MetroHealth
Devoted to Hope, Health, and Humanity

ABOUT METROHEALTH

Founded in 1837, MetroHealth is leading the way to a healthier you and a healthier community through service, teaching, discovery, and teamwork. Cuyahoga County's public, safety-net hospital system, MetroHealth meets people where they are, providing care through four hospitals, four emergency departments, and more than 20 health centers and 40 additional sites. Each day, our 8,000 employees focus on providing our community with equitable healthcare—through patient-focused research, access to care, and support services—that seeks to eradicate health disparities rooted in systematic barriers. **For more information, visit metrohealth.org.**

connect @metrohealthcle

MyChart
metrohealth.org/mychart

A GUIDE TO YOUR STAY AT THE

BEHAVIORAL HEALTH HOSPITAL

WELCOME TO THE BEHAVIORAL HEALTH HOSPITAL

Thank you for trusting us with your care. We're here to honor that trust and make sure you receive the safe, high-quality care that you deserve. We want you to go home having had the best possible hospital experience.

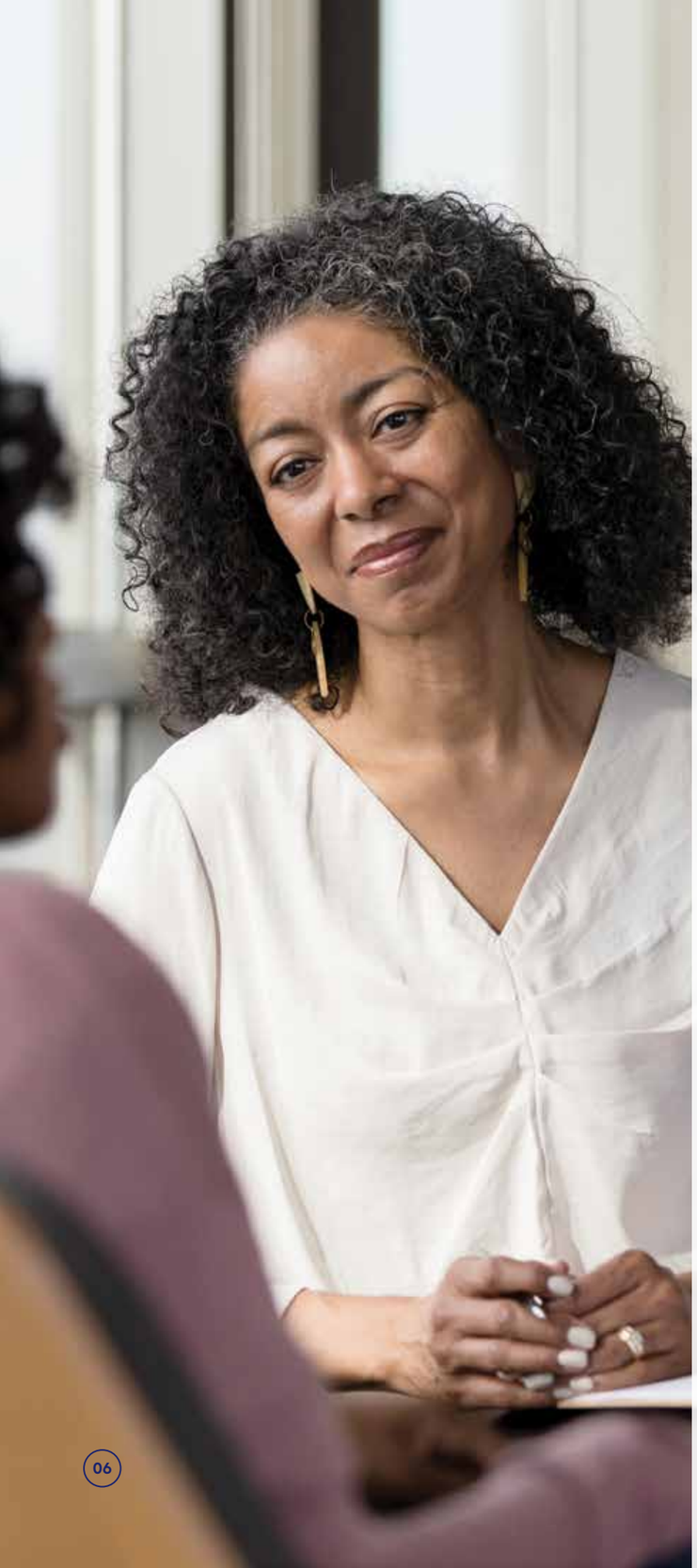
In this guide, we have provided you with some information on what to expect while you are here and what kinds of activities and services we offer.

If there's anything you need or any questions/concerns you have, we will listen and partner with you and your family to help you achieve the best health possible.

Best Regards,

Dr. Elizabeth DeOreo and
The Behavioral Health Team

WHAT'S INSIDE



YOUR CARE TEAM

Your Doctors and Nurses

There will be doctors and nurses that will accompany you throughout your stay.

Attending Doctors

Resident Doctors

Psychologists

Nurse Practitioners

Extra Care

Here is a list of several other care team members that will be helping you during your stay.

Patient Care Nursing Assistant

Behavioral Health Specialist

Social Worker

Nurse Manager

Recreational Therapist

Patient Advocate/Client Rights Officer

We encourage you to ask your care team any questions you have.

YOUR ROOM AND SERVICES

Your Room

Your room is built for your privacy, convenience, and safety. Rooms have a cubby for storing personal property. Other patients are not allowed in your room and you are not permitted in theirs.

Services

Showers and Laundry Room

- **Showers:** Private showers in each patient's room.
- **Laundry Room:** We will help you with your laundry.

Recreation Room/Outdoor Space

A recreation space and outdoor space are available based on your treatment plan.

Lounge

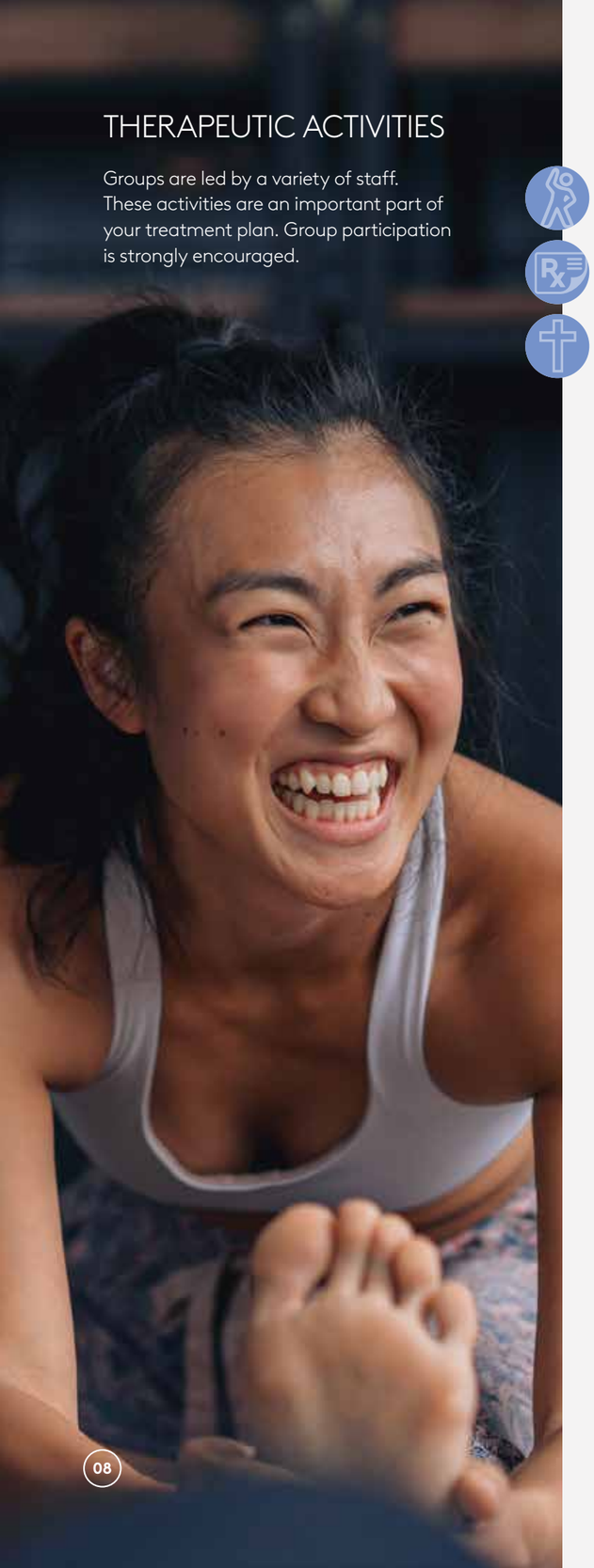
There are several lounges located across from the nurse's station, some designated for quiet and some 'noisy'. Chairs, table and television are in the lounge.

Dining/Multipurpose Room

Meals are scheduled at set times throughout the day.
Your nurse will discuss the daily menu with you.

Telephones

Phones for local calls.
Phone use hours: During your assigned personal time.
Phone call time limit: 15 minutes
When dialing outside of MetroHealth Hospital:
Press "9" then "1" with area code and phone number.



THERAPEUTIC ACTIVITIES

Groups are led by a variety of staff. These activities are an important part of your treatment plan. Group participation is strongly encouraged.

Recreational Therapy: Our recreational therapist will help you develop physically, emotionally and socially while having fun. Recreational therapy will help you relate with others, help you adjust to hospital routine, and provide interesting activities to help you be creative and express yourself.

Note: A recreation therapist will interview you within 24 hours of your arrival (if patient condition allows) and ask you to complete a survey about what you like to do for fun.

M.E.D.S. Group: The Medication Education Discussion and Support group is held by our pharmacist. The purpose of this group is to make sure you know your medication. We encourage you to attend sessions **prior to discharge**. Topics discussed include the importance of following a medication schedule, ways to help you remember to take your medications, methods to help side effects and how you feel about taking medication.

Spiritual Care Services: Spiritual Care is an integral part of the healing process. The Spiritual Care Department's team of clinically trained professional chaplains supports patients, families, and staff in times of crisis due to injury or illness. Chaplains provide comfort, direction, and counseling through a ministry of presence, empathic listening, guidance in prayer, meditation, end-of-life support, sacramental provisions, and worship services.

Chaplains respect the dignity of all persons they serve and do not impose their beliefs or any religious practices on anyone. If you would like to speak to a chaplain, please have a care team member contact us. We are available to visit upon request.

IMPORTANT EXPECTATIONS

Let's discuss some of the basic expectations:

- Dress: Please dress appropriately for the activities of the day.
- Make sure to be in your night clothes and ready for bed by 10:00 p.m. If you need to leave your room while you are wearing your nightclothes, please wear a robe.
- Slippers or hospital socks must be worn at all times.

***Note: Please bring enough clothing for 3 days (send your suitcases home with family/friends).*

Electrical Appliances: No electronic devices are allowed in patient rooms. This includes but is not limited to cell phones, laptops, tablets, DVD players and headphones. If brought in, they will be kept locked in a secure location until discharge.

Contraband: Contraband is any item (such as cigarettes, lighters, matches, drugs or alcohol) that hurts your treatment process. If contraband is found after a family/friend visit, your visitor privileges may be restricted.

Per hospital policy,* ***NO SMOKING *is permitted at any time on the hospital grounds.*

Health and Safety Inventory (Search): A search of your personal items is done on admission and when needed later in your hospital stay. Here are some things you should know about personal items:

- Personal medications, alcohol and dangerous items are not permitted.
- Sharp personal care and glass items will be stored in a locked area.
- Packages must be checked at the nursing station before you can receive them.

Housekeeping: Although we will be providing linens, you are responsible for keeping your bedroom and belongings clean. Please help us out by keeping public areas tidy.

Medication: On admission, you will be turning in all medications that you bring to the nursing staff. The medications will be returned to you at discharge. If you prefer, you may also choose to send it home with a family member. All medications you receive here are ordered by your physician, including any you can buy without a prescription.

Physical Contact: Please express your feelings verbally and avoid touching. Violent or aggressive physical contact and verbal abuse will not be tolerated.

Visitor hours:
Please check with unit staff for visiting hours.

Note: Only* ***2 visitors at a time *on the unit. Children* ***under the age of 18*** *are not able to visit without a special order from your doctor.*

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

The MetroHealth System supports patients understanding and participation in their healthcare. Participation is fostered if patients are made aware of their rights and responsibilities; the following document summarizes these rights and responsibilities. This document is for the use of The MetroHealth System, patients, their caregivers, representative and visitors. When the patient is a minor, these rights also apply to the parents or guardian.

The MetroHealth System staff treat all patients without regard to any dimension or characteristic of diversity of the potential patient. Examples of dimensions or characteristics of diversity include, but are not limited to: patient's race, color, citizenship, national origin, disability, age, gender, gender identify or expression, sexual orientation, pregnancy, veteran status, religion or other characteristics protected by law.

Rights – As a patient, caregiver or visitor of The MetroHealth System, you have a right to:	
Access:	Care and services without distinction. All persons and organizations having occasion to refer patients for services or to recommend The MetroHealth System are advised to do so without regard to any dimension or characteristic of diversity.
Respect and Dignity:	Respectful, considerate care, with recognition of your personal dignity.
Privacy:	Personal privacy during your treatment and care.
Security:	Receive care in a safe setting free from abuse and/or harassment.
Confidentiality of Medical Record:	Confidentiality of your protected health information (PHI).You have the right to review and access your PHI and instruct The MetroHealth System to send a copy of your PHI to someone else.
Advance Directives:	Formulate Advance Directives and to have staff who provide care comply with your directives.
Identity:	Know the names and responsibilities of all persons involved in delivering your healthcare.
Information:	Complete information about your condition and treatment, in terms you understand.
Decision-Making:	Make decisions related to your healthcare, to participate in ethical questions that arise during your course of care, including conflict resolution, withholding or withdrawing life-sustaining treatment, and participation in investigational studies. You also have the right to request treatment, refuse treatment and designate someone to make your decisions should you not be able to make them yourself (see Advanced Directives on page 22).
Pain Management:	Receive information about pain and pain relief measures. Healthcare providers will respond to your reports of pain and provide pain management therapies as appropriate.
Notification:	Have the following notified promptly of your admission, transfer or discharge: a caregiver or support person of your choice and your provider.
Restraints:	Be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
Freedom of Choice:	Select the providers of your post hospital care; this includes Skilled Nursing Facilities, Long Term Acute Care Hospitals, Hospice, Acute Rehabilitation, Durable Medical Equipment, Home Infusion Companies and Home Health Care Agencies.

Patient Responsibilities - You, your caregiver(s) and visitor(s) are responsible for:	
Consideration:	Being considerate of other patients, visitors, and hospital staff, and for following hospital rules. Rude, threatening behavior or use of profanity directed at your care team will not be tolerated. Threats of violence against staff may result in discharge or transfer of care and/or services.
Keeping Appointments:	Keeping appointments, or for rescheduling or canceling appointments in advance.
Giving Information:	Giving complete and accurate information about your health and medical history, including information about any recent changes or concerns related to your care. It is your responsibility to tell your provider or a member of your care team if you do not understand the treatments you are receiving or if you are unclear about plans for your on-going care.
Pain Management:	Informing your provider, nurse or other care team member about your pain so that they may help you control your pain.
Following Instructions:	Asking questions or telling us if you/your caregiver do not understand the instructions, or if you/your caregiver feel you cannot follow them so that your care team can partner with you on a care plan that will work best for you. If you/your caregiver choose not to follow instructions, you will be responsible for what happens to you.
Health Care Charges:	Making certain your healthcare bills are paid as soon as possible and for providing accurate information regarding your place of residence and medical coverage.

Privacy

You have the right to personal privacy during your treatment and care. You also have the right to receive a Notice of Privacy Practices (NoPP). The NoPP explains your HIPAA rights and tells you how MetroHealth uses and discloses your health information. You may have received the NoPP when you first arrived at the hospital or a recent encounter. You can also get a copy of the NoPP by asking your caregiver, visiting metrohealth.org, or sending a request to the MetroHealth Privacy Officer, 2500 MetroHealth Drive, Cleveland, OH 44109.

IMPORTANT CONTACT INFORMATION

The MetroHealth Department of Patient Relations - (216) 778-5800

The MetroHealth System is committed to providing quality care to our patients and ensuring that their rights are supported. As part of this commitment, we encourage you to share your opinions with us regarding our care and services.

If you have a complaint, we are committed to resolving your concerns quickly and at the first level of contact, whenever possible.

We encourage you to share your questions/concerns with a member of your healthcare team, physician, unit manager, or you may contact Patient Relations directly at 216-778-5800 or patientrelations@metrohealth.org. We will gather information, follow up with the appropriate individuals or departments, and attempt to resolve the issue to your satisfaction.

Although The MetroHealth System believes that concerns can be resolved through MetroHealth's complaint resolution process, you may at any time contact various agencies and entities. In addition to contacting Patient Relations, you may file a complaint/grievance with the following agencies:

- **Ohio Department of Health, Complaint Unit:**
  246 North High St.
  Columbus, OH 43215
  (800) 342-0553
  HCComplaints@odh.ohio.gov;
- **The Joint Commission's Office of Quality and Patient Safety:**
  One Renaissance Blvd.
  Oakbrook Terrace, IL 60181
  (800) 994-6610
  jointcommission.org
  ("Report a Safety Concern" under "Connect with Us")
- **Livanta (authorized quality improvement contractor of the Centers for Medicare & Medicaid Services):**
  (888) 524-9900
  https://www.livantaqio.com/en/states/ohio
- **The Medicare Complaints Hotline:**
  1-800-MEDICARE (1-800-633-4227)
  https://www.medicare.gov/my/medicare-complaint/step1
- **U.S. Department of Health and Human Services Office for Civil Rights:**
  (312) 886-2359
  OCRComplaint@hhs.gov

  Centralized Case Management Operations, U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Room 509F HHH Bldg.
  Washington, D.C. 20201

YOUR RIGHTS AS A CONSUMER OF BEHAVIORAL HEALTH SERVICES

- The right to be treated with consideration and respect for personal dignity, autonomy and privacy;
- The right to reasonable protection from physical, sexual or emotional abuse and inhumane treatment;
- The right to receive services in the least restrictive, feasible environment;
- The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;
- The right to give informed consent to or to refuse any service, treatment, or therapy, including medication absent an emergency;
- The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it;
- The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of harm to self or others;
- The right to be informed and the right to refuse any unusual or hazardous treatment procedures;
- The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, moves, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;
- The right to confidentiality of communication and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;
- The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction;
- The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary;
- The right to be informed of the reason for denial of a service;
- The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or any manner prohibited by local, state, or federal laws;
- The right to know the cost of services;
- The right to be verbally informed of all client rights, and to receive a written copy upon request;
- The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;
- The right to file a grievance;
- The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;
- The right to be informed of one's own condition; and,
- The right to consult with an independent treatment specialist or legal counsel at one's own expense.

If you have any questions or concerns, or for information about filing complaints and grievances, please call The MetroHealth System Client Rights Officers at 216-957-3590.

OHIO DEPARTMENT OF MENTAL HEALTH CONSUMER RIGHTS

All patients hospitalized or committed have the following rights:

1. Each person who accesses mental health services is informed of these rights:
   a. The right to be informed within twenty-four hours of admission of the rights described in this rule, and to request a written copy of these rights;
   b. The right to receive information in language and terms appropriate for the patient's understanding; and
   c. The right to request to speak to a financial counselor.
2. Services are appropriate and respectful of personal liberty:
   a. The right to be treated in a safe treatment environment, with respect for personal dignity, autonomy and privacy, in accordance with existing federal, state and local laws and regulations;
   b. The right to receive humane services;
   c. The right to participate in any appropriate and available service that is consistent with an individual service/treatment plan, regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;
   d. The right to reasonable assistance, in the least restrictive setting; and
   e. The right to reasonable protection from physical, sexual, or emotional abuse or harassment.
3. Development of service/treatment plans:
   a. The right to a current individualized treatment plan (ITP) that addresses the needs and responsibilities of an individual that specifies the provision of appropriate and adequate services, as available, either directly or by referral; and
   b. The right to actively participate in periodic ITP reviews with the staff including services necessary upon discharge.
4. Declining or consenting to services:
   The right to give full informed consent to services prior to commencement and the right to decline services absent an emergency.
5. Restraint or seclusion.
   The right to be free from restraint or seclusion unless there is imminent risk of physical harm to self or others.
6. Privacy:
   a. The right to reasonable privacy and freedom from excessive intrusion by visitors, guests and non-hospital surveyors, contractors, construction crews or others; and
   b. The right to be advised of and refuse observation by techniques such as one way vision mirrors, tape recorders, televisions, movies, or photographs, or other audio and visual recording technology. This right does not prohibit a hospital from using closed-circuit monitoring to observe seclusion rooms or common areas, but closed-circuit monitoring shall not be utilized in patient bedrooms and bathrooms.
7. Confidentiality:
   a. The right to confidentiality unless a release or exchange of information is authorized and the right to request to restrict treatment information being shared; and
   b. The right to be informed of the circumstances under which the hospital is authorized or intends to release, or has released, confidential information without written consent for the purposes of continuity of care as permitted by division (A)(7) of section 5122.31 of the Revised Code.
8. Grievances:
   The right to have the grievance procedure explained orally and in writing; the right to file a grievance with assistance if requested; and the right to have a grievance reviewed through the grievance process, including the right to appeal a decision.
9. Non-discrimination:
   The right to receive services and participate in activities free of discrimination on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws.
10. No reprisal for exercising rights:
    The right to exercise rights without reprisal in any form including the ability to continue services with uncompromised access. No right extends so far as to supersede health and safety considerations.
11. Outside opinions:
    The right to have the opportunity to consult with independent specialists or legal counsel, at one's own expense.
12. No conflicts of interest:
    No inpatient psychiatric service provider employee may be a person's guardian or representative if the person is currently receiving services from said provider.
13. The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual patient for clear treatment reasons in the patient's treatment plan. If access is restricted, the treatment plan shall also include a goal to remove the restriction.
14. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event.
15. The right to receive an explanation of the reasons for denial of service.

C. In addition to the rights listed in paragraph (D) of this rule, each consumer residing in an inpatient psychiatric hospital shall have the following sixteen rights:

1. Each consumer of mental health services are informed of these rights:
   a. The right to receive humane services in a comfortable, welcoming, stable and supportive environment; and
   b. The right to retain personal property and possessions, including a reasonable sum of money, consistent with the person's health, safety, service/treatment plan and developmental age.
2. Development of service/treatment plans:
   The right to formulate advance directives, submit them to hospital staff, and rely on practitioners to follow them when within the parameters of the law.
3. Labor of patients:
   The right to not be compelled to perform labor which involves the operation, support, or maintenance of the hospital or for which the hospital is under contract with an outside organization. Privileges or release from the hospital shall not be conditional upon the performance of such labor.
4. Declining or consenting to services:
   a. The right to consent to or refuse the provision of any individual personal care activity and/or mental health services/treatment interventions; and
   b. The right, when on voluntary admission status, to decline medication, unless there is imminent risk of physical harm to self or others; or
   c. The right when hospitalized by order of a probate or criminal court to decline medication unless there is imminent risk of harm to self or others, or through an order by the committing court, except that involuntary medication is not permitted, unless there is imminent risk of harm to self or others, for persons admitted for a competency evaluation under division (G)(3) of section 2945.371 of the Revised Code or admitted for sanity evaluation under division (G)(4) of section 2945.371 of the Revised Code. The inpatient psychiatric service provider shall provide the opportunity for informed consent.
5. Privacy, dignity, free exercise of worship and social interaction:
   The right to enjoy freedom of thought, conscience, and religion; including religious worship within the hospital, and services or sacred texts that are within the reasonable capacity of the hospital to supply, provided that no patient shall be coerced into engaging in any religious activities.

OHIO DEPARTMENT OF MENTAL HEALTH CONSUMER RIGHTS (continued)

6. Private conversation, and access to phone, mail and visitors:
   a. The right to communicate freely with and be visited at reasonable times by private counsel or personnel of the legal rights service and, unless prior court restriction has been obtained, to communicate freely with and be visited at reasonable times by a personal physician or psychologist;
   b. The right to communicate freely with others, unless specifically restricted in the patient's service/treatment plan for reasons that advance the person's goals, including, without limitation, the following:
      (i) The right of an adult to reasonable privacy and freedom to meet with visitors, guests, or surveyors, and make and/or receive phone calls; or the right of a minor to meet with inspectors, and the right to communicate with family, guardian, custodian, friends and significant others outside the hospital in accordance with the minor's individualized service/treatment plan;
      (ii) The right to have reasonable access to telephones to make and receive confidential calls, including a reasonable number of free calls if unable to pay for them and assistance in calling if requested and needed. The right of a minor to make phone calls shall be in accordance with the minor's individualized service/treatment plan; and
   c. The right to have ready access to letter-writing materials, including a reasonable number of stamps without cost if unable to pay for them, and to mail and receive unopened correspondence and assistance in writing if requested and needed subject to the hospital's rules regarding contraband. The right of a minor to send or receive mail shall also be subject to directives from the parent or legal custodian when such directives do not conflict with federal postal regulations.
7. Notification to family or physician:

   The right to have a physician, family member or representative of the person's choice notified promptly upon admission to a hospital.

D. Each inpatient psychiatric service provider shall provide a patient right advocate to safeguard patient rights. The client rights specialist or a designee shall:

1. Be appropriately trained and knowledgeable in the fundamental human, civil, constitutional and statutory rights of psychiatric patients including the role of the Ohio protection and advocacy system (disability rights Ohio);
2. Ensure that the patient, and as appropriate, the patient's family members, significant others, and the patient's legal guardian, are informed about patient rights, in understandable terms, upon admission, and throughout the hospital stay. Treatment staff shall also work with patient to assist them in understanding and exercising patient rights. For any person who is involuntarily detained, the inpatient psychiatric service provider shall, immediately upon being taken into custody, inform the person orally and in writing of their rights described in division (C) of section 5122.05 of the Revised Code;
3. Be accessible in person during normal business hours, and during evenings, weekends, and holidays as needed for advocacy issues. The name, title, location, hours of availability, and telephone number of the client rights specialist along with a copy of the client rights and grievance procedure as set forth in this rule shall be posted in an area available to the patient, and made available to the patient's legal guardian if any, and the patient's family and significant others, upon request at all times;
4. Assist and support patients, their family members, and significant others in exercising their legal rights and representing themselves in resolving complaints. This shall include providing copies of the inpatient psychiatric service provider's policies and procedures relevant to patient rights and grievances upon request, and assistance with the grievance procedure. This shall also include assistance in obtaining services of the Ohio protection and advocacy system (disability rights Ohio) in accordance with sections 5123.60 to 5123.601 of the Revised Code, and assistance in obtaining access to or services of outside agencies or resources upon request;
5. Not be a member of the patient's treatment team and not have clinical management or care responsibility for the patient for whom he or she is acting as the patient rights advocate; and
6. Maintain a log available for department review of patient grievances, including all allegations of denial of patient rights as identified by patients, family members of patients, significant others or other persons.

E. Each inpatient psychiatric service provider shall ensure that its staff members are knowledgeable about patient rights and referral of patients to the patient rights advocate.

F. Each inpatient psychiatric service provider shall ensure that patients and families of patients participate in an advisory capacity related to programming and relevant policies and procedures.

G. Each inpatient psychiatric service provider shall ensure that patient and family education is an interdisciplinary and coordinated process, as appropriate to the patient's treatment plan, consistent with patient confidentiality and documented in the medical record. Education shall incorporate appropriate members of the treatment team, types of materials, methods of teaching, community educational resources, and special devices, interpreters, or other aids to meet specialized needs.

H. Each inpatient psychiatric service provider shall obtain the informed consent of a patient or when appropriate, a guardian, for all prescribed medications that have been ordered, except in an emergency, and for those medical interventions as referenced in and in accordance with division (A) of section 5122.271 of the Revised Code.

1. Each inpatient psychiatric service provider shall ensure that the patient and legal guardian, when legally appropriate, receives written and/or oral information in a language and format that may be standardized and that is understandable to the person receiving it.
   a. Information shall include the anticipated benefits and side effects of the intervention, including the anticipated results of not receiving the intervention, and of alternatives to the intervention.
   b. Persons served shall be given the opportunity to ask questions, seek additional information and provide input before the intervention or medication is administered/dispensed.
   c. Documentation shall be kept in the patient's medical record regarding the patient's participation in this process, including the patient's response, objections, and decisions regarding the medication or medical intervention. Such documentation may be accomplished through a notation from an appropriate professional staff person, signature of the patient or guardian, or other mechanism.
2. For purposes of informed consent specific to medication, each psychiatric inpatient service provider shall ensure that the patient and parent or legal guardian when legally appropriate receives written and/or oral information from a physician, registered nurse, or registered pharmacist.

If you, your spouse, next-of-kin, guardian, parent, or other persons think that your rights have been violated, you should report this to the client advocate or client rights officer, your own lawyer or:

Disability Rights Ohio
800-282-9181 or 614-466-7264

The Joint Commission's Office of Quality Monitoring
The Joint Commission
One Renaissance Blvd
Oakbrook Terrace, IL 60181
1-800-994-6610

U.S. Department of Health and Human Services Office for Civil Rights (Region V)
(800) 368-1019

Ohio Department of Health
1-800-342-0553

Ohio Department of Health
Complaint Unit, HCComplaints@odh.ohio.gov

ORC 5122-14-11

Effective Date: 2/17/2017,
Five Year Review (FYR) Dates: 11/29/2016 and 02/17/2022

THE METROHEALTH SYSTEM PATIENT FINANCIAL BILL OF RIGHTS

Improving the health of the community is central to everything The MetroHealth System does. How MetroHealth fulfills that mission is also important. Service, accountability, respect and equality are among MetroHealth's core values.

MetroHealth supports the Patient Financial Bill of Rights. And here's how.

As a MetroHealth patient, I have ...

Provider Network

- The right to accurate and up-to-date information about MetroHealth's participation in my insurance plan's provider network.
  - I know I can obtain this information by calling MetroHealth's Customer Service Advocacy Department at 216-957-3250 Option 2.
- The right to collaborate with MetroHealth to help gain an understanding of what surprise billing is – and how to avoid it.
  - I know I can reach out to representatives from MetroHealth's Financial Clearance Department at 216-957-2325 Option 3, ask questions and get explanations about billing.

Charges

- The right to not be charged for covered preventive care services.
  - Preventive care keeps me and my family healthy. I know that many preventive care services are free under the law and that I will not be charged for these services. This link provides guidelines based on governmental preventive care visits: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/PreventiveServicesPoster.pdf Commercial insurance typically follows this list.
  - However, if my insurance does not pay, I know I can call MetroHealth's Customer Service Advocacy Department at 216-957-3250 Option 2 to assist me.
- The right to be informed, in advance, of any facility fees.
  - I understand that receiving care at hospital outpatient departments means that I have convenient access to more services and procedures.
  - know that I may receive two charges on my MetroHealth patient billing statement for the same date of service: one for where I receive my care/service and one for who provides it. For example, if I get an x-ray, I may receive a charge for where it is performed (the facility) and another charge for the clinician (the radiologist) reading the results.

Estimates

- The right to see a price estimate for services and a price list for elective procedures
  - MetroHealth offers an online "My Cost Estimator" tool that allows me to receive price estimates based on my coverage. I can find that tool at: www.metrohealth.org/patients-and-visitors/billing/patient-cost-estimator.
  - I will be able to review estimated costs for potential or scheduled services to help me understand my benefits and my out-of-pocket responsibility.
  - I will have access to a MetroHealth Financial Clearance Specialist who can assist me by calling 216-957-2325 Option 3.
- The right to be informed of lower-cost options.
  - MetroHealth seeks to provide me with choices – choices in location, types of procedures, and medications that may help me.
  - I can contact 216-957-2325 Option 3 to know what other options might be available for me.

Billing , Customer Service Advocacy, Financial Coordination

- The right to be informed about, and given access to, financial-assistance/financial-coordination programs and reduced-price care programs.
  - MetroHealth has always maintained a compassionate financial assistance policy.
  - I have the right to have my personal financial circumstances confidentially reviewed to see if I might qualify for assistance.
  - I deserve a process that is respectful, dignified and patient-centric with the goal of ensuring my uninterrupted care.
  - MetroHealth also maintains answers to frequently asked questions online at: www.metrohealth.org/patients-and-visitors/billing/billing-faq.
  - MetroHealth is available to answer my questions about potential financial assistance programs via phone at 216-957-2325 Option 1 or toll free 877-509-0597 Option 6.
- The right to receive a clear billing statement, in language I understand.
  - I know I will receive an Explanation of Benefits from my insurance company. This is not a bill. The Explanation of Benefits will list all charges, which ones will be paid by insurance and what, if anything, I owe.
  - If I owe something for my care, MetroHealth also will send me a statement after my insurance company processes the claim, which will clearly state how much I need to pay.
  - If I owe nothing, I will NOT receive a MetroHealth patient statement.
  - I can request additional information about my healthcare coverage, including my out-of-pocket responsibility, by calling 216-957-2325 Option 3. My responsibility will depend on my personal coverage.
  - If I do not have insurance, I will receive a MetroHealth patient statement reflecting my responsibility for payment.
- An accurate itemized bill.
  - Typically, only my insurer receives an itemized bill. However, I know I have the right to request MetroHealth to provide me with the same detailed bill.
  - I can request an itemized bill on MyChart, by email or by mail.
  - I know that I can call the MetroHealth's Customer Service Advocacy Department at 216-957-3250 Option 2 if I would prefer to speak with someone and get clarification.
- The right to know that if I dispute a bill, it will not be sent to a collection agency.
  - MetroHealth offers many payment options, including payment plans with 0% interest, and that I can contact the Customer Advocacy Department at 216-957-3250 Option 2 to find out more about these options.
  - MetroHealth also will carefully and thoroughly review any bills I dispute – and will not send the bill to a collection agency while it is being reviewed.
  - I understand that overdue bills that are not disputed may be sent out for collection.
- The right to be informed of any conflicts of interest.
  - MetroHealth maintains rigorous conflicts of interest policies and oversight.
  - I will be informed of any conflicts of interests involving my providers.

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. Please see the Model Notice Disclosure at www.metrohealth.org/NoSurprisesAct for more information on the new federal rules on surprise billing.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Health and Human Services at 1-800-985-3059 or visit https://www.cms.gov/nosurprises

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Ohio laws also protect patients against balance billing by out-of-network providers. For more information visit https://insurance.ohio.gov/strategic-initiatives/surprise-billing

ADVANCE DIRECTIVES

Fill Out Your Forms

Bring a copy of your advance directives with you the day of your procedure so your most current information and wishes are on file. For more information and if you need forms, contact the Social Work Office at 440-592-5635.

Choose Your Care

Fill out advance directives so your wishes are known, and your loved ones are sure of what you want. One of the most important decisions you can make about your care is to fill out advance directives in case you can no longer speak for yourself. Advance directives are documents that let others know your wishes about the type of care you want. They will only be used if you become unconscious or too ill to communicate yourself.

DIRECTIVES CAN INCLUDE:

Living Will

This set of instructions explains the type of life-prolonging medical care you wish to accept or refuse. It can include your wishes about the use of resuscitation (CPR) if your heart stops, a ventilator if you stop breathing, or feeding tubes or IVs if you cannot eat or drink.

Durable Power of Attorney for Healthcare

This is a legal document that names your healthcare proxy—someone who is 18 years or older and can participate in medical decisions for you if you're unable to do so. An official healthcare proxy can represent your wishes on emergency care, but also on other medical issues like potential treatment options, blood transfusions, kidney dialysis, etc. Choose someone you trust, discuss your medical wishes with them, and make sure the person agrees to represent you in this role.

Declaration for Mental Health Treatment

You may appoint a proxy 18 years or older to participate in treatment decisions for you if you lose the ability to make mental health treatment decisions. The instructions will be followed only when your designated physician or psychiatrist and one other mental health treatment provider who has examined you determine that you do not have the capacity to consent to mental health treatment decisions. At least one of the two people who make this determination shall not currently be involved in your treatment at the time of the determination.

IMPORTANT INFORMATION FOR MEDICARE BENEFICIARIES

Medicare Patients

We appreciate you choosing MetroHealth for your care. The Admitting Department is available to assist you with understanding your rights as a Medicare patient. In accordance with Medicare guidelines, as a patient this is required within 36 to 48 hours of admission, depending on the circumstances. It is important for us to explain to you your Medicare rights as they relate to your hospital stay.

A representative will reach out to you upon Inpatient or Observation services to review the Medicare form within the first or second day of your stay. You may also contact the Admitting Department at 216-778-8011 at your convenience to complete this process or if you have any questions. The Admitting Department is available 7 days a week/24 hour a day. Please remember, based on Medicare requirements, it is necessary for us to provide you or your designee with this important information.

Below is a summary of Medicare forms that could be reviewed with you or your representative that require your acknowledgment and signature. A copy of the required forms is included in this booklet. All completed forms will be sent to your room following a discussion with a representative.

Medicare Required Forms:

- An Important Message from Medicare (IM1) is a hospital inpatient admission notice given to all beneficiaries (patients) with Medicare coverage explaining your discharge and appeal rights.
  - The Medicare Outpatient Observation Notice (MOON) is a standardized notice to inform Medicare beneficiaries (patients) that they are an outpatient receiving observation services and are not an inpatient of the hospital.

Please remember, based on Medicare requirements, it is necessary for a representative to provide you or your designee with this important information, so your rights may be acknowledged, and a signature obtained.

Rights Under Medicare

Livantia LLC advocates for Medicare beneficiaries to ensure they receive all the healthcare benefits and rights entitled to them. Please feel free to contact Livantia if you have a concern.

Your Rights While You Are a Hospital Patient

You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to federal law, your discharge date must be determined solely by your medical needs, not by any method of payment.

You have the right to be fully informed about decisions affecting the coverage and payment for your hospital stay and for any post-hospital services.

Talk to Your Healthcare Team About Your Stay in the Hospital

You and your healthcare team know more about your condition and your healthcare needs than anyone else. Decisions about your medical treatment should be made between you and members of your healthcare team. If you have any questions about your medical treatment, your need for continued hospital care, your discharge or your need for possible post-hospital care, don't hesitate to ask your doctor or another member of your healthcare team. Your health plan, MetroHealth's patient representatives or your nurse case manager also will help you with your questions and concerns about hospital services.

If You Think You Are Being Asked to Leave the Hospital Too Soon and Are a Medicare Member

Upon admission, you will receive a written copy of an Important Message from Medicare about your rights. If you have not already received it, you may request it from your nurse case manager. This document explains your Medicare discharge rights regarding a peer review by a quality review organization. Peer Review Organizations (PROs) are groups of doctors who are paid by the federal government to review medical necessity, appropriateness and quality of hospital treatment provided to Medicare patients.

You may exercise your right to request an immediate review by the Peer Review Organization (PRO) if you disagree with the discharge plan and/or discharge date. Those enrolled in a managed care plan (like an HMO) have the same right to review.

IMPORTANT INFORMATION FOR MEDICARE BENEFICIARIES (continued)

How to Request an Immediate Review of the Decision for Discharge

If you disagree with your insurance plan's discharge decision, please contact your nurse case manager, and he or she will assist you in contacting the appropriate party. If you have Medicare, please contact the Quality Improvement Organization number on the form you received from your nurse case manager or request the form. You must contact the Quality Improvement Organization no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like co-pays and deductibles).

The Quality Improvement Organization can be reached at:

Ohio Livanta LLC
Toll Free Phone: 888-524-9900
TTY: 888-985-8775

When you call Livanta, ask for a fast-track review. You should have the sheet titled "An Important Message About Your Rights" in hand when you call. Patients are given this sheet upon admission and then again before they leave the hospital.

PLEASE NOTE:

- You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
- Ask the hospital if you need help contacting the Quality Improvement Organization.
- You will receive a detailed notice of discharge from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- The Quality Improvement Organization will ask for your opinion. You or your representative needs to be available to speak with the Quality Improvement Organization, if requested. You or your representative may give the Quality Improvement Organization a written statement, but you are not required to do so.
- The Quality Improvement Organization will review your medical records and other important information about your case.
- The Quality Improvement Organization will notify you of its decision within one day after it receives all necessary information.
- If the Quality Improvement Organization finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
- If the Quality Improvement Organization finds that you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the Quality Improvement Organization notifies you of its decision.
- If you do not request a review from the Quality Improvement Organization, the health plan or hospital may bill you for all the costs of your stay beginning at the point when the health plan's hospital coverage ends as noted in the "Important Message from Medicare."
- The health plan or hospital, however, cannot charge you for care unless you received the "Important Message" information.

If You Miss the Deadline to Appeal, You Have Other Appeal Rights

You still can ask the Quality Improvement Organization or your plan for a review of your case:

- If you have Original Medicare, call the Quality Improvement Organization listed at the top of this page.
- If you belong to a Medicare Advantage Plan or other Medicare managed care plan, call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call:
800-MEDICARE (800-633-4227)
TTY: 877-486-2048

IMPORTANT MESSAGE FROM MEDICARE

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- You can be involved in any decisions about your hospital stay.
- You can report any concerns you have about the quality of care you receive to your QIO at: Ohio Livanta LLC. The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.

Name of QIO: Ohio Livanta LLC
Toll Free Phone: 888-524-9900
TTY: 888-985-8775

- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.

Your Right to Appeal Your Hospital Discharge:

- You have the right to an immediate, independent medical review (appeal) of the decision to discharge you from the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the reviewer will each receive a copy of a detailed explanation about why your covered hospital stay should not continue. You will receive this detailed notice only after you request an appeal.
- If the QIO finds that you are not ready to be discharged from the hospital, Medicare will continue to cover your hospital services.
- If the QIO agrees services should no longer be covered after the discharge date, neither Medicare nor your Medicare health plan will pay for your hospital stay after noon of the day after the QIO notifies you of its decision. If you stop services no later than that time, you will avoid financial liability.
- If you do not appeal, you may have to pay for any services you receive after your discharge date.

The MetroHealth System
2500 MetroHealth Drive, Cleveland, OH 44109
Phone: 440 592 5635

How to Ask For an Appeal of your Hospital Discharge

- You must make your request to the QIO listed above.
- Your request for an appeal should be made as soon as possible, but no later than your planned discharge date and before you leave the hospital.
- The QIO will notify you of its decision as soon as possible, generally no later than 1 day after it receives all necessary information.
- Call the QIO listed in bold at the top of this page to appeal, or if you have questions.

IMPORTANT MESSAGE FROM MEDICARE (continued)

If You Miss The Deadline to Request An Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on Page 25.
- If you belong to a Medicare health plan: Call your plan.

Insurance Plan: _____ Insurance Telephone Number: _____

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048. CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Additional Information:

To Speak with someone about this notice, call: Center for Care Coordination: 440 592 5635

Hospital Name: The MetroHealth System **Provider ID:** **Acute:** 360059 **Psych:** 36S059 **Rehab:** 36T059

Please sign below to indicate you received and understood this notice.

I have been notified of my rights as a hospital inpatient and that I may appeal my discharge by contacting my QIO.

Signature of Patient or Representative Date / Time

THE MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

Medicare Outpatient Observation Notice (MOON), is a standardized notice to inform Medicare beneficiaries (patients) that they are an outpatient receiving observation services and are not an inpatient of the hospital. When you are an observation patient your current status does not meet Medicare's rules for inpatient admissions.

Medicare Part B covers outpatient hospital services, including observation services when they are medically necessary.

To review the Medicare Outpatient Observation Notice (MOON), please refer to the form below.

If you have any questions about the form, the Admitting Department can be reached at 216-778-8011 to answer any questions. The department is available 7 days a week/24 hours a day.

MEDICARE OUTPATIENT OBSERVATION NOTICE

Patient name: Patient number:

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

  NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

THE MEDICARE OUTPATIENT OBSERVATION NOTICE (continued)

Your costs for medications:
Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self- administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of- pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

Please sign below to show you received and understand this notice.

Signature of Patient or Representative

Date / Time

CMS does not discriminate in its programs and activities. To request this publication in alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

STATE, DISTRICT, COUNTY AND LOCAL AGENCIES

If you have any questions concerning the care you have received, you may, at any time, contact any of these agencies:

Department of Health – State Office Ohio Department of Health Health Care Facility Complaint Hotline, ODH, PCSU
246 N. High St.
Columbus, OH 43215
800-342-0553

Department of Health – Local Office Ohio Dept. of Health – N.E. District Office, Bureau of Long-Term Quality
161 S. High St., Suite 400
Akron, OH 44308-1612
330-643-1300

Ombudsman – State
2800 Euclid Ave., Suite 200
Cleveland, OH 44115
216-696-2719
216-696-6216 (fax)

Ohio Department of Insurance
50 W. Town St.
3rd Floor, Suite 300
Columbus, OH 43215-1067
800-686-1526 (Consumer Hotline)
800-686-1527 (Fraud Hotline)

Ohio Department of Insurance – Senior Hotline Ohio Senior Health Insurance Information Program (OSHIIP)
800-686-1578

Medicaid – Local
Ohio Medicaid Consumer Hotline
800-324-8680
Medicaid Consumer
Hotline –Fraud
1641 Payne Ave., Room 350
Cleveland, OH 44114
216-987-7000

Medicare Social Security Administration – Medicare Office
1240 E. Ninth St., Room 793
Cleveland, OH 44114
800-772-1213 (Social Security)
www.socialsecurity.gov
Medicare Hotline
(Fraud and Abuse)
800-633-4227

Medicare Complaint Hotline
800-404-8702

Department of Aging – State Ohio Department of Aging
50 W. Broad St., 9th Floor
Columbus, OH 43215-3363
800-266-4346
(General Information)

Western Reserve Area Agency on Aging
925 Euclid Ave., Suite 550
Cleveland, OH 44115
800-626-7277 (Ohio Only)

LEAVING AGAINST MEDICAL ADVICE

MetroHealth respects the decision of adult patients who have decision-making capacity and choose to leave their patient care unit at MetroHealth against medical advice (AMA).

The only exceptions are when staff accompanies the patient, the patient is in a rehabilitation unit and is signed out, a postpartum patient is signed out to the Neonatal Intensive Care Unit or the patient is signed out to a waiting room.

Smoking is not a reason to leave the patient care unit. No hospital equipment other than a wheelchair or walker can leave the unit.

If the patient is a minor and the parent takes the patient AMA, Child Protective Services may be contacted.

CLINICAL ETHICS CONSULT SERVICE

The role of the Clinical Ethics Consult Service is to assist patients, family members, friends, and healthcare professionals regarding ethical issues that arise in the healthcare setting.

- Understanding patient wishes and values and the role of a surrogate.
- Resolving conflicts regarding difficult treatment decisions or goals of care.
- Decision-making at or about end of life.
- Interpreting and applying advance directives.

Any patient, visitor, or healthcare professional may request a clinical ethics consultation. Page 216-207-1095 or call 216-778-8497.

NOTES: