paper chart; these notes are not part of the permanent medical record. These recommendations should be taken as advice. This is not to be confused with a formal ID consultation. When appropriate, national guidelines or relevant literature are referenced in the notes. Compliance rates for individual physicians are available and are reported anonymously back to the prescribers periodically. Standard ASP metrics are also reported periodically to the medical and hospital staff.

Advantages noted with the ASP include a decrease in the total length of therapy (LOT) without adversely affecting patient outcomes. We have also seen a marked reduction in C diff infection (CDI) and we currently rank in the top 10% nationally for CDI. ASP, in combination with Infection Control practices, is also attempting slow the emergence of MDR GNR infection.



Antibiotic Stewardship Program (ASP)

Procalcitonin (PCT) is a biomarker that helps to determine if an infection is bacterial or nonbacterial in origin. It also provides prognostic data as well as helping to guide the duration and necessity of antibiotic therapy. This test is performed “in house” with a turnaround time of about 90 minutes. Length of stay (LOS) and LOT are significantly shorter when PCT guidance of ABX use is available. We have shown that Antibiotic use is **avoided** in about 1/3 of all patients in whom PCT guidance is used. Active research with PCT is ongoing at Washington Regional.

All organisms are now identified at Washington Regional Medical Center via mass spectrometry (MALDI-TOF). This allows organism identification in less than 1 day compared to more than 2 days with standard microbiologic techniques. This provides more rapid information for changing empiric Antibiotic therapy to directed treatment. Shorter LOT leads to a lower risk of Antibiotic-related adverse effects, lower CDI rates, and slows the emergence of multidrug resistant pathogens. Innovative rapid diagnostic techniques are constantly being evaluated by the ASP.

Appropriate and rapid assessment and treatment of sepsis is also monitored by CMS. We have developed 2 “Sepsis PowerPlans” to guide appropriate and rapid treatment of sepsis from door-to-clinical stability. This incorporates automated, computer-generated “Sepsis Alerts” to identify septic patients which allows initiation of evidence-based “Early Goal-Directed Therapy”. Since the establishment of this program the sepsis mortality rate at Washington Regional has fallen from 28.5% in 2012 to 12.5% in 2015.



James “Buddy” Newton, MD
Director of Antimicrobial Stewardship



Central Line Associated Blood Stream Infection (CLABSI)



In the US, 15 million central venous catheter days occur in intensive care units each year. Central venous catheter-related blood stream increase hospital costs and length of stay. About 41,000 bloodstream infections strike hospital patients with central lines each year. Reducing the number of blood stream infections should be a multidisciplinary effort involving those who insert and maintain central venous catheters, infection control personnel, healthcare managers, CEOs, and patients.

CLABSI Prevention Strategies - Catheter/Site Selection and Placement

- Weigh the risks and benefits of placing a central access venous device prior to placement.
- Avoid using the femoral vein in adult patients
- Use the subclavian site, for non-tunneled catheters, rather than the internal jugular or femoral sites in order to reduce risk of catheter-related blood stream infection.
- Use ultrasound guidance for catheter placement, if available, in order to reduce the number of cannulation attempts (this should only be used by practitioners fully trained in this technique).
- Use a central venous catheter with smallest number of lumens required for therapy.
- Promptly remove any catheter that is no longer essential.
- Replace catheter as soon as possible (within 48 hours) when adherence to aseptic technique cannot be ensured.

Central Venous Catheter (CVC) Placement

- Prior to insertion, perform hand hygiene with alcohol foam or soap and water.
- Use maximal sterile barrier precautions for insertion of CVCs, PICCs, or guidewire exchange
- Cap
 - Mask
 - Sterile gown
 - Sterile gloves
 - Sterile full body drape
- Clean skin with >0.5% chlorhexidine preparation with alcohol before central venous catheter insertion and dressing changes. If this is contraindicated, tincture of iodine, an iodophor, or 70% alcohol can be used as alternatives.
- Allow the antiseptics to dry according to manufacturer's recommendation prior to placing the catheter.
 - No recommendation can be made for the safety or efficacy of chlorhexidine in infants less than 2 months.

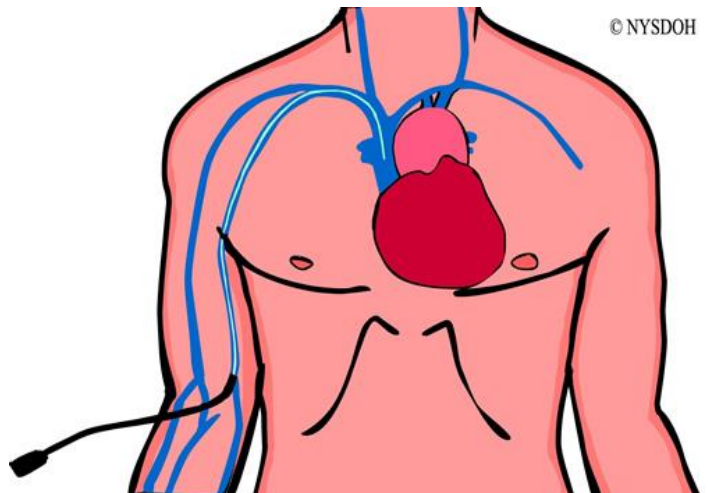
Central Line Associated Blood Stream Infection (CLABSI) Continued...

Dressing Changes

- Use either sterile gauze or sterile, transparent, semipermeable dressing to cover the site.
- If there is oozing at the site, use gauze dressing until this is resolved.
- Replace the dressing if it becomes damp, loose, or soiled.
- Replaced gauze dressings every 2 days and transparent dressings every 7 days.
- Use CHG impregnated sponge dressing for short-term CVCs in patient older than 2 months of age.
- **WRMC uses betadine for skin prep on infants.

Replacement of CVC's

- Do not routinely replace CVCs, PICCs, hemodialysis catheters, or pulmonary artery catheters to prevent catheter-related infections.
- Do not remove CVCs or PICCs on the basis of fever alone. Use clinical judgment regarding the appropriateness of removing the catheter if infection is evidenced elsewhere or if a noninfectious cause of fever is suspected.
- Do not use guidewire exchanges routinely for non-tunneled catheters to prevent infection.
- Do not use guidewire exchanges to replace a non-tunneled catheter suspected of infection.
- Use a guidewire exchange to replace a malfunctioning non-tunneled catheter if no evidence of infection is present.
- Use new sterile gloves before handling the new catheter when guidewire exchanges are performed.



Catheter Associated Urinary Tract Infection (CAUTI)



- Urinary tract infections are one of the most common hospital-acquired infections. 70 to 80% of these are attributable to an indwelling catheter.
- The daily risk of bacteriuria varies from 3% to 7% when an indwelling urethral catheter remains in situ.

Outcomes Associated with CAUTI

- Catheter use is associated with negative outcomes in addition to infection, including nonbacterial urethral inflammation, urethral strictures, mechanical trauma, and mobility impairment.
- CAUTI has been associated with increased mortality and length of stay (increased mortality may be a result of confounding clinical variables).
- Inappropriate treatment of catheter-associated asymptomatic bacteriuria promotes antimicrobial resistance.

CAUTI Prevention Strategies – Appropriate Urinary Catheter Use

- Insert catheters only for appropriate indications and leave in place only as long as needed.
- Minimize urinary catheter use and duration of use in all patients, particularly those at higher risk for CAUTI or mortality from catheterization such as women, the elderly, and patients with impaired immunity.
- Avoid use of urinary catheters in patients and nursing home residents for management of incontinence.
- Use urinary catheters in operative patients only as necessary, rather than routinely.
- For operative patients who have an indication for an indwelling catheter, remove the catheter as soon as possible postoperatively, preferably within 24 hours, unless there are appropriate indications for continued use.



Catheter Associated Urinary Tract Infection (CAUTI) Continued...



Washington Regional Approved Indicators for Indwelling Urinary Catheter

- Terminally ill/comfort care
- Critically ill requiring vasopressors
- Sedated or chemically paralyzed
- Urinary obstruction/retention
- History of neurogenic bladder
- Placement performed by urologist
- Catheter for chronic/long-term use
- Abdominal/pelvic/gynecological/ colorectal surgery or injury
- Incontinent with hourly output
- Diuretic administration with hourly output
- Wound that may be contaminated by urine

Catheter Maintenance Guidelines

- Maintain the tamper-evident seal intact
- Prevent dependent loops or kinks in the tubing
- Perform catheter care daily and prn with soap and water
- Use a securement device (stat-lock) to prevent urethral irritation.
- Assess necessity daily and remove if not indicated
- Maintain drainage bag below the level of the bladder
- Label drainage bag with insertion date





Pain Management

Acute Pain in a patient with Chronic Pain

- More than 75 million patients in the USA suffer from Pain
- Annual National Economic cost is greater than \$500 Billion
- When Acute Pain is not treated in time, it can convert into Chronic Pain
- Chronic Pain is no longer a symptom but a multisystem disease
- Treatment algorithms for Chronic Pain are complex and necessitate the use of multidisciplinary teams

Consequences of Unrelieved Pain

- Poor Sleep
- Reduced mobility
- Longer stays in the hospital
- Increased out patient visits
- Impaired relationships
- Anxiety & Lack of concentration
- Immune impairment / susceptibility to disease
- Unplanned & unnecessary readmissions
- Chronic pain & depression

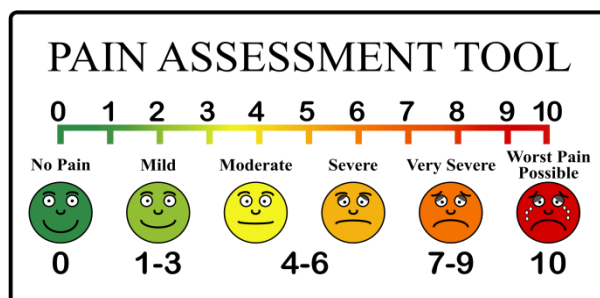
Joint Commission on Pain

Requires Organizations to:

- Recognize the Right of patients to appropriate assessment and management of pain
- Screen patients for pain during initial & periodic re-assessments during their stay
- Educate patients suffering from pain about pain management

Plan

- Treat Acute Pain aggressively & prevent it from converting to Chronic Pain
- Identify & address the cause of Acute Pain (Nociceptive, Idiopathic, Psychogenic & Neurogenic): Recent onset, transient and usually from an identifiable cause
- Treat Chronic Pain (ongoing pain, lasting greater than 3-6 months and adversely affecting the patient's lifestyle) concurrently
- Treat noninvasively as much as possible initially
- **Goal:** Improving function and sustaining quality of life
- A thorough History & Physical is a requirement before treating any patient





Practitioner Parking

PURPOSE

To provide designated parking for patients, visitors, volunteers, physicians, students and employees. This is required to assure that visitors and patients have available parking near the entrances of the hospital.


POLICY

Designated parking is provided for Physicians and CRNA's:

- The **Parking Garage**, located off Appleby Road and adjacent to the new Women and Infants Center, provides parking in a secured, gated area on Level A (the ground level) and is only accessible with an authorized Washington Regional ID badge. The entire garage is video-monitored 24/7. This area of parking is intended for routine, longer-term parking, i.e., all day. Levels B and C are open only to patients and visitors of the Women and Infants Center. Level D is general parking open to all.
- **Lot N** (near Ebbrecht Courtyard) is reserved for short-term and/or intermittent parking, urgent/emergent parking, on-call parking.

All other Allied Health Professionals (APRN's, CNS, PA, etc), Residents, Medical students, physician assistant students, nursing students and all other students should park in areas designated for employees: Lots E, K, L, M, O, S, T, U and V.

All of these areas require a "Parking Permit" which may be obtained from Medical Staff Services.



**Find a map on
the next page!**



= Designated Physician and CRNA Parking

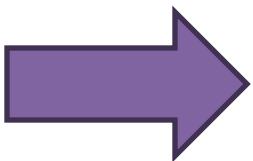




Thank You

Thank you for becoming part of our Medical Staff and being part of the Washington Regional System.

We look forward to working with you to ensure Washington Regional is the best place to receive care and the best place to give care.



Please click here to complete the Practitioner Orientation Attestation and a brief survey.