Medical Staff Orientation

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Huntington Hospital
Northwell Health™

Dear Colleague,

Huntington Hospital is at a crossroads. We are providing a greater depth and diversity of clinical services than ever before...Bariatric surgery, coronary intervention, electrophysiology, joint replacement, intracranial neurosurgery, neonatology, robotic surgery, spine care, traumatology and more. And we are being recognized for excellence more than ever before, by way of the **ANCC Magnet** designation for nursing, and **Joint Commission** Certification of Excellence for Hip and Knee Replacement Surgery and for Advanced Palliative Medicine. Your colleagues have helped our hospital to obtain similar Center of Excellence designations for Bariatric Surgery, Minimally Invasive Gynecologic Surgery, and Breast Surgery, among others. This past year, we achieved an "A" rating from the prestigious LeapFrog Group for exceptional **patient safety**. And recently, we were ranked among the top 5% of hospitals in New York State by US News.

The challenges, however, are daunting. Healthcare costs are rising at an unsustainable pace, even as many physicians face declining reimbursement. And despite our best efforts, healthcare errors are still too common. Patients, health professionals and the public are frustrated with the status quo. National leaders, therefore, are demanding that we think about healthcare delivery in dramatically different ways. A new term, "the value equation," is heard everywhere. Where in the past we were compensated for clinical activity, increasingly we will be compensated for outcomes. To be successful we will need to focus more than ever on reducing healthcare-associated harm, addressing our patients' preferences, improving care coordination across settings, providing excellent end-of-life care, and reducing waste.

In the midst of uncertainty, there are two things we know: first, that our medical staff must help lead transformative change, because meeting the above-cited challenges is our ethical responsibility as physicians individually, and as an organization collectively. Second, we need to help one another. The ever-increasing burdens on us as physicians have given rise to an important conversation about the problem of burn-out. We simply cannot be there for our patients and families if we are overwhelmed by the demands of contemporary healthcare. We entered the profession, after all, to make a difference. We simply must find ways to collaborate to create sustainability, honor our profession, and maintain a healthy work-life balance – for our own sakes, but also for our families, our patients and a community that looks to us as a trusted source of compassionate, high quality care.

Welcome to the Huntington Hospital medical staff and to Northwell Health! You will find colleagues who are focused on excellence and on building upon the great tradition of our profession. These are also individuals who comprise a closely knit community of professional fellowship. Huntington's medical staff members are exceptionally generous of spirit and collegial. We look forward to your contributions and your ideas. And speaking on my own behalf, please don't hesitate to call, email or stop by my office at any time.

Kind regards,

Michael B Grosso, MD, FAAP

Role of the Medical Staff in Improving Healthcare Quality

The millennium ushered in three revolutions in our thinking about healthcare, and each has challenged us as practicing physicians. The first was the realization that healthcare-associated harm was more common and more preventable than we had ever thought. The second was that a startling lack of standardization had limited the effectiveness of our healthcare system. And finally, a body of research highlighted the problem of "overuse": care that does not appear to improve clinical outcomes, but *does* expose patients to potential harm and create a drain on our limited resources.

Physicians at our hospital and across Northwell Health play a crucial role in providing leadership, creativity, expertise and initiative to a host of efforts aimed at making healthcare safer, more effective, more efficient and, critically, more patient-centered. These individuals understand that we need to collaborate across specialties and disciplines to engage in the hard work of redesigning how we delivery care. We need to think differently about what we do if we are to become better than we are. In the current environment, this is not only an ethical mandate but a prerequisite for survival.

Patient safety: what is it all about?

The term "patient safety" describes at once a problem in healthcare, a framework for understanding that problem, a social movement, and an academic discipline. The "problem" is avoidable harm that arises not from the patient's condition, but from our care. It is now clear that such harm is much commoner than once believed, and that entering a hospital is among the most hazardous acts most ordinary persons experience. Avoidable infections affect 96,000 Americans annually. Medication errors affect almost as many, killing 6,000. Wrong patient and wrong procedure mishaps are reported from almost every institution, large and small. More recently, diagnostic error has emerged as a prevalent and preventable cause of harm. Estimates of the death toll are variable, ranging from 44,000 annually to almost ten times that number.

How do we make healthcare safer? There is no magic bullet. Physicians play a critical role by participating in efforts to standardize care where possible, leading efforts to implement safety protocols, promoting team-based care, communicating effectively across disciplines, including patients and families at every step, and encouraging fellow caregivers to "stop the line" whenever they suspect a threat to safety.

What We Measure:
A Partial List

Stroke Care
IV tPA within 180 min of arrival

DVT prophylaxis

Antithrombotic therapy by day 2 and at discharge

Patients w Atrial fibrillation/atrial flutter receiving anticoagulation

Discharge on statin medications

Stroke education before discharge

Assessment for rehabilitation

Infection Prevention
Hand hygiene rate

Central line bacteremia rate

Catheter-associated UTI rate

Surgical Site Infection Rates

MRSA, VRE & C difficile rates

Sepsis
IV crystalloid initiated within 30 min of presentation for severe sepsis or septic shock

Antimicrobials initiated within 180 min

Safety Culture
AHRQ Culture of safety survey

Efficiency
LOS, Excess days, resource use

Patient Centered Care
HCAHPS measures

Outcomes
30 day readmission rates

Disease-specific mortality

Standardizing Care

We physicians often react with skepticism to organizational efforts to standardize care. There is some virtue to this skepticism: some aspects of care should *not* be standardized! This realization is at the very heart of "patient-centered care." But when we select the right things to standardize, we can make care better. Examples include "care bundles" for the prevention of central venous catheter-associated bacteremia, catheter-associated UTI and surgical site infection. Each has dramatically impacted outcomes. For example, CVC bacteremia events have declined by 93% in the last decade. The WHO Surgical Safety Checklist, implemented across all Northwell operating rooms, has in a similar way resulted in improved outcomes including decreased mortality, as documented in a large international study. Additionally, our electronic order sets promote care standardized to evidence-based practice in connection with COPD, heart failure, stroke, VTE, and a host of other conditions.

Improving Diagnosis by "De-standardizing" Care

In 2015, the Institute of Medicine published an important white paper on the problem of diagnostic error. In some ways, the problem of diagnosis is the opposite of the standardization problem. Authors like Jerome Groopman ("How Doctors Think") and researcher Pat Crosskerry ("dual processing theory") have taken pains to explain how we fall into cognitive traps related to natural habits of mind. As clinicians, we are especially challenged by three obstacles to smart diagnosis. First, some physicians need work in a fundamental skill: operating under conditions of clinical uncertainty. Uncertainty is ubiquitous and cannot be eliminated. Misguided efforts to do so (known collectively as "defensive medicine") usually have the paradoxical effect of *increasing* uncertainty, promoting misdiagnosis, creating iatrogenic misadventure and causing harm.

Good clinicians should wince whenever they hear a trainee or colleague refer to the "standard workup" for…almost anything: abdominal pain, headaches, chest pain, dyspnea. Yes, there may be a few common, useful investigations, but the only thing that should happen for every patient, every time, is a thorough, informed, "hypothesis-driven" history and physical examination. Everything else should depend on the need to sort through diagnostic possibilities.

The following is a real example. A 24 year old previously well Hispanic female comes to the Emergency Department with the abrupt onset of dyspnea. A D-Dimer test is elevated, occasioning an order for CTA. The case is referred for quality review because the patient inadvertently undergoes abdominal CT imaging because of a requisitioning error. Upon review, it is disclosed that the patient had volunteered upon initial history that her shortness of breath began abruptly after she inadvertently inhaled the vapors from a container of concentrated chlorine, intended for use in a swimming pool. She was a non-smoker, did not take oral contraceptives, and had no other risk factors for venous thrombo-embolic phenomena. (Conclusion: the root cause of the wrong imaging study was that thoracic CT was not indicated, and should not have been performed, because D-Dimer measurement was not indicated, and should not have been performed, because the pre-test probability of PE was much too low. Here's a shorter version, courtesy of William Osler: Listen to the patient, and he will tell you the diagnosis.)

Second, the throughput imperative has reduced the initial diagnostic encounter (in the mind of some) to "getting admission orders on the chart." This does not engender a culture of clinical excellence. Once a hastily created diagnostic impression is recorded, it may persist in the form of a working diagnosis despite the emergence of contradictory data (the so-called "anchoring" heuristic.) Finally, the EMR and physician note-writing in this environment has been the enemy of the thoughtful practice of Medicine. Too often, clinicians combine un-edited carry-forward and cut-and-paste content with a hash tag list of "problems" – reiterated daily to create a note that is fat with data but thin on evidence of cognition. The Nobel-prize winning author Toni Morrison has said, "I write

to find out what I think." Good physicians know by experience that the very process of setting down one's thoughts serves to clarify them and often to suggest additional ideas. This practice must be our goal.

Choosing Wisely

In an environment where limiting harm and cost are both priorities, the relationship between safety and efficiency deserves mention. Not only is there is a great deal of waste in our system that can be eliminated without adversely affecting safety. Work by a number of investigators suggests that "overuse" may actually drive down quality, exposing patients to harm associated with unnecessary tests and treatments while also negatively impacting patient experience of care (Davis and Schoen, 2007). Accordingly, efforts to improve safety and efficiency are seen by many experts not as competing priorities, but as essentially synergistic. The ABIM Foundation's ***Choosing Wisely*** Campaign is perhaps the most ambitious effort to date, drawing on more than 60 collaborating organizations to identify opportunities to achieve better quality by doing less. The adoption of these guidelines needs to be a high priority for our medical staff.

Using performance measurements to understand unexpected variation in practice, identify improvement opportunities and assess the effectiveness of quality initiatives

Performance measurement in healthcare remains an imperfect science. But there are strong reasons for us to understand the measurements that are now used by many stakeholders to measure and report on our performance – hospitals, CMS, the Joint Commission, the Department of Health, insurance companies, governmental and private stakeholders, and the press. Beyond this and despite various caveats, a number of measurements have proven their worth in helping us to improve care.

A full discussion of measurements and their use is beyond the scope of this short orientation. Here is a short primer:

Process measures describe the fraction of the time that an appropriate action occurs in relation to opportunities for it to occur. Examples include the fraction of patients with stroke who receive appropriate education prior to discharge.

Outcome measures describe the "results" of care, often as negative results – e.g. death, infection or other complications such as DVT or PE.

Structural measures describe characteristics of the healthcare delivery environment such as electronic prescribing and critical care models that include full time intensivists. Quality reporting organizations such as LeapFrog include structural measures in their hospital report cards.

Measurements can also be classified as informing us about different dimensions of performance, such as **safety** (measuring preventable harm), **timeliness** (e.g. door to balloon time for coronary interventions), **efficacy** (adherence to guidelines), **efficiency** (length of stay, resource utilization) and **patient-centeredness** (patient experience of care measures).

Measurements are used throughout our hospital to better understand our strengths and weaknesses, the results of quality improvement efforts and opportunity areas.

"Measure sets" have been created, validated and implemented by many regulators and quality improvement groups. For example, we track measures for pneumonia, surgical care, myocardial infarction, heart failure, stroke and pediatric asthma; infection rates for MRSA, VRE, and *C. difficile*; rates of central line bacteremia, catheter-associated UTI, ventilator associated pneumonia and surgical site infections. We also monitor a number of measures for patient experience. This is a partial list. Most measures are publicly reported, and some drive hospital reimbursement through the federal Value Based Purchasing program. Oversight for performance improvement comes occurs continuously at multiple levels – facility, department, service line and System-wide, and includes the work of site-specific and network-wide quality committees, your Medical Board and the hospital's governing body (Board of Directors).

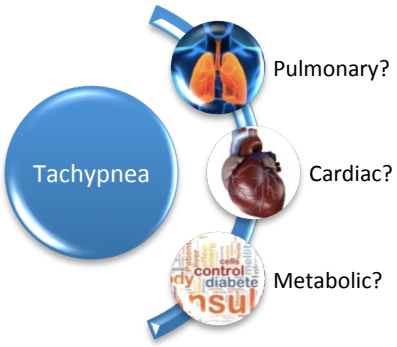
Responsibilities of the physician-of-record and consultants: ensuring coordination and continuity of care

An important responsibility of the physician of record is to oversee actively the work of any consultant that he has requested to participate in his patient's care. This begins with thoughtful consideration to the reason for any consultation. We have consultants for every organ system – merely *having* a condition that resides within a sub-specialty scope of practice is NOT an indication for consultation. Rather, the physician of record should seek consultation when diagnosis or management are outside his scope of practice, when the physician is unsure or the problem is unusual, or when a consultant is required to perform a procedure that the physician is not privileged to perform.

Additionally, the physician seeking consultation should communicate personally with the consultant to identify the issues (this is required for urgent consults but strongly advised for all.) An end-point for the consultation should be identified.

Finally, the physician of record is obligated to provide ongoing care coordination with her consultants. For example, Mrs. Jones is being managed by a general internist, who has sought Pulmonary and Infectious Disease consultations. A nurse calls the primary physician to report that the patient has new onset tachypnea. The internist suggests that the nurse call pulmonology. Why is this wrong? Because it is the primary physicians' responsibility to gather the relevant information, diagnose the problem, and THEN, if necessary, call the consultant personally. Having nurses serve as a go-between for the medical staff is a recipe for low quality care.

The physician-of-record's daily notes should include the findings of consultants, and in discussions with family he should direct his best efforts to communicating a comprehensive explanation of the patient's condition and treatment plan, inclusive of those issues addressed by his consultants. Not addressing these responsibilities results in poorly coordinated care, lesser quality and more errors. Inevitably, there is also a loss of confidence on the part of patients and families left to wonder "who is in charge of my care?" Doing this well, on the other hand, is a hallmark of effective, patient-centered care.



Managing the medical record – electronic or otherwise

Clinical Documentation Improvement

The patient's medical record serves **legal**, **risk management** and **regulatory** purposes in addition to its primary job of **facilitating communication** with other caregivers across medical specialties and healthcare disciplines for both concurrent care and for those who will provide future care. Electronic documentation has eliminated some of the problems – including poor penmanship – that characterized the paper record. However, many physicians legitimately criticize their colleagues whose notes display excessive use of cut-and-paste, are peppered with telegraphic problem lists, and are massively bloated with imported data, creating a nearly un-interpretable work product. **"The new illegibility"** is more than a dis-satisfier for the physician so unfortunate as to have the need to read such notes. It is, critically, an invitation to errors and poor care. Like the paper notes that it replaced, electronic physician notes must (1) tell a story, (2) be accurate, and (3) reflect the physician's own contribution to the patient's care.

Additionally, the record needs to be specific and clear, especially in light of ICD-10 level coding. When charts are reviewed by our CDI **(Clinical Documentation Improvement)** specialists and queries are directed to us, it is our obligation to address these promptly. The purpose here is to make the record complete and accurate. Not getting this right adversely affects not just reimbursement, but also hospital report cards by way of risk adjusted outcomes including complications, LOS, readmission rates and mortality.

CDI – FAQs

Q: The CDI specialist has suggested that I make an addendum to the closed medical record. Is this OK to do?

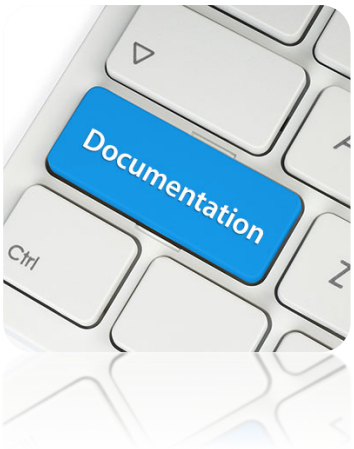
A: Again, the purpose of CDI is to cause the medical record to reflect the actual condition and care of the patient. Sometimes addenda are necessary to include pathological data that is pertinent to the case, or to clarify a diagnosis that was either missed or recorded in a way that was less specific than it could be. Appropriately date and time-stamped addenda to a closed medical record are completely appropriate from any regulatory, legal or risk management perspective and have become standard practice.

Q: The CDI specialist saw my notation of "Lo Na^+" and asked if I meant "hyponatremia." Maybe it would be better if I wrote in the chart "as advised by the CDI team, the patient has hyponatremia."

A: Federal rules specifically prohibit the CDI program from dictating what physicians enter into the medical record. If the CDI specialist was correct, you inadvertently omitted a code-able diagnosis or condition (hyponatremia). This is your opportunity to better complete the medical record. It is inappropriate to reference the CDI query in the chart. Either you agree that this was an inadvertent omission and you are correcting it, or you disagree, and you should NOT be writing it.

Principal Diagnosis is the condition established after study to be chiefly responsible for the admission of the patient to the hospital. It is not necessarily the most resource consuming diagnosis. The admitting diagnosis or chief complaint should not necessarily be listed as the principal diagnosis. Likewise, do not list symptoms of an underlying cause. List symptoms, signs or abnormal test results as principal diagnosis only if the actual etiology was not determined.

List all diagnoses, which affect the current hospital stay. These included diagnoses which:



- Exist or present on admission.
- Arise during the course of hospitalization.
- Affect treatment and/or length of stay, and are on consultations, and other pertinent reports.
- Status post, only if they are relevant to the admission and treatment.
- Do not designate complications arising during the course of hospitalization as a principal diagnosis since they did not "occasion the admission" of the patient to the hospital.

When a patient is admitted for multiple reasons, any of which could be the principal diagnosis, determine which diagnosis used the most resources and list that as principal.
If the patient has both an acute and chronic illness, list the acute condition as the principal diagnosis and the chronic condition as secondary. If the patient is admitted for a complication of another disease, that complication should be the principal diagnosis and the original disease should be the secondary diagnosis (e.g., cirrhosis due to alcoholism).

Guidelines- Principal Procedure

List all procedures, which were performed on the current admission.

Principal Procedure: A definitive procedure would be designated as the principal procedure when both a diagnostic and definitive procedure was performed in relation to the principal diagnosis regardless of which procedure was performed first.

Unrelated diagnostic or definitive procedure may be listed as the principal procedure if no procedures were performed that relate to the principal diagnosis.

If a patient has two or more definitive procedures or two or more diagnostic procedures related to the principal diagnosis, list as principal the definitive procedure, which relates to the principal diagnosis.

Examples for Specific Diagnoses

If the patient has cerebrovascular disease with hypertension, list the cerebrovascular disease as the principal diagnosis.

If the patient has ischemic heart disease with hypertension, the ischemic heart disease should be the principal diagnosis.

A patient who is admitted for a residual effect (i.e., the late effect resulting from a previous acute illness or injury) should have his or her residual condition listed as the principal diagnosis. The cause of the late effect should be secondary diagnosis.

List the most severe injury or multiple injuries as the principal diagnosis.

If the patient is admitted for a drug poisoning, the principal diagnosis should relate to the specific drug involved (e.g. Valium overdose). The manifestations of the poisoning should be the secondary diagnosis.

If the patient has an adverse reaction to the correct substance (e.g., allergic reaction) the manifestation should be listed as the principal diagnosis.

If the primary site of a neoplasm was removed from a previous hospitalization and there is no recurrence of the original site, list as the principal diagnosis the metastatic site. List the history of the primary site as the secondary diagnosis.

MI ruled out is not a discharge diagnosis. The chest pain, which causes the admission to rule out the MI, resulted in a diagnosis of either atypical chest pain, angina, CAD with angina, epigastric, musculoskeletal etc.

If the diagnosis has been made, please document it. Document all procedures as completely as possible. Wording is very important. (e.g., excisional vs. nonexcisional debridement. Do not write “debridement” – instead, explain whether the wound was cleaned, and if skin cut or a use of scalpel and if muscle, subcutaneous tissue or bone excised.

Clinical Outcomes as a Function of Team Effectiveness: Team STEPPS

A provocative study from the world of pediatric critical care identified a statistically significant, inverse relationship between the rates of central line bacteremia across various units and the number of physicians and nurses in the units who used first names on a regular basis.

Analysis of severe adverse outcomes -- like operation on the wrong patient or delayed intervention in the deteriorating patient -- identifies time and again the role of communication and teamwork. In fact, the Joint Commission's database of "Sentinel" events demonstrates that communication problems were contributory in full two thirds of cases.

Cardiac surgeons know how important the team is. Safety experts believe that much the same is true in the ED, the Delivery Room and many other environments where health professionals interact. Recently, there has been interest in adapting team expertise from other high risk industries to healthcare. Few of us trained in teams, though this is now changing. Key issues include effective communication among team members, an unfettered exchange of ideas and mechanisms that "stop the line" when a team member believes that an unsafe condition exists. (Click here for comments by patient safety expert and surgeon Lucien Leape on teamwork and medical error.)

Team STEPPS is a program developed by the Agency for Healthcare Research and Quality in collaboration with the Department of Defense and other stakeholders. Building on principles adapted from aviation and the military, TS equips members of healthcare teams with the skills and tools necessary to maximize coordination of care through effective teamwork. All physicians credentialed at NSLIJ hospitals should complete the Team STEPPS curriculum.

Our Code of Professional Conduct…

Northwell Health and our local medical board have approved a CODE which describes our commitment as physicians and other professionals to HONESTY and integrity, patient confidentiality, RESPECT for staff, patients and families, RESPONSIBILITY for our patients, and CLINICAL EXCELLENCE achieved through lifelong learning and participation in quality improvement.

At the same time, we commit to strictly avoiding DISRUPTIVE behavior, including any behavior that could reasonably viewed as demeaning or intimidating, including profane or disrespectful language, verbal or physical outbursts, criticism of staff in front of patients or other staff and the like.

Such behaviors negatively impact recruitment, retention, and staff well-being. Critically, disruptive behavior negatively impacts communication and patient safety.

(See: Code of Professional Conduct, Medical Board Policy)

Hofstra -- Northwell School of Medicine

In 2006 the Association of American Medical Colleges, citing population increases, a doubling of the number of citizens over the age of 65 between 2000 and 2030, and an aging physician workforce, recommended that medical school enrollment be increased by 30% by 2015. Concurrently, Hofstra University and the Northwell Health each had reached a rapid-growth stage of development at which collaborating to develop a nationally renowned medical school became a highly attractive and advantageous endeavor.

Thus began Hofstra Med, our Health System's own medical school and the region's first new school in four decades. Founded on principles of community, scholarship, innovation, professionalism, patient-centeredness, humanism and the vision of Dr. Lawrence Smith, a past member of the Huntington medical staff, the School of Medicine opened its doors in August 2011.

Huntington is one of several System hospitals to host first and second year students in the **Introductory Clinical Experience**, part of a program known as Patient, Professional and Society. Community preceptors in Medicine, Surgery, Obstetrics, and Pediatrics are partnering with students in a learner-centered program that creates synergy between the Basic Sciences and the bedside from the first weeks onward.

Other Huntington physicians are devoting their energy and expertise to medical education as faculty in the Structure Lab (once known as Anatomy!), in interactive case-based sessions and in our simulation center with standardized patients mentoring students on history taking and physical examination. Initial appointments to the School of Medicine are typically at the Assistant Professor level.

Telling our stories…

Narrative Medicine at Hofstra Med

"Illness is the night-side of life, a more onerous citizenship," writes Susan Sontag. Narrative Medicine acknowledges and moves beyond the limitations of the patient's "history" to invite exploration of the story, that is, the experience of illness.

At the same time, Narrative work creates opportunities for the caregivers themselves to express and share the profound experience of working so intimately with fellow human beings who are suffering.

Medical educators have long been aware of the erosive effects of a "hidden curriculum" which results in a gradual blunting of empathic capacity among trainees. Narrative is widely viewed as a corrective to this erosive process.

Hofstra students and their faculty will engage in ongoing journaling to promote reflection and encourage personal growth. Its relationship to so many values of this new school places Narrative at the very heart of the curriculum.

HUNTINGTON PHYSICIANS AND HOFSTRA MED STUDENTS:
ONE-ON-ONE LEARNING

More than sixty preceptors are interacting with MS1 and MS2 students as part of the Introductory Clinical Experience (ICE). Building on work at Harvard, Case Western and elsewhere, students learn in an environment in which continuity is the organizing principle…continuity of site, of mentorship and of patients and families. Patients benefit from the extra attention from a long-term partner in their care. Preceptors derive professional and personal satisfaction from learning new skills and observing the long-term growth of their students.

Doing the Right Things for the Right Reasons

Bioethical Imperatives, Dilemmas and Conundrums in Everyday Practice

How do we best support the patient's right to autonomous decision-making about her own body? What constitutes informed consent? What do we mean by decisional capacity? How do we help the family of the dying patient that "wants everything" including futile care? What about the family member who is making decisions that are well known to be in contradiction to the prior declared wishes of the now-incapacitated patient? What if the wishes of a family member conflict with the ethical precepts of the physician?

These questions and scores of others are addressed by the field of Bioethics. The Bioethics Consultation Service is available to physicians, nurses, other health professionals, patients and family members to address conflicts and concerns. Additionally, Northwell policies provide guidance on a number of these issues. Readers can find them on the Northwell Intranet. (From the drop down menu on the Intranet home page, click on "I want to…Review a Policy".) Additionally, see the separate document in these orientation materials entitled ***Bioethics Bulletin***.

100.23 Informed Consent

100.24 Withholding and Withdrawing Life Sustaining Treatment (Including DNR)

Patient Experience of Care – What Does it Mean?

Patients and families are surveyed about their hospital care under the federal H-CAHPS (Hospital – Consumers Assessment of Hospitals, Providers and Systems) program, which collects comparative data intended to drive performance improvement at many levels. HCAHPS data are also included in publicly reported quality dashboards and drive institutional reimbursement through the federal Value Based Purchasing program.

What patients are asked about their care by doctors

Patients are asked about several aspects of their care in the HCAHPS surveys distributed after discharge. In addition to a section on "Your care by doctors" there are questions on care by nurses, the hospital environment, "When you left the hospital" and "Understanding your care when you left the hospital" (addressing transitions in care and patient education). Some questions may be impacted by physician interactions even though they are not specifically included in the section entitled "Your care by doctors." Here are some HCAHPS questions and how they relate to our care:

Question: ***(Available answers are Always, Often, Sometimes, or Never)***	**DOMAIN**	**Primarily addresses MD (P) or Multidisciplinary with MD contribution (MC)**
During this hospital stay, how often did doctors treat you with courtesy and respect?	Professionalism	P
During this hospital stay, how often did doctors listen carefully to you?	Communication	P
During this hospital stay, how often did doctors explain things in a way you could understand?	Communication	P
During this hospital stay how often was your pain well controlled?	Quality	MC
During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?	Quality	MC
Before giving you any new medicine how often did hospital staff tell you what the medicine was for?	Communication Patient Education	MC
Before giving you any new medicine how often did hospital staff explain possible side effects in a way you could understand?	Communication Patient Education	MC

FAQs

First it was Press Ganey and now HCAHPS. Why is healthcare so focused on patient satisfaction? Isn't real quality of care more important?

This is a very common question and an important one, because it reflects several misunderstandings. While Press Ganey measures "satisfaction," the HCAHPS survey doesn't ask any questions about whether patients are "satisfied" with their care. As an experience of care tool, HCAHPS was developed to drive quality improvement efforts. It is well validated and much less susceptible than PG to cultural bias. Like the Core Measures, it helps leaders

determine how often and how consistently key actions occur. The table above links specific questions to domains of clinical performance.

At Northwell, our thinking about patient experience is constantly evolving. While the focus a few years ago was on "wowing the customer," feedback from physicians and nurses have made it very clear that our mission is higher and our obligation greater than that of hoteliers and restauranteurs. The word "patient" after all, means "one who suffers." Our goal must be to understand the "fog of war" that is the patient's experience of hospital care.

And so, the aim is not to make health professionals into customer relations experts, but rather to provide us the tools we need while nurturing a culture that serves as a counter-weight to callousness, one where empathy is honored and the work of good doctors and nurses supported so that patients and families experiencing the uncertainty and the existential terror of serious illness can at least be reassured that the physicians, nurses and many other professionals coming in and out of the room are there because they care.

How would doing better on HCAHPS actually help our patients?

Put aside for a moment the fact that HCAHPS results drive hospital reimbursement and influence the institution's reputation. What are patients telling us when they say that we are not "explaining things in a way they can understand?" We pride ourselves on being superior communicators. But when patients say anything other than "ALWAYS" they are sending us strong signals that, as a medical staff, we are not doing as well as we need to. The literature tells us that the successes and failures reflected in these results are powerful drivers of hospital readmission and other preventable adverse outcomes.

There is an additional issue. The doctor-patient relationship is under siege. When patients feel that we are not connected by a bond of solemn responsibility (reflected by courtesy and respect), many untoward consequences ensue. There is a rich literature documenting that an effective relationship improves diabetes control, adherence to medical advice for a host of chronic conditions and health status overall. Even if these HCAHPS data are an imperfect measure of our bedside work, we need to think long and hard when our patients tell us that we have not earned their trust. Click here for more…

Committee Membership and Teaching at Huntington Hospital

Giving Back to our Hospital While Enriching our Professional Lives

COMMITTEES. Physicians have the opportunity to participate in a number of committees that perform important functions for the Medical Staff and the hospital. All of them share as their mission the pursuit of clinical excellence for the benefit of our patients and families. The appointment process is delineated in the Bylaws of the Medical Staff. You may also consult your department Chairperson, the Office of Medical Affairs or the Medical Director for more information.

Bioethics Committee

Bylaws Committee

Cardiology Quality Committee (Cardiology PICG)

Credentials Committee

Critical Care Committee

Emergency Medicine Quality Committee

Infection Prevention and Control Committee

Medicine Quality Committee

Pharmacy and Therapeutics Committee

PICG (Hospital-wide Performance Improvement)

Sepsis Task Force

Stroke Committee

Surgical Quality Committee (S-PICG)

TEACHING. One residency program (Family Medicine) is co-located between Glen Cove and Huntington Hospital, with most in-patient activity being on our campus. Rotations include Adult Medicine teaching service, Pediatrics, Obstetrics, Surgery, Critical Care and Palliative Medicine.

Northwell residency programs with rotations at Huntington include Emergency Medicine and Orthopedics. Fellows in Cardiology, Pediatric Emergency Medicine and other programs do rotations at Huntington on a regular basis.

Physicians with an interest in participating as teaching faculty are encouraged to contact their department Chairperson or the Medical Director.