HOLLYWOOD
PRESBYTERIAN MEDICAL CENTER

New Physician Orientation

About Us

CHA Hollywood Presbyterian Medical Center (HPMC) is part of the CHA Health Systems (CHS), a global healthcare enterprise which owns and operates healthcare facilities in the United States, Korea, Japan, Singapore, Armenia, Australia, and Taiwan. CHS includes six general hospitals, a medical university, numerous fertility centers, and a premium anti-aging life center.

HPMC has the distinction of being one of the first hospitals in Los Angeles and the first hospital in Hollywood. It is also the first hospital to start a Critical Care Program, conduct an inner ear cochlear implant, and offer Emergency Medicine as a subspecialty.

The seeds for the hospital were planted in 1920, when physicians and community members realized the need in the Los Angeles area to accommodate a growing population. This need spurred an effort to raise funds to build a hospital in Hollywood. Despite numerous obstacles in getting the project off the ground, construction on the hospital began in 1922 and Hollywood Hospital received its first patients on May 15, 1924.

Over the years, the hospital has grown and evolved to accommodate the diverse needs of our community. Today, HPMC is a 434-bed acute care facility with more than 600 physicians representing virtually every specialty. Despite nearly a century of change, one thing remains the same: Our commitment to being the difference. The difference to our patients; the difference to our community; the difference to you.

Administration

Robert Allen, President and Chief Executive Officer (pictured)
Angelie Gaweco, Chief Financial Officer
Harold Newton, Vice President, Operations
Irene Ruiz, Vice President, Human Resources
Jamie Chang, MD, Chief Clinical Operations Officer
Joung Lee, MD, Chief Administrative Officer (pictured)

Medical Staff Leadership

Peter H. Lee, MD, Medical Staff President
Dallas Cottam, MD, President-Elect
Arus Zograbyan, MD, Secretary
Edwin Lee, MD, Treasurer

Chae Suh, MD, Department of Anesthesiology and Pain Management
John Lin, MD, Department of Diagnostic Imaging
Shahrokh Kohanim, DO, Department of Emergency Medicine
Benjamin Behroozan, MD, Department of Family Practice
Elizabeth Yoo, MD, Department of Medicine
Bente Kaiser, MD, Department of Obstetrics and Gynecology
Lilian Sababa, MD, Department of Pediatrics
Antoine Mansour, MD, Department of Surgery

About Medical Staff Services

The Medical Staff Services Department of CHA Hollywood Presbyterian Medical Center (HPMC), as much as possible, will ensure that physicians remain highly engaged and committed to their profession.

We believe that physicians feel a professional commitment to healing and providing care.

We believe that a physicians' greatest source of satisfaction is his/her engagement with patients (patient encounters).

We trust that what attracts most physicians to medicine is the unique nature of the physician-patient relationship.

We believe that the majority of physicians submitted to the grueling and expensive grind of medical education and training primarily to play a positive role in the lives of other human beings.

Therefore, the Medical Staff Services Department will at times function as a challenge network so that physicians can improve each other.

What Can Medical Staff Services Do For You?

The Medical Staff Services Department performs service encounters for the following functions:

Credentialing
Initial (new) appointment and Reappointment.

Medical Staff Meetings
Schedule, coordinate, attend, record, and prepare materials and correspondence for.

Graduate Medical Education
Coordinate and process Student and Resident Trainees, Faculty, and shadow observers.

Research (IRB)
Coordinate and process requests for all human research trials.

Continuing Medical Education
Coordinate, schedule, record attendance, and provide accreditation support.

On-Call Schedule
Manage and publish the Emergency Room On-Call Schedule.

Orientation
Orient new providers, including ID verification, EMR training, badging, lab coats, QuickCharge, and tours.

Payments and Reservations
Dues, fines, and Medical Staff events; Pay stipends.

Meet Your Medical Staff Services Team

medstaff@hpmedcenter.com

Guenther Baerje, Director

The Director of Medical Staff Services provides leadership, management, and operational oversight of the Medical Center's Medical Staff organization and it's support services. The Director works collaboratively with the Medical Staff President, the Medical Executive Committee, and other Medical Staff Leaders, to:

- Plan, organize, direct, and coordinate the programs and activities of the Medical Staff organization
- Ensure that the strategies of the organization are supported and attained
- Ensure that the goals and plans are realized
- Ensure that there is adherence to the requirements of regulatory and accreditation bodies that are relevant to the organized Medical Staff

Guenther is also responsible for coordinating the following meetings: Bylaws Committee; Code of Conduct Committee; Contracts Review Committee; Medical Bioethics Committee; Medical Executive Committee; Quality Management Committee; and Wellbeing Committee

Delia Connelly, Associate Director

In addition to supervising the Medical Staff Services Department, Del manages the Graduate Medical Education program and the Emergency Call Panel.

She is also responsible for coordinating the following meetings: Cardiology Section; Continuing and Graduate Medical Education; Utilization Management

Laura Castro, Medical Staff Coordinator

Laura is responsible for credentialing members of the **Departments of Family Practice, Obstetrics and Gynecology, and Pediatrics**. She is also responsible for coordinating meetings for these same Departments. And she starts the reappointment application process for all practitioners.

Rachel Hernandez, Medical Staff Coordinator

Rachel is responsible for credentialing members of the **Department of Medicine**. She also coordinates the following committees: Credentials, Interdisciplinary Practices

Kelly Phan, Credentialing Coordinator

Kelly is responsible for Continuing Medical Education and Research. She also credentials members of the **Department of Surgery**. And she coordinates the Department of Surgery meeting and Robotics Steering and Research Oversight Committees.

Nancy Rodriguez, Credentialing Coordinator

Responsible for credentialing members of the **Departments of Anesthesiology, Diagnostic Imaging, and Emergency Medicine**. Also responsible for coordinating meetings for these same Departments, and the Emergency Department Performance Improvement Committee. And she manages all expireables.

Did you know that in 2018 …?

101
New provider applications were processed

136
Medical Staff Committee meetings were held

168
Reappointment applications were processed

Proctoring

Why care about proctoring?

Provisional members of the Medical Staff cannot schedule surgical cases, nor admit patients without a proctor. Further, you cannot serve on the Emergency Call Panel until you are released from proctoring. And physicians who fail to complete proctoring can only qualify for reappointment to the Affiliate Staff; these are members *without* privileges.

How quickly do I need to complete proctoring?

Immediately. Completion of proctoring is volume-dependent, not time-dependent. If you are a surgeon, you must have your first six cases concurrently proctored. Non-surgeons should have their first six History and Physicals retrospectively reviewed with a proctor within 24-48 hours of admission. Thereafter, within 14 days of discharge, the accompanying Discharge Summaries should be reviewed by a proctor.

Who is my proctor?

A list of eligible proctors is attached to your appointment letter. Surgical cases should be scheduled around your proctor's calendar.

When am I released from proctoring?

You are not released from proctoring until the Credentials Committee approves the proctoring reports submitted by your proctors. Approval will be communicated to you in writing, after the Governing Board meeting; letters are sent at the beginning of each month.

Can I proctor my own associate?

If there are a limited number of physicians who qualify as proctors, then it might be acceptable for a Provisional member to be proctored by his or her associate. This will have to be approved *beforehand* by the member's Department, which is typically done by vote. A proctor may also serve as the assistant surgeon.

Anything else I should know?

Provisional members should not see proctoring reports. These reports are considered peer review and are confidential.

Be the Change!

The Medical Staff needs physicians to participate in its self-governance. Rather than complain about situations that you find irritating or frustrating, volunteer on a committee and **get involved**. Review the list of committees below and ask to volunteer on one or more.

You may also want to talk with your Department Chair to participate in your Department's peer review and/or proctoring.

<u>Appointment and Reappointment</u>
Credentials
Interdisciplinary Practices

<u>Setting and Communicating Expectations</u>
Bylaws
Continuing and Graduate Medical Education
Medical Bioethics
Research Oversight

<u>Using Data to Improve Patient Safety</u>

Infection Prevention
Pharmacy and Therapeutics
Quality Management
Utilization Management

Medical Staff Meetings are typically held in one of three rooms in the **<u>Doctors Tower</u>**:

Administrative Conference Room (ACR)
On the second floor, adjacent to the Administrative Suite.

Tower Surgery Conference Room (TSCR)
Also on the second floor, adjacent to Outpatient Surgery.

Medical Staff Conference Room (MSCR)
Level "A" near the Auditorium and Lecture Hall, adjacent to Health Information Management (Medical Records).

Acceptable and Prohibited Conduct

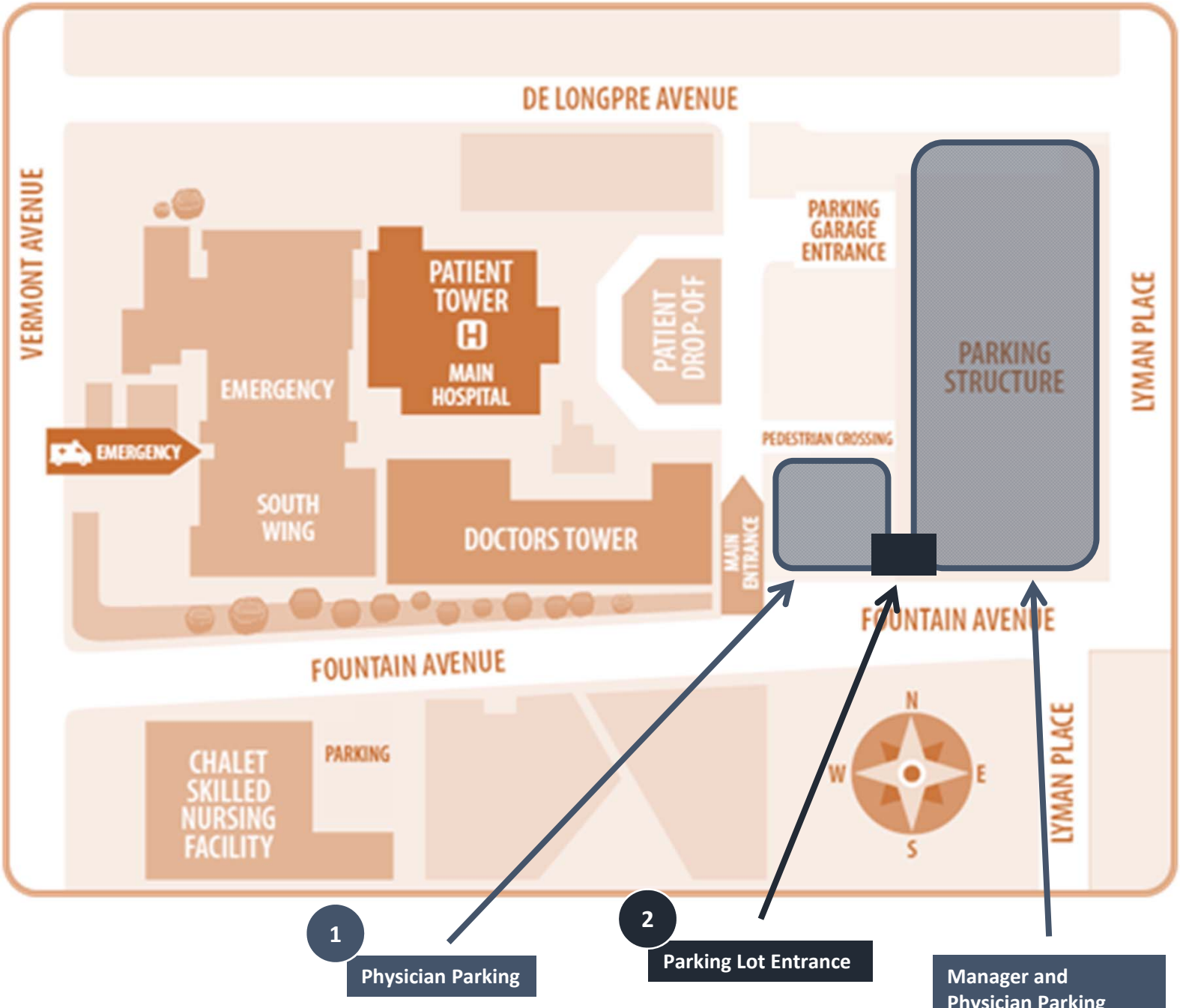
The Medical Staff has defined **Acceptable Conduct** as conduct that enables others to perform their duties and responsibilities safely and effectively, and contributes to respectful and constructive communication. Examples of Acceptable Conduct include but are not limited to: (a) Respectful communication in a calm and professional manner, (b) Addressing disagreements professional and factually, without animus or personal attacks, (c) Timely and appropriate response to requests and concerns, (d) Communication and personal interaction in a manner that is respectful of an individual's culture and beliefs.

Prohibited Conduct is any conduct, including without limitation, harassment, sexual harassment, unethical, or other forms of inappropriate conduct, which jeopardizes or is inconsistent with quality patient care at the Hospital, or constitutes the physical or verbal abuse of patients or others involved with providing quality patient care at the Hospital, and is manifested through personal interaction with practitioner, Hospital personnel, patients, family members, or others, which: (a) interferes or tends to interfere with high quality patient care or the orderly administration of the Hospital or the Medical Staff, or (b) Creates a hostile work environment, or (c) Is directed at a specific person or persons, causes substantial emotional distress, and serves no legitimate purpose.

Examples of Prohibited Conduct include (a) Any offensive striking, pushing, or touching of Hospital Staff or others; (b) Any conduct that would violate Medical Staff and/or Hospital policies relating to discrimination and/or sexual harassment; (c) Throwing, hitting, pushing, or slamming objects in an expression of anger or frustration; (d) Yelling, screaming, or using an unduly loud voice directed at patients, Hospital employees, other practitioners, or others; (e) Refusing to respond to a request by any caregiver for orders, instructions, or assistance with the care of a patient, including but not limited to, repeated failure to respond to calls or pages; (f) Use of racial, ethnic, epithetic, or derogatory comments, or profanity, directed at Hospital employees or others; (g) Undue criticism of Hospital or Medical Staff personnel, policies or equipment, or other negative comments that undermine patient trust in the Hospital or Medical Staff in the presence or hearing of patients, patients' family members, and/or visitors; (h) Use of medical record entries to criticize Hospital or Medical Staff personnel, policies, or equipment, other practitioners, or others; (i) Unauthorized use and/or disclosure of confidential or personal information related to any employee, patient, practitioner, or other person; (j) Use of threatening or offensive gestures; (k) Intentional filing of false complaints or accusations; (l) Any form of retaliation against a person who has filed a complaint against a practitioner alleging Prohibited Conduct; (m) Use of physical or verbal threats to Hospital employees, other practitioners, or others, including without limitation, threats to get an employee fired or disciplined; (n) Persisting to criticize, or to discuss performance or quality concerns with particular Hospital employees or others after being asked to direct such comments exclusively through other channels; (o) Persisting in contacting a Hospital employee or other person to discuss personal or performance matters after that person or a supervisory person, the Chief Executive Officer or designee or Medical Staff leader has requested that such contacts be discontinued.

Medical Staff Category Options

Category	Active	Courtesy	Provisional	Allied Health	Affiliate	Medico Administrative	Honorary / Emeritus	Leave of Absence
Privileges	Yes, Unsupervised	Yes, Unsupervised	Yes, Supervised	Yes, Supervised	No	No	No	No
Vote, Hold Office	Yes	No	No	No	No	No	No	No
Paragon	Yes	Yes	Yes	Yes	Yes *	No	No	No
Dues	$350	$350	$350	$100	$350	$350	$0	$350
Designed for	Regularly admit or treat patients in the Medical Center Attend Medical Staff meetings Participate in peer review Proctor new Provisional members	Engage in patient care but are not Active	Newly appointed physician who require proctoring	Physician extenders	Physicians who are not requesting privileges, and will not be authorized to provide any patient care services * Read-only access	By contractual arrangement, provide consultative and administrative services to the Medical Center	Former leader / contributor who has retired but wants to remain a part of the Medical Staff community	A leave of absence is intended to provide a mechanism by which a practitioner may temporarily leave the area and/or active practice without undergoing a full credentialing process upon returning to practice. A leave of absence will not be approved for members remaining in active practice in the area or remaining on the medical staff of another area hospital.



Physician Parking Lot

1. Physician Parking is located off of Fountain and Lyman.

2. The entrance to this parking lot is on Fountain. Use your badge to open the gate and barrier. Then proceed straight to the next card access parking barrier on the left.

PLEASE DRIVE RESPONSIBLY
You will be responsible for all damage and injuries caused by unsafe driving.

HIPAA Reminder

Patients have a right to privacy, including patients that are our family members and co-workers.

If / when you become aware of a family member or fellow staff member that is hospitalized, please note that none of us is authorized to look at a patient's medical record without patient authorization or a work-related need to do so (e.g., *current* treating relationship).

Please be advised that access to patients' records are audited. Corrective action will be taken against those identified as accessing a patient chart without a work-related need to do so. Fines and penalties are also applicable under the law.

Remember, violating patient privacy is against the law.

Cafeteria and Doctor's Dining Room

Located on the first floor of the Patient Tower, the **Doctor's Dining Room** is the only sit down, table service Doctor's Dining Room in the Downtown Los Angeles area. Physicians who are actively seeing patients may eat at no charge.

Medical Executive Committee

The Medical Executive Committee (MEC) acts as a representative of the medical staff. The committee proposes changes and enacts policies, procedures, and other items in an effort to improve patient care and medical staff structure.

The MEC is composed of the Medical Staff Officers (President, President-Elect, Secretary, Treasurer, two Members-At-Large, and the past President), Department Chairs (Anesthesia, Diagnostic Imaging, Emergency Medicine, Family Practice, Medicine, Obstetrics and Gynecology, Pediatrics, and Surgery), and the following Committee Chairs: Quality Management, Utilization Management, Credentials, Bylaws, and Continuing and Graduate Medical Education.

The goal of the MEC is to preserve and continually enhance the adequacy and quality of medical care rendered to patients in the Medical Center. The MEC also endeavors to adapt and excel in response to the ever-changing external forces that affect hospital-based patient care and physician practice. The MEC is committed to supporting members of the Medical Staff as a liaison between physicians and hospital Administration.

The Bylaws also require that the MEC …

- Recommend action to the Chief Executive Officer on matters of Medico Administrative nature;
- Make recommendations on Medical Center management matters and long-range planning;
- Report to the Governing Board on medical care rendered to patients in the Medical Center;
- Educates the Medical Staff concerning accreditation requirements;
- Reviews credentials of applicants and makes recommendations concerning membership and privileges;
- Periodically reviews the performance and clinical competence of all staff members;
- Ensure professional ethical conduct and competent clinical performance of the Medical Staff;
- Commences investigations or recommends / imposes discipline that may result in a fair hearing review

Well-Being Committee

The purpose of the Well-Being Committee is to support the health and wellness of Medical Staff members, and in so doing, protect patient welfare, improve patient care, and improve Medical Staff functioning. The Committee works to achieve this purpose through prevention of, and intervention in, alcohol-related, drug-related, and behavioral problems affecting members of the Medical Staff. The Committee also supports Medical Staff members who are involved with the Medical Board regarding impairment issues.

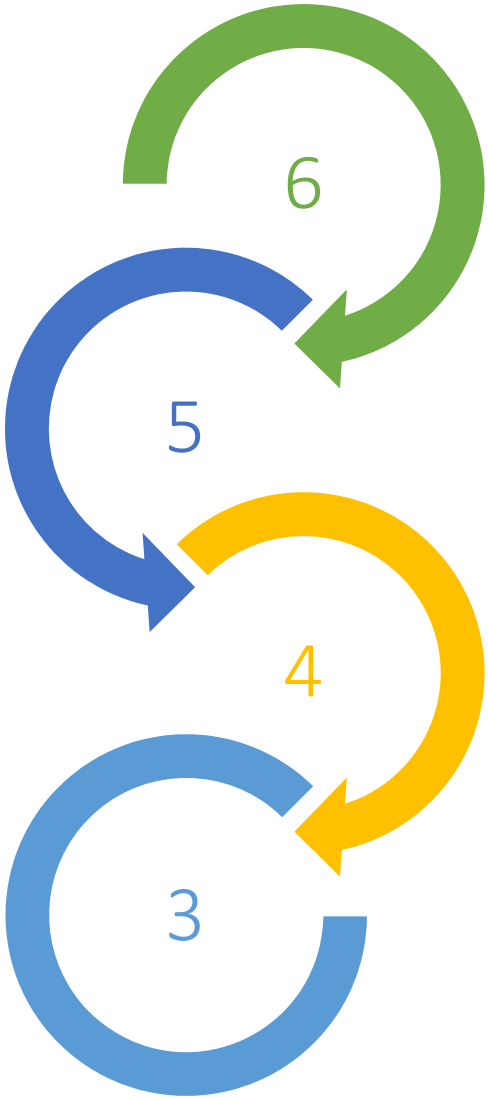
The Well-Being Committee has developed a supportive, non-punitive process for identifying, referring for treatment, and monitoring Medical Staff members who may be suffering from impairment resulting from drug or alcohol use or other disabling psychiatric or physical conditions that pose a threat to acceptable professional functioning and patient care.

The process is designed to provide assistance and rehabilitation rather than discipline to aid Medical Staff members in retaining acceptable professional functioning consistent with quality of care.

The process is confidential. All consultations and discussions are held in private locations, and documentation and records are handled confidentially.

Reappointment

The Joint Commission (TJC) and the Medical Staff Bylaws require that all practitioners be reappointed at least every 24 months, to validate current clinical competency. The process follows this timeline →



6 Months

Medical Staff Services will request an activity report from Health Information Management (HIM) to determine if you qualify for clinical privileges. If you qualify, an appropriate application will be emailed to you (Active or Courtesy).

Providers who have had zero activity (or have not completed proctoring) will only qualify for reappointment to the Affiliate Staff. These providers will be telephoned and asked if they wish to reapply as an Affiliate member, or voluntarily resign. The appropriate form will then be emailed.

5 Months

Medical Staff Services will telephone and email reapplicants who have not responded to the six-month notice.

4 Months

Medical Staff Services will provide the names of reapplicants who have not responded to the appropriate Department Chair and the Medical Staff President for follow-up telephone calls.

3 Months

Reapplicants who have not submitted a "complete" reapplication or voluntarily resigned, will be deemed voluntary resignations, and reported to the Credentials Committee, Medical Executive Committee, and Governing Board.

Frequently Asked Questions

What if I believe that the clinical activity report from Health Information Management (HIM) is inaccurate?
We encourage you to speak directly with them by calling 323.913.4852 and discussing your clinical practice. HIM may be able to write a specific report for you to capture your clinical activity.

What is considered a "complete" application?
In addition to answering all questions on the application form …

Affiliate and Medico Administrative Staff must submit a listing of CME obtained during the past two years. Allopathic (MD) physicians who are Board Certified must submit a total of 50 hours; non-Board Certified allopathic and Osteopathic (DO) physicians must submit 100 hours.

In addition to the above, Active Staff must also submit a completed privilege form.

And Courtesy Staff, in addition to the above, must also submit peer references, and a clinical activity report from another local healthcare facility that lists the number of patients seen, and the number and types of procedures performed during the past two years.

Clinical Activity Reports

Initial applications and reapplicants to the Courtesy Staff are required to submit a hospital-generated **activity report** for the immediate-past two years. This report must list (a) the number of patients seen and (b) the number and types of procedures performed. Ideally the report will look something like this:

To obtain a clinical activity report from HPMC, call Health Information Management at 323.913.4852.

Facility Name: ABCD Medical Center
Provider Name: House, Gregory, MD
Specialty: Infectious Disease
Date Range: 01/01/2017 through 12/31/2018

Total patients seen: 169
Total procedures performed: 308

Procedure	Date	Masked ID
Insertion arterial line	12/17/2017	2002-905-XXXX
Paracentesis	03/15/2018	2002-071-XXXX
Lumbar puncture	01/02/2018	2001-854-XXXX

In lieu of a hospital-generated activity report, a Courtesy Staff member may submit a copy of his or her most-recent Ongoing Professional Practice Evaluation (OPPE) report. OPPE reports submitted must include all six of the following competencies, and list metrics and outcomes with each competency:

Patient Care
Medical Knowledge
Practice-Based Learning and Improvement
Interpersonal and Communication Skills
Professionalism
Systems-Based Practice

A third option would be to submit at least five each of the following:

History and Physical
Consultation
Discharge Summary
Procedural / Operative Report, per privilege listed

Bylaws and Rules Links

Medical Staff Bylaws
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/Final-Bylaws-Approved-March-31-2019.pdf

General Rules
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/GeneralRules-04-2019.pdf

Allied Health Professional Staff Rules
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/AlliedHealthRules-03-2019.pdf

Department Rules, Anesthesiology and Pain Management
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/Anesthesiology-09-2018.pdf

Department Rules, Diagnostic Imaging
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/Diagnostic-Imaging-11-2018.pdf

Department Rules, Emergency Medicine
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/Emergency-Med-10-2018.pdf

Department Rules, Family Practice
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/Family-Practice-04-2019.pdf

Department Rules, Medicine
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/Medicine-04-2019.pdf

Department Rules, Obstetrics and Gynecology
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/ObGynRules-10-2018.pdf

Department Rules, Pediatrics
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/Pediatrics-04-2019.pdf

Department Rules, Surgery
https://www.hollywoodpresbyterian.com/wp-content/uploads/2019/07/Surgery-10-2018.pdf

Serious Illness Conversation Guide

Set-Up

- Thinking in advance
- Is this okay?
- Hope for best, prepare for worst
- Benefit for patient / family
- No decisions necessary today

Guide

Understanding

What is your understanding now of where you are with your illness?

Information Preferences

How much information about what is likely to be ahead with your illness would you like to hear from me?

For example, some patients like to know about time, others like to know what to expect, others like to know both

Prognosis

Share prognosis as a range, tailored to information preferences

Goals

If your health situation worsens, what are your most important goals?

Fears / Worries

What are your biggest fears and worries about the future with your health?

Function

What abilities are so critical to your life that you can't imagine living without them?

Trade-Offs

If you become sicker, how much are you willing to go through for the possibility of gaining more time?

Family

How much does your family know about your priorities and wishes?

Suggest brining family and/or healthcare agent to next visit to discuss together

Act

- Affirm commitment
- Make recommendation about next steps
- *Acknowledge medical realities*
- *Summarize key goals / priorities*
- *Describe treatment options that reflect both*
- Document conversation in Paragon
- Provide patient with Family Communication Guide

General Inpatient Hospice Care (GIP)

Did you know …?

Administrative and Medical Staff Leadership believe that primary care physicians are the *best* advocate for their patients? You've had a relationship with your patients for years, perhaps decades, so you understand their backgrounds and the resources that are available to them.

Administration and Medical Staff Leadership also trust that you want to provide the very *best* care possible for your patients, doing everything within your power to support and comfort your patients.

We recognize, however, that many primary care physicians feel uncomfortable when confronted with dying patients. Despite your *best* intentions, it is challenging to single-handedly manage the physical and psychological needs of end-of-life patients.

In fact, most end-of-life patients want to spend the rest of their life comfortable with their loved ones, and wish that hospice options would have been discussed and started **sooner**.

This is why CHA Hollywood Presbyterian Medical Center has contracted with Charter Healthcare to provide inpatient hospice care.

How general inpatient (GIP) hospice works

1. The patient's Attending Physician will need to enter a "Discharge to Inpatient Hospice" order.

2. After the patient has been discharged in the electronic health record, either the Attending or a Hospice physician will enter an "Admit to Inpatient Hospice" order, which will generate a new account number for the patient.

3. The Attending or Hospice physician will then need to enter an admission note, explaining that the patient was discharged and readmitted to Inpatient Hospice, and that an H&P can be found under the previous account number (this number must be documented).

But what if …

I feel that I am letting down, or quitting on, my patient?
This is a common feeling. Hopefully this will give you some comfort: Hospice (and palliative care) are not about wanting to die. Rather, it is about *extending* and making the most of your patient's time. Hospice services provide comfort and improve quality of life, carrying out wishes of your patient. In fact, patients who choose hospice may live longer than those who do not choose hospice. This is because hospice care manages the wants and needs of your patient.

I think that hospice won't *do* anything for my patient?
This is a misconception. Transferring a patient to hospice gives your patient and their family access to an expert team of physicians, nurses, hospice aides, social workers, chaplains, bereavement coordinators, and other caregivers to meet every end-of-life need. They will educate your patient and their family about the disease process and end of life care. The team will also take into consideration the trajectory of the disease, and treatment options to enhance the patient's quality of life. They can help manage both physical and non-physical symptoms. Further, family members will receive spiritual and emotional support. Bereavement care and counseling are offered to surviving family and friends for 13 months post death.

GIP (continued)

But what if …

I don't want to let go of my patient?
Then don't - stay involved as the attending physician! Here're a few things to help with this. For necessary care related to the hospice diagnoses, the attending physician may bill Medicare Part B for evaluation and management (E&M) services with code "GV". The E&M services provided by the attending physician, but not related to the hospice diagnosis, are covered when billed to Medicare Part B with the code "GW" or the condition code "07".

But if you decide to remain involved in a supportive capacity, know this: The hospice team will keep you apprised of changes in your patient's status on a regular basis and wants your collaboration in the patient's care. In fact, if you choose not to sign the death certificate, the hospice medical director can do so.

My patient wants hospice, but the family does not?
This happens. Just know that hospice is your patient's choice and can be arranged whether family members are able (or want) to help with care or not. Remember, anyone can make a referral for hospice care – a family member, a caregiver, or the patient themselves.

The family cannot afford hospice?
Patients are never denied hospice care. We'd suggest that you speak with a hospice community relations representative. Hospice care is covered under the Medicare hospice benefit, or by Medicaid, and/or most private insurance plans.

Did you know…?
Federal and State law mandate that patients have the *right* to request education on hospice care.

See it. **Say it.**

Zero harm is the goal for every healthcare provider! The only way to achieve this is for **Patient Safety** to be deeply embedded in our workplace culture. If you see something unsafe ... **SPEAK UP!!!**

When we talk about **Patient Safety**, we're really talking about how we can protect our patients from errors, injuries, accidents, and infections.

Zero harm is the goal for every healthcare provider! The only way to achieve this is for **Patient Safety** to be deeply embedded in our workplace culture. If you see something unsafe ... **SPEAK UP!!!**

When we talk about **Patient Safety**, we're really talking about how we can protect our patients from errors, injuries, accidents, and infections.

At CHA HPMC, **Patient Safety** is a **Top Priority.** Strong healthcare teams reduce infection rates, put checks in place to prevent mistakes, and ensure strong lines of communication between hospital staff, patients and families.

Patient Safety is everybody's responsibility. We need to work together to keep our patients safe all the time. No unsafe condition should occur in our shift! We are all accountable for our patients, visitors, and each other. Let's always keep **Patient Safety** a priority!

Don't hesitate to escalate, if you see a practice, behavior or condition that could harm a patient.

If you see it, **say it.**

CHA HOLLYWOOD PRESBYTERIAN MEDICAL CENTER

Clinical Documentation Improvement

If you have questions, please call:

Max Bekalo, Sr. Director
323.913.4523

Christ Nazarians, Manager
323.913.4867

Severe Inflammatory Response Syndrome (SIRS)

- SIRS Criteria (2 or more)
- Temp > 100.95 or < 98.6 F
- HR > 90 beats per min
- RR > 20 breaths per min
- WBC > 12,000 or < 4,000
  or Bands > 10%

Organ dysfunction variables
- SBP < 90 mmHg
- MAP < 65 mmHg
- Bilirubin > 2.0 mg/dL
- Platelets < 100K
- INR > 1.5 or aPTT > 60s
- Lactate > 2 mmol/L
- CR > 2.0 mg/dL or Urine Output < 0.5 ml/kg/hr for 2 hrs

Sepsis, Severe Sepsis and Septic Shock

- Sepsis: SIRS criteria met + any documented or suspected infection
- Severe Sepsis: Sepsis criteria met + acute organ dysfunction
- Septic Shock: Severe Sepsis criteria met + two or more consecutive low blood pressure readings (SBP <90) within one hour of concluding fluid resuscitation (30 ml/kg/hr) or lactic acid ≥ 4 mmol/L

Acute Renal Failure

- Acute Kidney Injury **Change** in Sr. Cr. ≥ 0.3 mg/dL (in 48 hrs)
  - **Change** in Sr. Cr. ≥ 50% (1.5 fold from baseline) or
  - **Decrease** in Urine Output (<0.5 ml/kg per hour for > 6 hrs)

[Critical Care, 2007, 11:R31]

- Other Definitions
  - **Increase** in Sr. Cr. ≥ 0.5 mg/dL (in ≤2 wks if baseline < 2.5 Mg/dL)
  - **Increase** in Sr. Cr. > 20% mg/dL (in ≤ 2 wks if baseline > 2.5 mg/dL)

[JAMA< 2003, Vol. 298, No. 6]

Acute Respiratory Failure

- **Arterial PCO_2 > 50 mmHg** *
- **Arterial PCO_2 < 60 mmHg** *
- O_2 Sat < 89%
- PO_2 or FiO_2 < 250 on 50% FiO_2
- **Change in Arterial PO_2 or PCO_2 ≥ 10-15 mmHg from baseline** *
- Rapid deep breathing (Respiratory rate > 20 per min)
- Paradoxical breathing, Intercostal retraction, Cynosis, Anxiety
- May use Venous Blood Gas (VBG) in lieu of ABG

*** Absolute criteria**

[Coding Clinic: 3rd Q 1988, p7; 2nd Q 1990, pp 20-21]

Congestive Heart Failure

Complete documentation requires both Acuity and Type specifications.

- Acuity: Acute, Acute on Chronic, or Chronic
- Type: Systolic, Diastolic, or Combined

Encephalopathy

"Metabolic Encephalopathy" (delirium/acute confusional state) can be caused by brain tumors, brain metastasis, cerebral infarction or hemorrhage, cerebral ischemia, uremia, poisoning, sepsis, multi-organ failure, delirium from withdrawal from sedative / hypnotic / anxiolytic drugs.

Malnutrition

Mild and Moderate Malnutrition
- Serum Albumin 2.8 to 3.5 g/dL, Pre-albumin 5 to 15 mg/dL
- Inadequate nutritional intake, NPO ≥ 5 days
- Weight loss: Up to 5% in one month, 7.5% in three months, or 10% in six months
- Weight 75 to 90% of height standard

Severe Malnutrition
- Serum Albumin < 2.8 g/dL, Pre-albumin < 5.0 mg/dL
- Lymphocytes < 1500/µL, BMI < 18.5
- Hypermatabolic states, e.g. major trauma, sepsis, pancreatitis, burns, etc.
- Weight loss: > 5% in one month, > 7.5% in three months, or > 10% in six months
- Weight < 75% of height standard

Antimicrobial Stewardship Program (ASP)

Antimicrobial Stewardship is defined by the Infectious Diseases Society of America (IDSA) as “coordinated interventions designed to improve and measure the appropriate use of [antibiotic] agents by promoting the selection of the optimal [antibiotic] drug regimen including dosing, duration of therapy, and route of administration.” According to the California Department of Public Health (CDPH), ASPs improve patient outcomes while minimizing adverse events associated with antimicrobial use such as toxicity, *C. diff* infections and the emergence of antimicrobial resistant organisms. Additional benefits include improving susceptibility rates to targeted antibiotics and optimizing resource utilization.

California was the first state to enact antimicrobial stewardship legislation:

- California Senate Bill 739: Hospitals are required to develop a process for monitoring the judicious use of antibiotics, the results of which are monitored by quality improvement committee(s).

- California Senate Bill 1311: Hospitals are further required to adopt and implement an antimicrobial stewardship policy in accordance with guidelines established by federal government and professional organizations, and to establish a multidisciplinary antimicrobial stewardship committee with at least one physician or pharmacist who has undergone specific training related to stewardship.

- California Senate Bill 361: Skilled nursing facilities are required to adopt and implement an antibiotic stewardship policy by January 1, 2017.

Effective January 1, 2017 the Joint Commission has required that all hospitals and nursing care centers in the country have antimicrobial stewardship programs consisting of eight elements of performance in the New Antimicrobial Stewardship Standards (MM.09.01.01):

Antimicrobial Stewardship Program (ASP) (continued)

1. Hospital leaders establish ASP as an organizational priority.

CHA Hollywood Presbyterian Medical Center (HPMC) developed an ASP in 2011 as a subcommittee of the Pharmacy and Therapeutics (P&T) Committee. Members of the committee meet quarterly to discuss plans to improve antibiotic use at HPMC.

2. The hospital provides education to staff and licensed independent practitioners about antimicrobial resistance and antimicrobial stewardship practices.

The ASP publishes an annual antibiogram on the Hospital intranet which shows trends of antibiotic resistance. Information about antimicrobial stewardship will be published in the Annual Safety Information for Medical Staff mailer. ASP leaders have performed CME lectures, medical staff committee presentations, targeted in-person and web-based educational experiences. The ASP has published booklets for the medical staff which offers education about causes and trends of antibiotic resistance and guidance on approaches to promote optimal prescribing.

3. Education is provided to patients and patients' families regarding appropriate use of antimicrobials as needed. Antibiotic information is included in patient education materials.

4. The hospital has an antimicrobial stewardship multidisciplinary team that includes the following members:

- ID physicians – Suman Radhakrishna, MD and Joseph Nussbaum, MD
- Pharmacist – Avo Karapetyan, PharmD
- Infection Preventionist – Ardalan Issa, IP Director
- Microbiology Supervisor – Shirley McGovern

5. ASP core elements (from the CDC):

- Leadership commitment: dedicating necessary human, financial, and information technology resources for ASP.
- Accountability: a single leader is responsible for ASP outcomes. The ASP committee is chaired by Dr. Alan Rothfeld, MD and coordinated by Avo Karapetyan, PharmD.
- Drug expertise: a single pharmacist leader is responsible for working to improve antibiotic use. Avo Karapetyan, PharmD is certified in developing and implementing ASPs and coordinates the ASP at HPMC.
- Action: implementing recommended actions set forth by ASP guidelines. Some examples include requiring documentation of indication and duration for all antibiotic orders, developing facility specific treatment recommendations based on national guidelines and local susceptibility data, developing standard order sets for common clinical syndromes and much more.
- Tracking: ASP monitors antibiotic use and resistance patterns by quarterly reports of antibiotic expenditure per patient day, antibiotic utilization through Days of Therapy per 1,000 Days at Risk, and annual antibiograms.
- Reporting: ASP regularly reports information at the quarterly ASP meetings, P&T, Infection Prevention and Quality Improvement committees.
- Education: educating practitioners, staff, and patients about ASP.

6. ASP uses organization-approved multidisciplinary protocols.

The following are examples antibiotic protocols implemented at HPMC: antibiotic formulary restrictions, pharmacist dosing and monitoring of vancomycin and aminoglycosides, IV to PO conversion protocol,7 day hardstops, renal dosing protocols, dose optimization policies such as extended infusion zosyn, order sets for common infectious disease states such as pneumonia, UTI, sepsis and more.

7. ASP data is collected, analyzed, and reported at quarterly committee meetings.

We have recently acquired data mining software that will enable us to use the CDC's National Healthcare Safety Network (NHSN) Antimicrobial Use option to report, track and analyze Antibiotic Utilization data.

8. The hospital takes action on improvement opportunities identified by the ASP.

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HOLLYWOOD PRESBYTERIAN MEDICAL CENTER

PRESS GANEY®

Patient Satisfaction: Communication with Doctors

During this stay, how often did doctors …

… treat you with courtesy and respect?

… listen carefully to you?

… explain things in a way you could understand?

During this stay, how often did doctors treat you with courtesy and respect?

This question asks patients to assess the frequency with which they perceived you as courteous and respectful. Both elements are judged on your verbal and nonverbal behavior. It is also important to convey a sense of caring for each patient. By treating each individual as a person, rather than simply as a patient, you can make patients feel respected.

> "It is so great to when your doctor visits you just to see how you are coming along. They showed that you are their first concern."

> "Our doctor started courses of treatment without speaking to us. We were in the dark, and if felt very disempowering."

Behaviors to Consider

- **Knock** before entering a patient's room.
- Before entering the room, **ask if you may** enter.
- **Introduce yourself** and **explain your purpose** to patients and family members.
- Ensure that conversations with patients and family members are **private** and cannot be overheard by others.
- Communicate at **the patient's level** by sitting on a chair or stool.
- **Maintain eye contact**. Few gestures carry more weight that looking someone in the eye. This act displays your willingness to listen and your acknowledgment of the other person's worth.
- **Allow patients to express their concerns fully** without interruption. Physicians tend to interrupt with a solution before patients have finished expressing concerns. Rather than jumping in with a solution, allow the patient to express his or her concerns and anxiety. Then, respond with empathy to demonstrate how you care for the person and not only the diagnosis.
- Express **interest in the patient as a person** by asking questions about his or her life beyond the hospital.
- **Speak positively** about other patients, staff members, and the Medical Center.
- Ask patients and family members if there is **anything else** you can do before leaving the room.

To Try

Physicians should follow a three-step process when introducing themselves to a patient for the first time:

1. **Shake the patient's hand.**
   Meanwhile, remain sensitive to nonverbal cues that might indicate whether the patient is open to shaking hands. (Patients may not want to shake hands if they cross their arms, don't reach out to reciprocate your handshake, won't make eye contact, etc.)
2. **Greet the patient using his or her name.**
   This might sound like, "Good morning, Meghan. It's a pleasure to meet you."
3. **Introduce yourself using your first and last name.**
   This might sound like, "My name is John Branson."

During this stay, how often did doctors listen carefully to you?

This question asks patients to estimate how frequently they felt physicians effectively listened. Patients respond positively to physicians who encourage the disclosure of feelings, elicit and respect concerns, and acknowledge patients' fears. Patients respond negatively to physicians who interrupt them, ignore them, or seem uncomfortable with patients' emotional expressions.

> "Doctor Bowers has an exceptional bedside manner. He communicates well and makes sure he's understanding and addressing your problems. I'm very grateful to have had him as my doctor during my hospital stay."

> "My doctor seemed to listen and smile, but I'm not sure he heard what I was saying."

Behaviors to Consider

- Communicate **at the patient's level** by sitting on a chair or a stool.
- Use body language that demonstrates careful listening, such as **nodding** and **eye contact**.
- **Confirm** that you understand what a patient is saying by using verbal cues as they speak, such as "I see" or "Okay," and by **summarizing** what the patient has said once he or she is finished.
- **Avoid interrupting**. Out of concern, physicians often jump in with a solution before a patient has finished expressing him or herself. When a patient is interrupted regularly, or when the solutions offered do not meet a patient's needs, anxiety may increase. Give each person time to finish talking before responding. Acknowledge what the patient said, empathize with his or her feelings, and respond accordingly.
- **Be inquisitive about the patient *and* the person.** Ask patients questions about their health, what caused the hospitalization, and how they feel about being in the Medical Center. Moreover, demonstrate caring that goes beyond the diagnosis by engaging patients in conversations about their lives. Refer back to these responses in future conversations with patients. Create rapport with a patient by asking questions beyond diagnosis:
    - Inquiring about appropriate aspects of the patient's personal lives (e.g., if the patient caught last night's game, will be taking any vacations this season, etc.)
    - Stating your observations about the way a patient may be feeling (e.g., "that must have made you very anxious.")
- By **establishing rapport**, a patient will be more likely to open up with questions and concerns during the visit. Therefore, physicians will have a greater opportunity to listen to the concerns and questions at the heart of the patient's medical issues.

During this stay, how often did doctors explain things in a way you could understand?

This question asks patients to recollect the frequency with which physicians provided easy-to-understand explanations. The physician is usually the one who communicates the most emotionally significant and technically complex information to patients. The patient will try to look back at each specific encounter with the physician and recall whether or not the physician effectively communicated the situation and resolved the patient's questions, reservations, and uncertainties.

"My doctor took the time to explain my condition. He reviewed everything twice, so he was sure I got it."

"The doctors did not tell me I had a kidney stone show up on the CT scan or that I had diverticulitis."

Behaviors to Consider

- **Use written materials** to complement verbalized instructions.
- **Use plain language.** Patients may not be familiar with medical jargon, acronyms, tests, procedures, lab results, etc. that are common knowledge for you. Don't assume that patients know what is being explained.
- Assess what the patient already knows. **Determine what he or she understands or misunderstands** about his or her condition at the outset.
- Confirm that a patient understands by asking him or her to **summarize or "teach-back"** what has just been explained. It is not effective to simply ask patients or family members if they understand because most will say they do without giving it must thought o because they are embarrassed for not knowing.
- At the end of every patient encounter, ask, **"what other questions can I answer for you?"**

To Try

Leverage learning principles.
Using proven teaching techniques, such as calling upon a patient's prior experiences when introducing new concepts, can help improve a patient's understanding and retention of information.

Use the "teach-back" method.
This is a tool that can be used to ensure that patient's understand explanations provided by you. Studies show that 40 to 80% of the medical information that patients receive is forgotten immediately, and nearly half of the information that is retained is incorrect. "Teach-back" can help you confirm that you explained something to a patient in a manner that the patient understands.

Conveying empathy.
Reducing suffering starts with connecting to the patient's personal experience. One tactic for addressing a patient's fear and anxiety is to explain things clearly. Addressing fear and anxiety begin with empathy and compassion.

Communicating With Patients Using AIDET

All employees of HPMC are required to use AIDET with speaking with patients.

AIDET was created to decrease anxiety and increase compliance, which improves clinical outcomes.

A	**Acknowledge**	Greet the patient by name. Make eye contact, smile, and acknowledge family or friends in the room.
I	**Introduce**	Introduce yourself with your name, skill set, professional certification, and experience.
D	**Duration**	Give an accurate time expectation for tests, physician arrival, and identify next steps. When this is not possible, give a time in which you will update the patient on progress.
E	**Explanation**	Explain step-by-step what to expect next, answer questions, and let the patient know how to contact you, such as a nurse call button.
T	**Thank You**	Thank the patient and/or family. You might express gratitude to them for choosing your hospital or for their communication and cooperation. Thank family members for being there to support the patient.

No Passing Zone

All employees of HPMC feel that care of the patient is *everyone's* responsibility and are expected to respond to alarms and patient call lights when walking through hallways. They cannot pass by a patient's room or someone in need of help without stopping to assist.