Health Central Hospital
Medical Staff Orientation
Medical Staff Orientation

Orlando Health is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Orlando Health designates this educational activity for a maximum of 2.0 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The Orlando Health CME Committee have disclosed no significant financial relationships relevant to the CME activity.

OBJECTIVES:
1. Describe the Mission, Vision and Values of Health Central Hospital as well as the team concept needed to provide quality care.
2. Comply with and carry out the Health Central Hospital Code of Conduct.
3. Carry out the CMS Core Measure requirements and national patient safety goals.
4. Construct a clear plan to avoid and control infections.
5. Be prepared for a Joint Commission visit and non-clinical emergency situations.
6. Apply Health Central's documentation requirements.
Welcome to the Health Central Hospital Medical Staff Orientation program. Thank you for considering us as your premier choice for patient care in the area. We look forward to you joining our staff upon successful completion of the application and credentialing process.

Health Central Hospital has been a staple in West Orange County for over 60 years. We take our mission extremely seriously and want all our potential new members to reflect upon our mission statement and values.
Our Mission & Values

- **Our Mission:**
  Improving the health of our community.

- **Our Values:**
  
  *We are people caring for people*
  Our relationships with patients/residents, family members, and team members are cherished. We treat others, as we would have them treat us.

  *We believe people matter*
  An individual’s dignity is values in all interactions.

  *We contribute*
  Quality care drives all of our actions and decisions.

  *We succeed*
  As healthcare advocates for our community, we are guided by ethics and financial integrity.
Service Standards

“People Caring for People”

We demonstrate “People caring for People” to each and every patient/resident, family member and team member each and every day by:

1. Being personally prepared daily to represent Health Central with a professional look and a CARING attitude.
2. Providing a warm and gracious greeting to everyone we come into contact with, thus creating a CARING environment at Health Central.
3. Seeking to anticipate and understand patient/resident, family member, and team member needs; and then providing appropriate service in a CARING way.
4. Taking a vigorous approach to improving the experience and resolving issues in a way that demonstrates a commitment to CARING for people.
5. Individualizing the Health Central experience by providing the highest quality healthcare and CARING enough to understand the specific wants and needs of each patient/resident, family member, and team member.
6. Creating a lasting impact that will leave everyone we come into contact with the knowledge that Health Central is about people CARING for people.
PATIENT EXPERIENCE
• Patient Experience is an integrated part of Patient First

• The Orlando Health Board has established the goal to achieve the national Top 10% by 2017

• Annual Inpatient and Emergency goals are set to achieve Top 10% by 2017
# Value-Based Purchasing (VBP)

<table>
<thead>
<tr>
<th>What is VBP?</th>
<th>Another word for Pay-for-Performance, this is a program intended to transform healthcare by fostering a joint clinical and financial accountability system.</th>
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<tbody>
<tr>
<td>Why is it important?</td>
<td>This new payment system will change CMS from a “passive payer” of services into an “active purchaser” of value which is high quality, affordable, safe healthcare.</td>
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<tr>
<td>How will it be used?</td>
<td>Hospitals will be reimbursed based on their performance, not just reporting, of quality metrics, including the patient perception of quality.</td>
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If you perform “better” – you’ll be paid more  
Better = patient-centered, efficient, quality care
HCAHPS Update (Public View)

Government mandated, publicly reported survey

Patients can use HCAHPS data to “shop” for the “best” hospital. CMS will use it to pay high performers more, low performers less.
HCAHPS Doctor Questions

Communication with Doctors Composite

How often did doctors...

• Treat you with courtesy and respect?
• Listen carefully to you?
• Explain things in a way you could understand?

Scale: Never, Sometimes, Usually, Always

% Always Reported
Expanded HCAHPS Survey

January 1, 2013 Discharges

3 Care Transition Items (4-point Agreement Scale)
(Strongly Disagree, Disagree, Agree, Strongly Agree)

➢ During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

➢ When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

➢ When I left the hospital, I clearly understood the purpose for taking each of my medications.

(Health Literacy, Family Involvement and Teachback)
January 1, 2013 Discharges

Demographic Items in the “About You” section

1. During this hospital stay, were you admitted to this hospital through the Emergency Room? (Yes/No)

2. In general, how would you rate your overall mental or emotional health? (Excellent, Very Good, Good, Fair, Poor)

For additional details on these new HCAHPS items from CMS, please refer to HCAHPS Quality Assurance Guidelines v7.0 at http://www.hcahpsonline.org/qaguidelines.aspx.
Physician Communication

**Best Practices**

- Handshake
- Sitting down
- Mindful Presence
- Good eye contact
- Thoughtful listening
- Ensure understanding by the patient and family
- Highly coordinated care among the team
Physician practical takeaways…

- Treat patients with dignity; and include them in decision making
- Work with a team you can be proud of
- Elicit patients' concerns by asking questions such as “What are you afraid of?”
- Don't forget to smile
- Lastly, find pleasure in what you do. Physicians who report high professional satisfaction have patients who are more satisfied with their care.
In addition to the HCAHPS survey the following questions are asked in regards to the physician on the Press Ganey Survey

- Time physician spent with you
- Physician’s concerns for your questions and worries
- How well physician kept you informed
- Friendliness/courtesy of physician
- Skill of physician
- Your rating of the Hospitalist
CODE OF CONDUCT
The Code of Conduct policy outlines specific expectations for your behavior as a member of the medical staff. The content of the code is as follows:

All individuals working within the healthcare environment must treat others with respect, courtesy and dignity and conduct themselves in a professional and cooperative manner.

This policy is intended to address the conduct of Medical staff members and promote a Code of Conduct.

Medical Staff Bylaws, Policies, Rules & Regulations can be found at www.healthcentralmedicalstaff.org
1. I agree to treat hospital personnel and physicians practicing at Health Central Hospital in a courteous and professional manner. I will not in any way demean, belittle, or berate Health Central personnel or medical staff members. I will not intentionally intimidate, undermine confidence, or imply stupidity or incompetence.

2. I will not use profane, threatening or abusive language.

3. I shall refrain from making degrading or demeaning comments regarding patients, families, nurses, physicians, hospital personnel or Health Central Hospital.
4. I will not engage in inappropriate physical contact that is threatening, intimidating, or of a sexual nature.

5. I will not throw charts, equipment, surgical instruments, or any other objects or items.

6. I agree to refrain from making derogatory, impertinent or inappropriate comments about Health Central or others in any patient’s medical record or other official documents that impugn the quality of care delivered or received. Medical records must be used only to record patients’ conditions and care received.
7. I will not obtain or review the medical record or information of patients who are not my own. I will not use patient information obtained from Health Central to further my self-interest.

8. I will use appropriate administrative channels to register complaints or concerns about others practicing at Health Central.

9. I will not engage in any verbal or physical activity that could be interpreted as sexual harassment.

10. I agree to abide by all bylaws, policies, rules and regulations of Health Central and the Medical Staff and understand that any violation of the same shall be a violation of my appointment.
CORE MEASURES
2017 Core Measures

• Core Measures are standardized, evidence-based quality performance measures/indicators that are proven to reduce errors.

• Additional information regarding these reportable measures can be viewed at www.hospitalcompare.hhs.gov

• The Quality Department at Health Central abstracts and analyzes information related to the Core Measures. The information is presented to various medical staff departments so appropriate actions can be taken to ensure compliance with the measures.
2017 Core Measures

• Stroke Core Measures
• Sepsis Early Management Bundle
• Alcohol Use
• Tobacco Use
• VTE
• Immunization
• Outpatient Core Measures
• Perinatal Care
Core Measures

Criteria for Stroke Core Measures

- Stroke patients have VTE prophylaxis, or documentation as to why no VTE prophylaxis was given, on day 1 of patient’s admission
- Stroke patients are discharged on antithrombotic therapy
- Stroke patients with atrial fibrillation/flutter will receive anticoagulation therapy at discharge
- Acute Stroke patients who arrive within 2 hours of the last known well time will have IV t-PA initiated, or documentation as to why it is contraindicated
- Stroke patients will be administered antithrombotic therapy by the end of hospital day 2
- Stroke patients will be prescribed statin medications at discharge or have documentation as to why it is contraindicated
Critenia for Stroke Core Measures (Continued)

- Stroke patients will receive written and verbal education regarding how to initiate the emergency medical system, the need for follow up after discharge, medications prescribed, risk factors for stroke and warning signs and symptoms of stroke
- Stroke patients will be assessed for rehabilitation prior to discharge
Core Measures

Criteria for Outpatient Core Measures

- Median time from ED Arrival to ED departure for Patients admitted (lower is better)
- Median time from ED Arrival to patient departure for Psychiatric or Mental Health Patients

Criteria for Immunization Core Measures

- Screening and intervention of vaccine administration when indicated for Pneumococcal and Influenza Vaccines.
- Contraindications must be documented
Core Measures

Criteria for Tobacco Use Screening

- Patients must be screened with the first 3 days for tobacco use.
- Patients identified as tobacco users in the past 30 days will receive counseling and receive FDA approved cessation medications during their hospital stay.
  - If patient refuses, the refusal must be documented.
- Patients will be referred to evidence based outpatient counseling at discharge.
  - If patient refuses, the refusal must be documented.
- Discharged patients identified as tobacco users will be contacted by the Quality Management department between 15 and 30 days after hospital discharge to follow up regarding tobacco use status.
Core Measures

Criteria for Alcohol Use Screening

- Patients must be screened with the first 3 days for unhealthy alcohol use
- Patients identified as alcohol users in the past 30 days will receive counseling and brief intervention
  - If patient refuses, the refusal must be documented
- Patients will be referred to evidence based outpatient counseling at discharge
  - If patient refuses, the refusal must be documented
- Discharged patients identified as alcohol users will be contacted by the Quality Management department between 15 and 30 days after hospital discharge to follow up regarding alcohol use status
Criteria for VTE (Venous Thromboembolism Prophylaxis)

- Patients will receive VTE prophylaxis on day 1 of admission or have documentation as to why the prophylaxis is contraindicates.

- Patients who present on admission with a confirmed acute DVT will receive parenteral anticoagulation as the first line of therapy for at least five days, or have documentation as to why parenteral anticoagulation was discontinued.

- Patients with a confirmed DVT who are discharged on warfarin will received written discharge instructions that address all of the following:
  - Compliance Issues
  - Dietary advice
  - Follow up Monitoring
  - Information about the potential for adverse drug reactions/interaction
Core Measures

Criteria for Sepsis Early Management Bundle

• Patients who received all of the following:
  – Received within 3 hours of presentation of severe sepsis
    • Initial lactate level measurement
    • Broad spectrum or other antibiotics administered
    • Blood cultures draw prior to antibiotics
  – AND received within 6 hours of presentation of severe sepsis
    • Repeat lactate level measurement only if initial lactate level is elevated
  – AND ONLY if Septic Shock is present:
  – Received within 3 hours of presentation of Septic Shock
    • Resuscitation with 30 ml/kg crystalloid fluids
  – AND ONLY if hypotension persists after fluid administration, received within 6 hours of the presentation of Septic Shock
    • Vasopressors
    • Repeat volume status and tissue perfusion assessment
Core Measures

Criteria for Perinatal Care

– Early Elective Deliveries
  • Reduce the incidence of elective deliveries at >=37 and < 39 weeks
– C-Sections Rates
  • Reduce the incidence of C-Section rates
– Exclusive Breast Milk Feeding
  • Increase the number of infants who are fed with exclusive breast milk
– Antenatal Steroids
  • Increase the use of antenatal steroids in pregnant women between 24 weeks and 34 weeks of gestation and who are at risk of preterm delivery
– Blood Stream Infections in Infants
  • Decrease the number of blood stream infections in infants
NATIONAL PATIENT SAFETY GOALS
National Patient Safety Goals

NPSGs were developed by the Joint Commission to promote specific improvements in patient safety.

Numbered goals are published yearly but not all apply to the hospital setting. Others are initiated by disciplines other than a physician. Applicable ones are listed on the following slides.
GOAL 1 — Improve the accuracy of patient identification – use at least two patient identifiers when providing care, treatment or services.

GOAL 2 – Improve the effectiveness of communication among caregivers.

Physicians must participate in the “read-back” process when giving verbal or telephone orders or receiving critical test results. This ensures that the person giving and the one receiving the information agree on what was said so appropriate action can be taken.
National Patient Safety Goals

- Legibility issues can lead to medication errors. Health Central has made it mandatory to use your four digit dictation number for any written orders.

- Use of your ID number allows the correct physician to be contacted if the nursing staff or pharmacists have questions about an order.

- If you do not include your number on a written order, the order will not be processed until you are called and the order is verified.

Avoid this extra step by remembering to include your ID number when you write orders!
National Patient Safety Goals

• **GOAL 3** – Improve the safety of using medications. Use only approved abbreviations.

  • **Do not abbreviate the name of any medication**

<table>
<thead>
<tr>
<th>DO NOT WRITE</th>
<th>WRITE</th>
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<tr>
<td>U</td>
<td>UNIT</td>
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<tr>
<td>IU</td>
<td>INTERNATIONAL UNIT</td>
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<tr>
<td>Q.D., QD</td>
<td>DAILY</td>
</tr>
<tr>
<td>Q.O.D., QOD</td>
<td>EVERY OTHER DAY</td>
</tr>
<tr>
<td>MS, MSO4</td>
<td>MORPHINE SULFATE</td>
</tr>
<tr>
<td>MgSO4</td>
<td>MAGNESIUM SULFATE</td>
</tr>
<tr>
<td>UG</td>
<td>MCG OR MICROGRAM</td>
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<tr>
<td>HS</td>
<td>BEDTIME</td>
</tr>
<tr>
<td>hs</td>
<td>HALF STRENGTH</td>
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<tr>
<td>TIW</td>
<td>3 TIMES WEEKLY OR 3 TIMES A WEEK</td>
</tr>
<tr>
<td>AS, AD, AU</td>
<td>LEFT EAR, RIGHT EAR, BOTH EARS</td>
</tr>
<tr>
<td>OS, OD, OU</td>
<td>LEFT EYE, RIGHT EYE, BOTH EYES</td>
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<tr>
<td>SS</td>
<td>SLIDING SCALE</td>
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National Patient Safety Goals

- Never use a trailing or terminal zero after a decimal point for doses expressed in whole numbers.
  - Always write the dose as a whole number without a decimal point.
  - e.g.: 5mg or 1 gram

- Never omit a leading zero before a decimal point when the dose is less than a whole unit.
  - Always use a leading zero before a decimal point when the dose is less than a whole unit.
  - e.g.: 0.125 MG or 0.75 MCG
National Patient Safety Goals

• **GOAL 7** – Reduce the risk of health-care associated infections.

  All caregivers must comply with the CDC hand hygiene guidelines. Remember to wash your hands before and after each patient contact.

• **GOAL 8** – Accurately and completely reconcile medications across the continuum of care.

  Health Central provides a list of each patient’s pre-hospital medications to use for medication reconciliation. Information for completion and review of the form is a joint effort among the patient, physicians, nurses and pharmacists.
Universal Protocol is a process for eliminating wrong site, wrong procedure, wrong person surgery. To achieve that goal the following steps must be taken:

1. **Preoperative verification process** - to validate that all the relevant documents and studies are available prior to the start of the procedure.

2. **Marking the operative site** - to positively identify the intended site of the incision or insertion involving the patient if possible.

3. **Time out immediately before starting the procedure** – active communication among all members of the surgical/procedure team. This is the final verification for the correct patient, side and site, agreement on the procedure to be done, correct patient position and availability of correct implants and equipment.

   Physician participation in this protocol is essential
National Patient Safety Goals

**S B A R**  *Situation, Background, Assessment, Recommendation*

- Your participation in a standardized, interactive approach to “hand off” communication is required.

- This approach provides the opportunity for questions between the giver and receiver when a patient transfers from one care setting or provider to another.

- The objective of a “hand off” is to provide accurate information about a patient’s care, treatment, current condition and any recent or anticipated changes to all involved in the care process.

- Hand off can be verbal, written or in an electronic format.
National Patient Safety Goals

S – Situation
Identify yourself, patient’s name and current situation.

B – Background
Relevant H&P information, physical assessment pertinent to the situation, treatment/clinical course summary, abnormal test results and pertinent changes.

A – Assessment
Offer conclusions about the present situation.

R – Recommendation
Explain what you think needs to be done and what the patient needs; allow questions.
Health Central has established an Infection Control Program, which requires the participation support and cooperation of all personnel.

In addition to screening for and reporting isolation cases, suspected infections and positive cultures, as well as providing required follow-up information, each department will be responsible for full and timely cooperation with the Infection Control Committee/Infection Control Practitioner to develop and implement remedial/corrective action.

Good infection control practices are critical for maintaining a safe environment for your patients and for you. Following precautions that are presented in the next few slides will ensure protection for everyone.
Hand Hygiene is recognized as a National Patient Safety Goal and the foundation of effective infection control practice.

- All patient care areas have alcohol-based antiseptic available in addition to soap and water.
- Artificial nails, extenders, fingernail wraps, or other fingernail applications shall not be worn, system-wide, by healthcare providers working in/with patients and their supplies.
- Hands will be cleaned with soap and water or alcohol antiseptic when entering and leaving a patient’s room.

WASH IN, WASH OUT
Infection Prevention: Standard Precautions

- Assess the risk and use appropriate personal protective equipment (PPE):

  **GLOVES** – will be worn when the hands may directly contact blood or other potentially infectious material.

  **GOWNS** – wear if splashing/spraying expected OR in rooms identified as requiring contact isolation.

  **FACE/EYE PROTECTION** – if spraying/splashing is expected.
Infection Prevention: Expanded Precautions (Isolation)

- **Contact precautions** – e.g., multi-drug resistant organisms such as MRSA, VRE, C-difficile and *multi-drug resistant* gram negative organisms, scabies, lice, major draining wounds require **gown and gloves**.

- **Droplet precautions** – e.g., bacterial meningitis, pertussis, influenza require **regular mask/gloves when entering the room**.

- **Airborne precautions** – e.g., TB or suspected TB, chickenpox (with contact precautions) require **N-95 fit tested mask and negative airflow room**.
Infection Prevention: Tuberculosis

• Following a positive screening by an RN your patient is placed on airborne precautions or masked until placement can be made.

• You will be called to make further assessment for the need to isolate the patient of begin the process to rule out TB.
ENVIRONMENT OF CARE
The Joint Commission mandates that Licensed Independent Practitioners be familiar with their roles and responsibilities relative to the Environment of Care.

RATIONALE: Plans and procedures are of no value if those who work in the organization do not know how to follow them. Everyone who works in the organization is responsible for safety. It is important for them to know how to identify and minimize risks, what actions to take when an incident occurs, and how to report it.
Environment of Care

- High level management plans and the policies and procedures pertaining to the Environment of Care can be found in the Safety Manual by accessing HCNet or contact Medical Staff Services.


- Emergency Codes are listed on the back of your Health Central issued ID badge.

- To report an Emergency, contact the PBX hotline at ext. “33”.

- To report an Environment of Care incident, malfunction, or physical risk, contact the Call Center at ext. 1700.
THE JOINT COMMISSION
The Joint Commission

- The Joint Commission survey process focuses on the actual delivery of care, treatment and services.
- Surveys are unannounced.
- Patients, physicians, and staff may contact the Joint Commission if issues of patient safety are not addressed.
- Patients receive information about how to contact the Joint Commission if they have complaints. As a result, surveyors can visit our facility at any time to follow up on these complaints.
- We strive to be ‘ever ready’ for any survey from any regulatory agency.
DOCUMENTATION
Your cooperation with creating a comprehensive medical record for your patient is essential. Complete and accurate documentation is critical to our goal of delivering high quality, safe patient care.

The following slides emphasize the importance of good documentation. Please review the requirements for H&P’s, the appropriate use of restraints and general documentation requirements.
PER HEALTH CENTRAL MEDICAL STAFF RULES AND REGULATIONS

• A patient admitted for inpatient care or ambulatory surgery will have a medical history taken and an appropriate physical examination performed by a qualified physician.

• A history and physical examination is documented in the patient’s medical record within 24 hours of admission. If a history and physical examination have been performed within 30 days before admission, a durable, legible copy of this report may be used in the patient’s medical record, provided any changes that may have occurred are recorded in the medical record at the time of admission.
A history and physical examination shall contain

• a chief complaint

• details of present illness

• relevant past medical history, past surgical history, current medications, relevant social and family history, and allergies

• inventory of body systems

• comprehensive and current physical assessment including a minimum of heart and lungs as well as pertinent normal and abnormal findings

• provisional diagnosis and plan of care
• Date and sign each entry.

• Enter orders directly into HEO (Computerized Practitioner Order Entry)

• Use your physician ID/dictation number when writing orders.

• Do not use prohibited abbreviations.

• Do not document anything inflammatory in the medical record. There are other avenues to address any concerns you may have.
The attending physician is responsible for a complete and legible medical record for each patient. The record shall include:

- identification data
- name of any legally authorized representative
- emergency care, if provided
- patient assessments, medical history and physical examination
- diagnosis and reasons for admission
- goals of treatment
- evidence of known advance directives
- informed consent
- diagnostic and therapeutic orders and test results
- operative and other invasive procedures performed
- progress notes

continued
• reassessments and revisions to treatment plans
• clinical observations
• the patient’s response to care
• consultation reports
• medications ordered for inpatients, medication dispensed to any patient on discharge, every medication administered and any adverse drug reaction
• all relevant diagnoses established during the course of care
• referrals and communications made to external or internal care providers and to community agencies
• conclusions at termination of hospitalization
• discharge instructions and discharge summary or final progress note.
Documentation: Medical Records

• No medical record shall be filed until complete, or certified final although incomplete, by the Medical Records Advisor.

• All medical records shall be completed within 30 days from the date of the patient's discharge. The physician not completing the records within the 30 days will have monetary fines imposed per the Medical Records Delinquency Policy until the records are complete.

• A medical record will be considered delinquent if the verbal orders, discharge summary, operative report, history and physical and or consultation reports are not completed and authenticated within 30 days of discharge.
The use of verbal/telephone orders is discouraged.

Verbal/telephone orders should be used infrequently and limited to situations in which it is impossible/impractical for the ordering practitioner to manually write the order or enter it electronically.

Orders shall be read back to the person dictating the order to verify accuracy.

Authenticate/cosign all verbal and telephone orders for DNR, narcotics and restraints within 24 hours.
Documented

• If nurses can’t read it, your order cannot be carried out.
• If other physicians can’t read it, they will not be able to coordinate the patient’s care with you.
• If coders can’t read it, how can they code it correctly?
Federal:
• Centers for Medicare and Medicaid Services (CMS) – focus is on proper reimbursement.
• Office of Inspector General (OIG) - monitors payment errors to physicians.
• The Joint Commission – accreditation permits billing to government payers such as Medicare and Medicaid.

State:
• Agency for Healthcare Administration (AHCA) – maintains statistics for Florida and profiles physicians practices.

Health Central:
• HIM – ensures compliance with all regulatory agencies and maintains statistics for reappointment.
• Coding – assigns appropriate and accurate codes for reimbursement and statistics.
Restraint Use

- Health Central works towards the goal of a restraint-free environment by creating strategies that limit the need for restraints by focusing on alternative methods for ensuring patient safety.

- When unavoidable, restraints are utilized based on the individually assessed needs of the patient and only as a last resort after alternatives to restraint and less restrictive measures have proven unsuccessful.

- Restraint Protocols have been developed for use with the patient who has an individually assessed need for restraint.

- The use of restraint or seclusion in any form for the purposes of coercion, discipline, retaliation, or staff convenience is strictly prohibited.
Restraint Use

• No PRN or standing orders for restraints are permitted.

• You must sign initial written or verbal orders within 24 hours of the initiation of restraint use.

• Health Central has a *Clinical Protocol Restraint: Justification and Order form* which includes all required elements.

• You must examine the patient to verify the need for restraints.

• Verbal and written orders for restraint use for the violent, self-destructive patient must be time limited and may only be renewed for up to 24 hours.
Thank you!

We hope this presentation is helpful to you as you begin your practice at Health Central.

Please contact Medical Staff Services at 407-296-1822 if you have any questions.

Welcome to the Health Central team!

Medical Staff Bylaws, Policies, Rules & Regulations can be found at

www.healthcentralmedicalstaff.org