Methodist The Methodist Hospital System

LEADING MEDICINE™

New Physician Orientation Manual 2012

Welcome to The Methodist Hospital! We have compiled this packet of information meant to serve as an orientation to our facility. We hope you will find the information provided informative and educational.

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Methodist The Methodist Hospital

LEADING MEDICINE℠

Welcome to The Methodist Hospital Medical Staff!

On behalf of the Committee on New Physicians and the entire Methodist Medical Staff, we are honored to welcome you. We are so pleased you have chosen to practice at Methodist. The Committee on New Physicians is a subcommittee of the Committee for Excellence, whose mission is to provide a mutually supportive and strategically aligned forum in which the Medical Staff and its leaders, with the Methodist Hospital Administrative team, develop an ongoing partnership to guide decisions to achieve pre-eminence in clinical care, education, and research.

Here at Methodist, we are dedicated to *Leading Medicine* by delivering the highest quality patient care. This dedication is evident when you speak to members of our staff about patient care, and it is this dedication that has brought us so many honors and accolades, such as being ranked in US News and World Report's Best Hospitals. As fellow physicians, we understand that in order to keep these high standards and exceed our patients' expectations, we must find a way to work together as a Medical Staff in a way that promotes both innovation and a culture of excellence.

As you begin your practice at Methodist, please know that we are here to help answer your questions and make your orientation and continued practice as smooth as possible.

If there is anything we can do to help you, please let us know.

Sincerely,

Robert E. Jackson, M.D.
Co-Chair

Roberta L. Schwartz
Co-Chair

Kevin E. Varner, M.D.
Vice Chair

Methodist The Methodist Hospital

LEADING MEDICINE℠

Welcome to The Methodist Hospital. As a member of our medical staff, you are joining an organization that has served Houston and surrounding communities since 1919. The Methodist Hospital has done this with an emphasis on its spiritual and academic mission, vision and values.

Our success depends on our ability to recruit and retain the best talent in the industry. It is through your committed efforts that we will make progress in achieving our mission to provide the best health care to the Houston community.

You represent Methodist to patients and visitors every day. Your job makes a vital contribution to accomplishing our objectives: caring for the sick and injured and their affected loved ones; promoting wellness; focusing on patient satisfaction; and striving for excellence. Please continue to demonstrate your commitment to providing the highest quality of patient care by living the Methodist values in your daily activities. It is through Integrity, Compassion, Accountability, Respect and Excellence that you make The Methodist Hospital an even better place for you and our patients.

This orientation has been designed to help you become familiar with The Methodist Hospital and includes information you will want to know before your first day in the hospital. It also summarizes Business Practices responsibilities and a few specific laws and policies that speak to ethics and compliance. We are committed to complying with all Federal and State standards, with an emphasis on preventing fraud and abuse. Therefore, Methodist expects all hospital governing body members, officers, managers, employees, physicians, contractors and other agents to meet the high standards that are set forth in the orientation.

Please use this orientation guide as an informative resource of programs, policies and procedures that apply to our credentialed physicians and allied health professionals. Keep it handy as a quick reference to questions you may have.

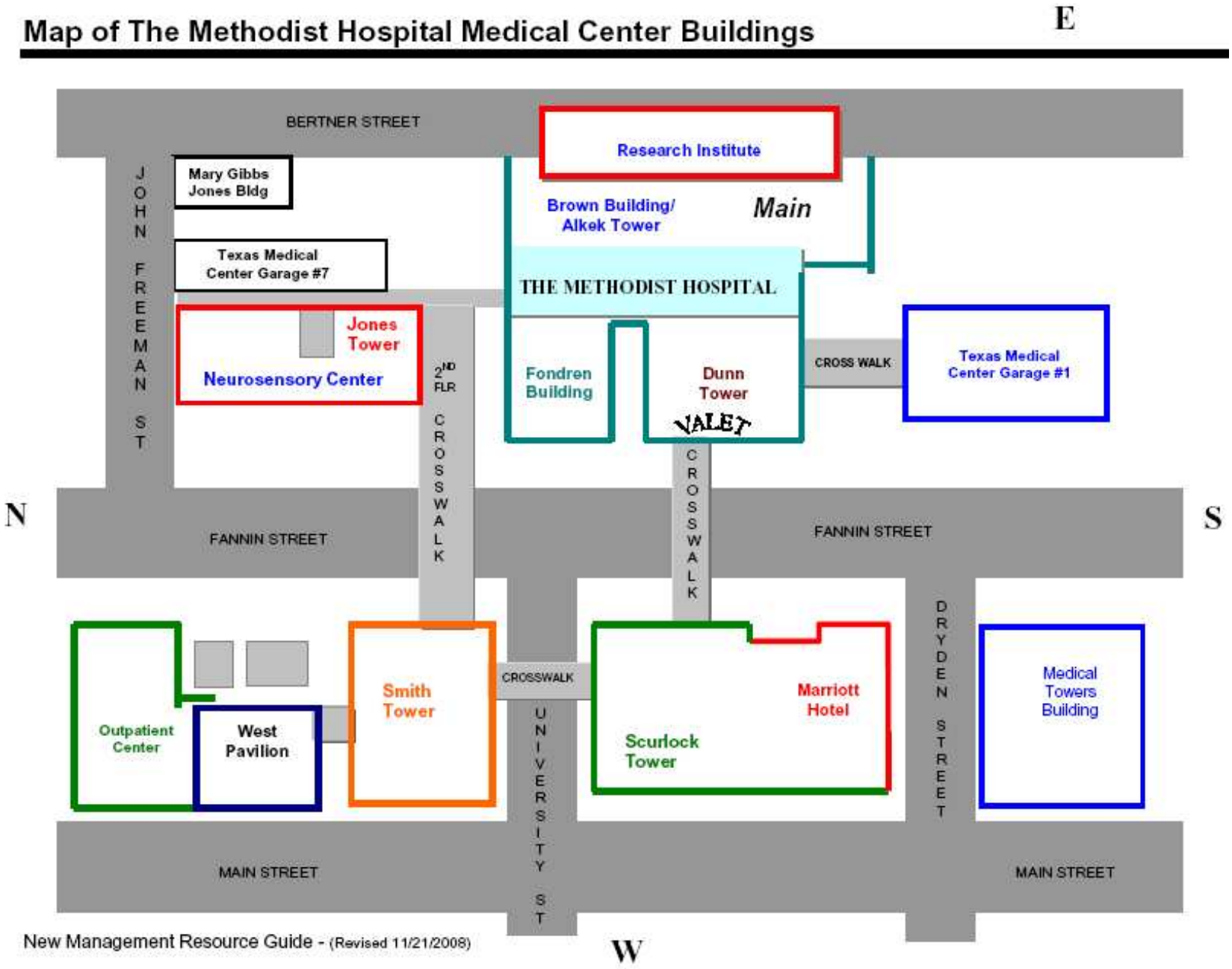
Employees, physicians, and volunteers throughout our community work together to make Methodist one of the finest health care organizations in the world, and you are an important part of our team.

Roberta L. Schwartz

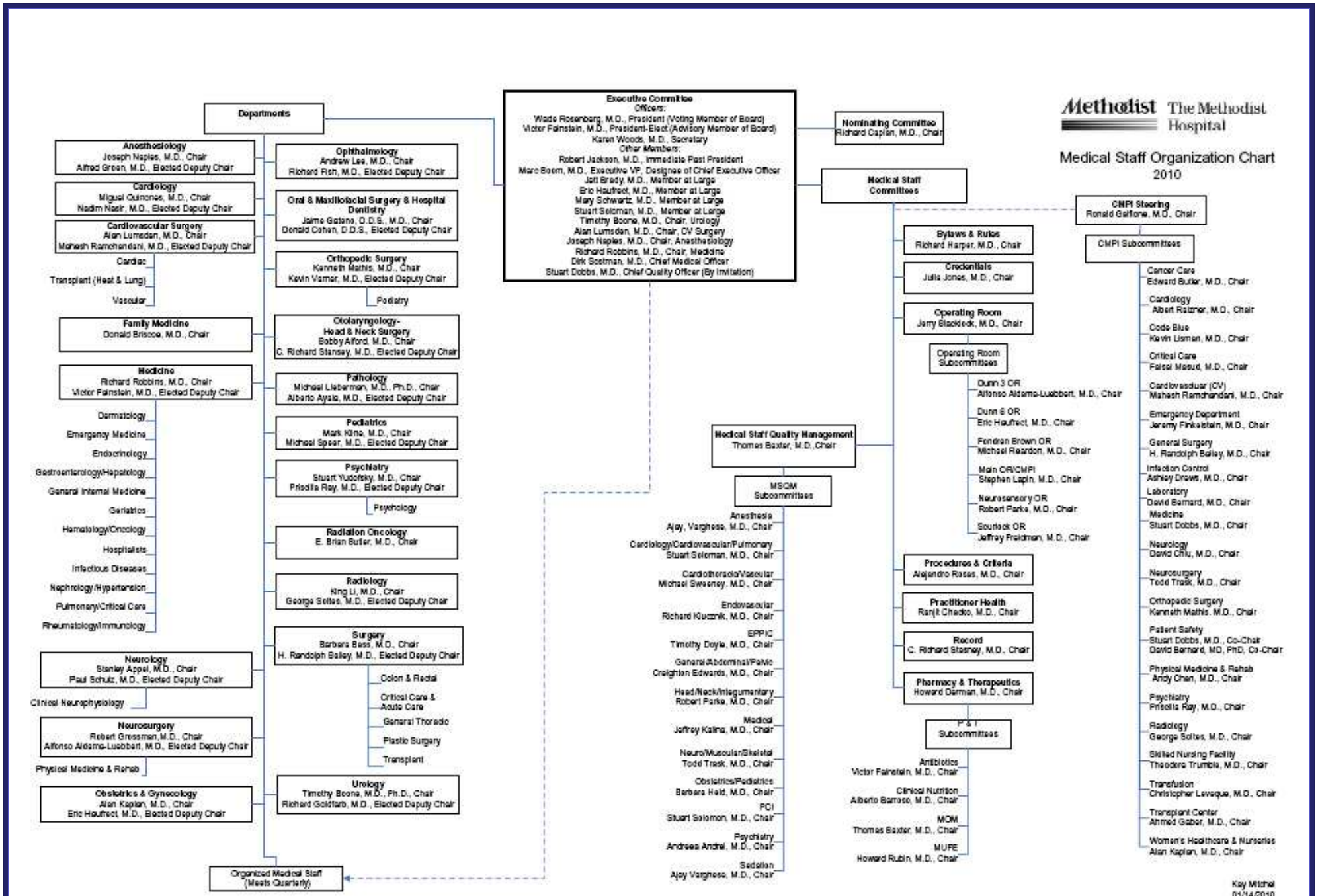
Executive Vice President

The Methodist Hospital

Map of The Methodist Hospital Medical Center Buildings



New Management Resource Guide - (Revised 11/21/2008)


Methodist The Methodist Hospital
Medical Staff Organization Chart
2010
Departments
Anesthesiology
Joseph Naples, M.D., Chair
Alfred Green, M.D., Elected Deputy Chair
Cardiology
Miguel Quinones, M.D., Chair
Nadim Nasir, M.D., Elected Deputy Chair
Cardiovascular Surgery
Alan Lumsden, M.D., Chair
Mahesh Ramchandani, M.D., Elected Deputy Chair
Cardiac
Transplant (Heart & Lung)
Vascular
Family Medicine
Donald Briscoe, M.D., Chair
Medicine
Richard Robbins, M.D., Chair
Victor Fainstein, M.D., Elected Deputy Chair
Dermatology
Emergency Medicine
Endocrinology
Gastroenterology/Hepatology
General Internal Medicine
Geriatrics
Hematology/Oncology
Hospitalists
Infectious Diseases
Nephrology/Hypertension
Pulmonary/Critical Care
Rheumatology/Immunology
Neurology
Stanley Appel, M.D., Chair
Paul Schulz, M.D., Elected Deputy Chair
Clinical Neurophysiology
Neurosurgery
Robert Grossman, M.D., Chair
Alfonso Aldama-Luebbert, M.D., Elected Deputy Chair
Physical Medicine & Rehab
Obstetrics & Gynecology
Alan Kaplan, M.D., Chair
Eric Haufrect, M.D., Elected Deputy Chair
Ophthalmology
Andrew Lee, M.D., Chair
Richard Fish, M.D., Elected Deputy Chair
Oral & Maxillofacial Surgery & Hospital Dentistry
Jaime Gateno, D.D.S., M.D., Chair
Donald Cohen, D.D.S., Elected Deputy Chair
Orthopedic Surgery
Kenneth Mathis, M.D., Chair
Kevin Varner, M.D., Elected Deputy Chair
Podiatry
Otolaryngology-Head & Neck Surgery
Bobby Alford, M.D., Chair
C. Richard Stansay, M.D., Elected Deputy Chair
Pathology
Michael Lieberman, M.D., Ph.D., Chair
Alberto Ayala, M.D., Elected Deputy Chair
Pediatrics
Mark Kline, M.D., Chair
Michael Speer, M.D., Elected Deputy Chair
Psychiatry
Stuart Yudofsky, M.D., Chair
Priscilla Ray, M.D., Elected Deputy Chair
Psychology
Radiation Oncology
E. Brian Butler, M.D., Chair
Radiology
King Li, M.D., Chair
George Soltes, M.D., Elected Deputy Chair
Surgery
Barbara Bass, M.D., Chair
H. Randolph Bailey, M.D., Elected Deputy Chair
Colon & Rectal
Critical Care & Acute Care
General Thoracic
Plastic Surgery
Transplant
Urology
Timothy Boone, M.D., Ph.D., Chair
Richard Goldfarb, M.D., Elected Deputy Chair
Organized Medical Staff
(Meets Quarterly)
Executive Committee
Officers:
Wade Rosenberg, M.D., President (Voting Member of Board)
Victor Fainstein, M.D., President-Elect (Advisory Member of Board)
Karen Woods, M.D., Secretary
Other Members:
Robert Jackson, M.D., Immediate Past President
Marc Boom, M.D., Executive VP, Designee of Chief Executive Officer
Jeff Brady, M.D., Member at Large
Eric Haufrect, M.D., Member at Large
Mary Schwartz, M.D., Member at Large
Stuart Seloman, M.D., Member at Large
Timothy Boone, M.D., Chair, Urology
Alan Lumsden, M.D., Chair, CV Surgery
Joseph Naples, M.D., Chair, Anesthesiology
Richard Robbins, M.D., Chair, Medicine
Dirk Soelman, M.D., Chief Medical Officer
Stuart Dobbs, M.D., Chief Quality Officer (By Invitation)
Nominating Committee
Richard Caplan, M.D., Chair
Medical Staff Committees
Bylaws & Rules
Richard Harper, M.D., Chair
Credentials
Julia Jones, M.D., Chair
Operating Room
Jerry Blacklock, M.D., Chair
Operating Room Subcommittees
Dunn 3 OR
Alfonso Aldama-Luebbert, M.D., Chair
Dunn 6 OR
Eric Haufrect, M.D., Chair
Fondren Brown OR
Michael Reardon, M.D., Chair
Main OR/CMPI
Stephen Lapin, M.D., Chair
Neurosensory OR
Robert Parks, M.D., Chair
Sourlock OR
Jeffrey Freidman, M.D., Chair
Medical Staff Quality Management
Thomas Baxter, M.D., Chair
MSQM Subcommittees
Anesthesia
Ajay, Varghese, M.D., Chair
Cardiology/Cardiovascular/Pulmonary
Stuart Seloman, M.D., Chair
Cardiothoracic/Vascular
Michael Sweeney, M.D., Chair
Endovascular
Richard Kluczmik, M.D., Chair
EPPIC
Timothy Doyle, M.D., Chair
General/Abdominal/Pelvic
Creighton Edwards, M.D., Chair
Head/Neck/Integumentary
Robert Parks, M.D., Chair
Medical
Jeffrey Kalina, M.D., Chair
Neuro/Muscular/Skeletal
Todd Trask, M.D., Chair
Obstetrics/Pediatrics
Barbara Hald, M.D., Chair
PCI
Stuart Salomon, M.D., Chair
Psychiatry
Andrsea Andral, M.D., Chair
Sedation
Ajay Varghese, M.D., Chair
Procedures & Criteria
Alejandro Rosas, M.D., Chair
Practitioner Health
Ranjit Chacko, M.D., Chair
Record
C. Richard Stesney, M.D., Chair
Pharmacy & Therapeutics
Howard Gorman, M.D., Chair
P & T Subcommittees
Antibiotics
Victor Fainstein, M.D., Chair
Clinical Nutrition
Alberto Barroso, M.D., Chair
MOM
Thomas Baxter, M.D., Chair
MUFE
Howard Rubin, M.D., Chair
CMPI Steering
Ronald Gallone, M.D., Chair
CMPI Subcommittees
Cancer Care
Edward Butler, M.D., Chair
Cardiology
Albert Ratzner, M.D., Chair
Code Blue
Kevin Lisman, M.D., Chair
Critical Care
Faisal Masud, M.D., Chair
Cardiovascular (CV)
Mahesh Ramchandani, M.D., Chair
Emergency Department
Jeremy Finkelstein, M.D., Chair
General Surgery
H. Randolph Bailey, M.D., Chair
Infection Control
Ashley Drews, M.D., Chair
Laboratory
David Bernard, M.D., Chair
Medicine
Stuart Dobbs, M.D., Chair
Neurology
David Chiu, M.D., Chair
Neurosurgery
Todd Trask, M.D., Chair
Orthopedic Surgery
Kenneth Mathis, M.D., Chair
Patient Safety
Stuart Dobbs, M.D., Co-Chair
David Bernard, MD, PhD, Co-Chair
Physical Medicine & Rehab
Andy Chen, M.D., Chair
Psychiatry
Priscilla Ray, M.D., Chair
Radiology
George Soltes, M.D., Chair
Skilled Nursing Facility
Theodore Trumble, M.D., Chair
Transfusion
Christopher Levesque, M.D., Chair
Transplant Center
Ahmed Gaber, M.D., Chair
Women's Healthcare & Nurseries
Alan Kaplan, M.D., Chair
Kay Mitchel
01/14/2010

MEDICAL STAFF OFFICERS

2012

PRESIDENT:	Victor Fainstein, M.D.
PRESIDENT-ELECT:	Eric J. Haufrect, M.D.
SECRETARY:	C. Richard Stasney, M.D.
PAST PRESIDENT:	Wade R. Rosenberg, M.D.

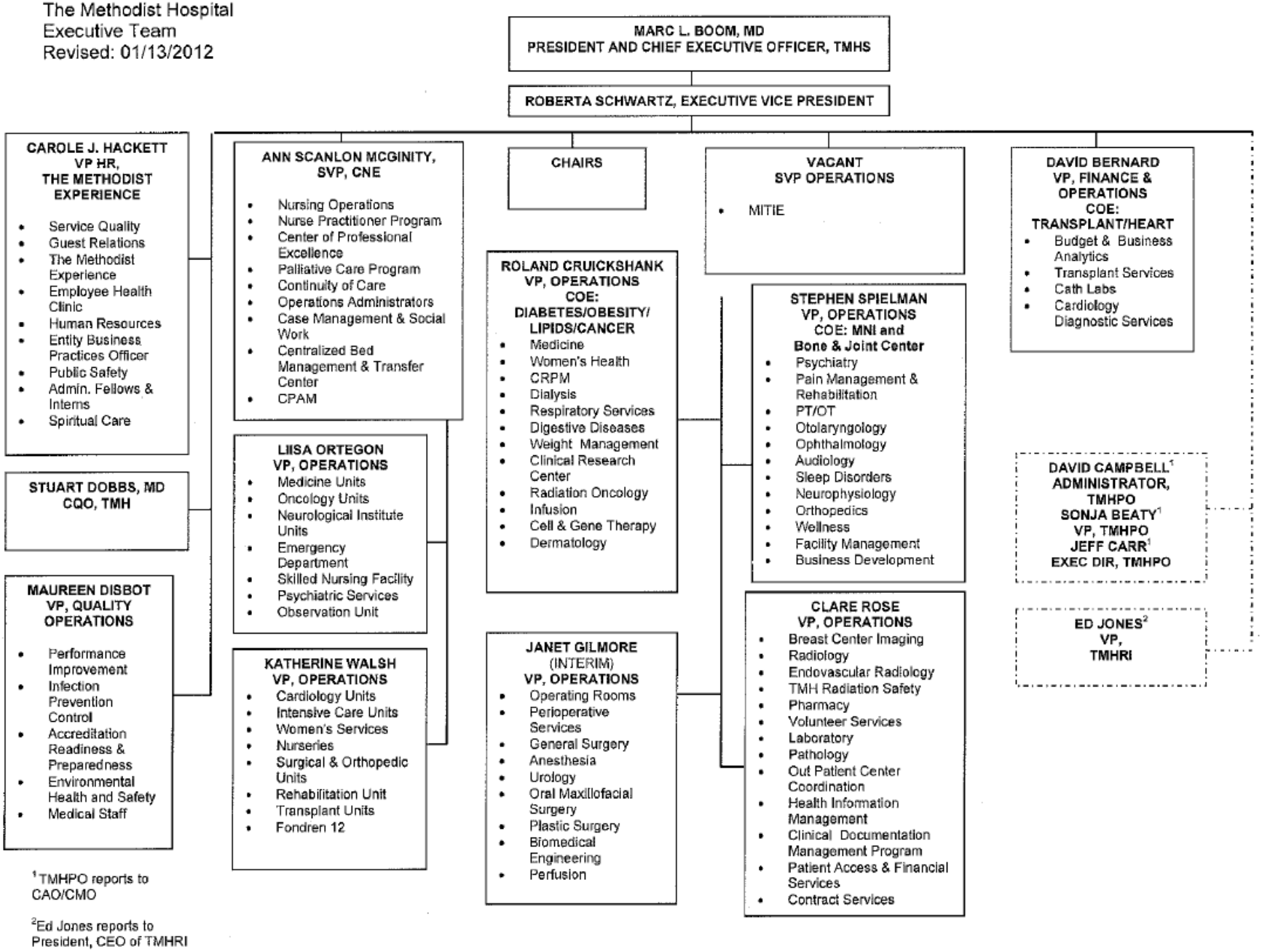
THE METHODIST HOSPITAL
Medical Staff Leadership

DEPARTMENT	CHAIR OF DEPARTMENT/ DIVISION CHAIR	MGMT RESP	DEPUTY CHAIR(S)
ANESTHESIOLOGY	**Joseph J. Naples, M.D.** Sherri Saunders / B 452 / P : 1-3492 / F : 790-2006 ; E : ssaunders@tmhs.org Zbiginew Wojciechowski, M.D., Vice Chair, Research/Education	Gilmore	Alfred L. Groen, M.D. (E)
CARDIOLOGY	**Miguel A. Quiñones, M.D.** Almanubia Cespedes / SM 1901/P: 1-1100; F: 790-2643/ E: acespedes@tmhs.org Albert E. Raizner, MD, Vice Chair, Clinical Affairs	Bernard	Nadim Nasir, Jr., MD (E)
CARDIOVASCULAR SURGERY Cardiac Transplant (Heart & Lung) Vascular	**Alan B. Lumsden, M.D.** Yvette Whittier / SM1401 / P : 1-6511 or 1-6201 / F : 1-6298/ E: ywhittier@tmhs.org Division Chiefs: Michael J. Reardon, M.D. ----- Eric Peden, M.D., Acting	Bernard	Mahesh Ramchandani, M.D. (E)
FAMILY MEDICINE	**Donald A. Briscoe, M.D.** **Erika Robinson/ 424 Hahlo/ P: 713-674-3326/ F: 713-674-3332**	Cruickshank	
MEDICINE Dermatology (Rose) Diabetes/Obesity/Lipids Emergency Medicine Endocrinology Gastroenterology/Hepatology General Internal Medicine Geriatrics Hematology/Oncology (Rose) Hospitalists Infectious Diseases Nephrology/Hypertension Pulmonary/Critical Care Rheumatology/Immunology	**Richard J. Robbins, M.D.** Roberta "Bert" Miller /SM1001 /P: 1-1576/ F: 790-2797 E: ramiller@tmhs.org Stuart M. Dobbs, MD, Vice Chair, Clinical Affairs Jose A. Perez, Jr., M.D., Vice Chair, Education Edward C. Lynch, M.D., Vice Chair, Academic Affairs Clinical Service Chiefs: John E. Wolf, MD Dale Hamilton, MD Jeremy Finkelstein, MD Included in DOL Gulchin Ergun, MD James Muntz, MD George Taffet, MD Lawrence Rice, MD Anh Nguyen, MD Victor Fainstein, MD Horacio J. Adrogue, MD William Lunn, MD / J. Mario Gonzalez, MD (all apps go to Dr. Lunn – he will forward if need to go to Dr. Gonzalez) Richard Rubin, MD	Cruickshank	Alberto Barroso, M.D. (E) Garrett R. Lynch,M.D. (A)
NEUROLOGY Clinical Neurophysiology	**Stanley H. Appel, M.D.** Mary Louise Spears / ST802/ P: 1-3765 / F: 793-7271/ E: mspears@tmhs.org Amit Verma, MD, Section Chief	Spielman	John Volpi, MD (E) David B. Rosenfield, MD (A)
NEUROSURGERY PM&R	**Robert G. Grossman, M.D.** Peggy Kelly / ST 944 / P: 1-3800 / F: 793-1015 / E: pkelly@tmhs.org Jenny M. Lai, MD	Spielman	Alfonso E. Aldama-Luebbert, MD (E)

THE METHODIST HOSPITAL
Medical Staff Leadership
(continued)

DEPARTMENT	CHAIR OF DEPARTMENT/DIVISION CHAIR	MGMT RESP.	DEPUTY CHAIR(S)
OBSTETRICS & GYNECOLOGY	**Alan L. Kaplan, M.D.** Barbara Hagemeister / SM 901A /P:1-3193/ F:790-2048 / E: bhagemeister@tmhs.org	Cruickshank	Eric Haufrect, MD (E) Alredo Gei, M.D. (A - Ob) Keith O. Reeves, M.D. (A - Gyn)
OPHTHALMOLOGY	**Andrew G. Lee, M.D.** Lin Cramer /ST2100 / P : 441-8823 / F : 441-6463 / E : lcramer@tmhs.org	Spielman	Richard H. Fish, MD (E) Amy G. Coburn, M.D. (A) Hilary Beaver, MD (A)
ORAL & MAX - Hospital Dentistry	**Jaime Gateno, M.D., D.D.S.** Kathleen Funk / ST 1228 P: 441-5577 / F: 793-1869 / E: kfunk@tmhs.org	Gilmore	Donald F. Cohen, DDS (E) Terry D. Taylor, DDS (A)
ORTHOPEDIC SURGERY Podiatry	**Kenneth B. Mathis, M.D.** Linda Theriot / SM 2500 / P: 1-3740 / F: 790-2141 E: lteriot@tmhs.org	Spielman	Kevin E. Varner, MD (E) Sherman Nagler, D.P.M. (Peer Review - Podiatry)
OTOLARYNGOLOGY – Head & Neck Surgery	**Donald T. Donovan, M.D., Interim Chair** Anne Cannon/ NA 102/ P:798-5906/ F: 3403/ E: acannon@bcm.edu	Spielman	C. Richard Stasney, MD (E) Donald T. Donovan, MD (A)
PATHOLOGY	**James M. Musser, M.D, Ph.D.** Liz Al-Ateeqi/ B 490/ P: 1-3883 / F: 1-3886 / E: liza@tmhs.org	Rose	Alberto G. Ayala, MD (E)
PEDIATRICS	**Mark W. Kline, M.D.** Carrell Briley P:713-798-7059/ TCH MC CC1210/ P: 713-798-6776 / F: 713-798-7119	Cruickshank	Michael Speer, MD (E) 790-4593 (M605)
PSYCHIATRY Psychology	**Stuart C. Yudofsky, M.D.** Lynn Sanders / 6655 Travis / P: 798-4945/ F: 796-1615 / E: asander1@bcm.edu	Spielman	Ranjit Chacko, MD (E) As of 1/1/09: Priscilla Ray, M.D. Harvey Levin, PhD (Peer Review – Psychology)
RADIATION ONCOLOGY	**E. Brian Butler, M.D.** / MS121B / P: 713-790-2637/ F: 713-793-1300	Cruickshank	N/A
RADIOLOGY	**King Li, M.D.** Lien Nguyen / D280 / P: 1-4862 / F: 790-6474 / E: lmnguyen@tmhs.org	Rose	George D. Soltes, MD (E)
SURGERY Colon & Rectal Critical Care and Acute Care General Thoracic Plastic Surgery Transplant	**Barbara L. Bass, M.D.** Clarice Brewer (1-5133)/SM 1661A /P:1-5132/F:790-6300/ E : cbrewer@tmhs.org Wade R. Rosenberg, MD, Vice Chair, Clinical Affairs Division Heads : H. Randolph Bailey, MD Frederick A. Moore, MD Shanda Blackmon, MD Jeffrey D. Friedman, MD Osama Gaber, MD	Gilmore	H. Randolph Bailey, M.D. (E)
UROLOGY	**Timothy B. Boone, M.D., Ph.D.** James Papirtis / ST 2100/ P: 441-6458/ F:441-6463/ E:jcpapirtis@tmhs.org	Gilmore	Richard A. Goldfarb, MD (E) Seth P. Lerner, MD (A)

The Methodist Hospital
Executive Team
Revised: 01/13/2012



[1] TMHPO reports to CAO/CMO

[2] Ed Jones reports to President, CEO of TMHRI

Our Hospitals

The Methodist Hospital corporation is a nonprofit health care organization based in Houston, Texas. It has extended the world-renowned clinical and service excellence of its founding entity, The Methodist Hospital, through a network of community based hospitals. Affiliated with the Texas Annual Conference of the United Methodist Church, The Methodist Hospital corporation works closely with local church leaders to bring compassion and spirituality to all of its endeavors and to help meet the health needs of the community it serves.

- The Methodist Hospital
- Methodist Sugar Land Hospital
- Methodist West Houston Hospital
- Methodist Willowbrook Hospital
- San Jacinto Methodist Hospital

The Methodist Hospital Research Institute

The Methodist Hospital Research Institute is a cornerstone of The Methodist Hospital's strategic vision for its future as a top-ranked academic medical center. The Methodist Hospital Research Institute will conduct groundbreaking translational and clinical research to provide the best possible care for our patients. Our goal is to make the latest laboratory findings available to patients in the form of new treatments and clinical trials as rapidly as possible. The Institute is committed to moving the latest discoveries in the laboratory to the bedside in order to provide a new standard of care for our patients and those in other parts of the country.

The Methodist Hospital Foundation

The Foundation was established to ensure The Methodist Hospital has the support needed to achieve its vision for excellence in research, education and patient care. Governed by a board of directors, the Foundation accepts all gifts on behalf of The Methodist Hospital for the benefit of the organization. The Foundation helps to accomplish the priorities of The Methodist Hospital through fundraising, volunteerism, gift management and stewardship.

The Methodist Hospital Physician Organization

Established as a non-profit corporation certified by the Texas State Board of Medical Examiners, The Methodist Hospital Physician Organization enables physicians to maintain autonomy with respect to their clinical practice while growing their practice within an academic environment. As part of this organization, physicians are affiliated with The Methodist Research Institute, and are encouraged to seek a Weill - Cornell faculty appointment.

Leading Medicine

The Methodist Hospital has earned worldwide recognition since it opened its doors in 1919.

As a private, adult teaching hospital affiliated with Weill Medical College of Cornell University, it offers the latest innovations in medical, surgical and diagnostic techniques. Methodist also maintains various joint programs with Baylor College of Medicine.

The hospital, one of only a handful in Texas recognized by The Best Hospitals in America, is among the country's largest non-profit health care providers. Its medical staff, meanwhile, include dozens of physicians listed in The Best Doctors in America.

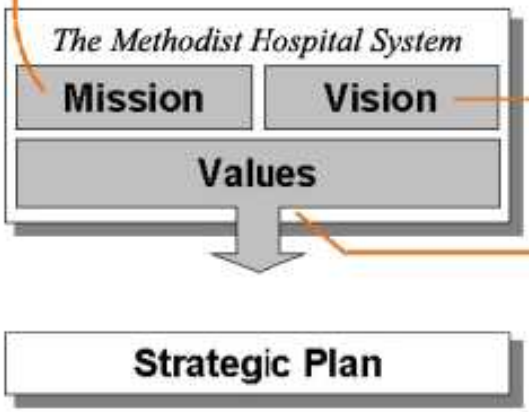
The Methodist Hospital is nationally ranked in 12 specialties by U.S. News and World Reports

Certified by the Joint Commission of Accreditation of Healthcare Organizations, Methodist is a leader in such specialties as:

- Cardiovascular Surgery (pioneered by famed heart surgeon Dr. Michael E. DeBakey)
- The Treatment of Cancer and Epilepsy
- Obstetrics/Gynecology
- Nephrology/Kidney Disease
- Endoscopic Surgery
- Otolaryngology
- Neurology and Neurosurgery
- Organ Transplants
- Orthopedics
- Urology

Methodist's Mission, Vision and Values Statement

"To provide high quality, cost-effective health care that delivers the best value to the people we serve in a spiritual environment of caring in association with internationally recognized teaching and research."



"People will seek Methodist as a globally recognized leader of pioneering medical expertise and innovative, personalized care."

- *Integrity – "We are honest and ethical in all we say and do."*
- *Compassion – "We embrace the whole person and respond to emotional, ethical and spiritual concerns as well as physical needs."*
- *Accountability – "We hold ourselves accountable for our actions."*
- *Respect – "We treat every individual as a person of worth, dignity and value."*
- *Excellence – "We strive to be the best at what we do and a model for others to emulate."*

Methodist The Methodist Hospital System

The Methodist Hospital

MEDICAL STAFF GUIDING PRINCIPLES

Integrity

1. Take action with shared goal and purpose in mind.
2. Drive our business processes through a patient-centered focus.
3. Optimize career choices consistent with ICARE values.
4. Align priorities to our values so that we make time to talk about things that are important.

Compassion

5. Treat each other with caring professionalism.
6. Greet each other, smile, slow down to acknowledge and appreciate each other.
7. Use the phrase "Let me help you with that" more often.

Accountability

8. Your word is your bond; if you say you will do something, follow through (on a personal and institutional level).
9. Measure positive "we can do" attitude; and share ownership for shared results.
10. Show institutional commitment through participation in activities.
11. Follow the 5-year vision, and demonstrate our commitment to the vision with actions.
12. Align institutional vision to common good for all stakeholders (patients, physician, institutions we serve).

Respect

13. Appreciate differing points of view.
14. Listen to dissenting opinion in respecting fashion – at all levels, across all professions and disciplines.
15. Exhibit a cooperative attitude – offer help, compromise. Collective need transcends individual need.
16. Seek to create generative relationships.
17. Work as a team.

Excellence

18. Reach toward lofty goals. Create a culture that rewards risk-taking.
19. Recognize and reward teaching in all areas, both locally and nationally.
20. Benchmark and monitor (quantify, assess) our performance in safe environment. Give feedback (through outcomes) without blame.
21. Consistently measure and celebrate education and discovery (generating knowledge, research). They are our legacy.
22. Apply business principles and processes to our projects.
23. Set the stage for excellent performance.
24. Have fun.

Approved: Executive Committee, 3/10/06
Medical Staff, 3/21/06

COMPLIANCE AND ETHICS

The following section contains information about Methodist's commitment to compliance and ethics through the Methodist Business Practices Program.

Business Practices Program

Program Vision: All actions taken in the name of Methodist are consistent with strong moral values, high ethical standards and the law.

With a focus on organizational ethics and regulatory compliance, the Business Practices Program (Program) helps all employees make this vision a reality. The Board of Directors has adopted the Business Practices Policy and the Business Practices Program Plan.

The Policy directs all Directors, officers, medical staff members, and employees of all Methodist entities to perform patient care activities and business operations in a manner consistent with the Program's vision and Methodist's core values, ICARE. Methodist's strategic plan, policies and procedures are designed to support this commitment in all areas including patient rights; respect for medical staff and employees; marketing; admission, transfer and discharge of patients; billing, including fraud prevention and detection programs; and, resolution of conflicts.

The Methodist Business Practices Officer leads the Program and reports directly to the Methodist Board of Directors and President and Chief Executive Officer. Each Methodist hospital has a Business Practices Officer who directs the Program at that location consistent with the corporate Program. To contact the Entity Business Practices Officer, Vicki Brownewell, 713 441 4922, or call the Ethics Line 1 800 500 0333.

Do the Right Thing!
Many times throughout your day, you exercise judgment and make decisions where there are no written policies or procedures. Here are some tips to help you determine if you are doing the right thing in those circumstances. Take the test:

- Headline Test
  If the Houston Chronicle or the six o'clock news reported on an action you performed at work, would you feel good about it? If the answer is no, then it's probably not the right thing to do. Get some clarification before you proceed with that act.
- Pride Test
  Could you tell your children or your mother about what you did and feel good about it? If the answer is no, then it's probably not the right thing to do. Again, get some clarification before you proceed with that act.
- Smell Test
  Have you ever said to yourself "This doesn't smell right?" Well if it doesn't, then it probably isn't. So don't do it. Use your good instincts to help you determine if something is right or not. If you are not sure, get clarification from another source.

Follow Approved Medical Staff By-Laws
Follow the Medical Staff By-Laws set by the Medical Staff of The Methodist Hospital.

Live Methodist Values in all Work
Integrity, Compassion, Accountability, Respect and Excellence: these are Methodist's core values. All physicians and allied health professionals are expected to demonstrate these values in their relationships with patients, medical staff, hospital employees and guests.

Report Questionable Practices
Any physician or allied health professional who learns about a situation that appears to violate the law or appears not to be the right thing, should report that situation or concern. Physicians and/or allied health professionals need to report questionable practices for two reasons:

- The practice or concern will not be addressed unless management knows about it
- Doing so is part of each employee's responsibility to make The Methodist Hospital even better

You may report a questionable practice to any of the following:

- Your Departmental Chairperson
- President of the Medical Staff of The Methodist Hospital
- Senior Management of The Methodist Hospital
- Business Practices Office
- EthicsLine, 1-800-500-0333
  Callers do not have to give their name when they call EthicsLine and EthicsLine does not trace incoming calls. EthicsLine sends a report of each call to the Methodist Business Practices Office who investigates the situation. EthicsLine will give each caller a tracking number that the caller can use to ask the Business Practices Office about the status of the investigation. The Methodist Business Practices Office does not have Caller-ID.

All reports of questionable practices are taken seriously and are investigated in a timely manner. Retaliation against employees, physicians or allied health professionals making these reports in good faith is prohibited and will not be tolerated.

CONFIDENTIALITY OF METHODIST INFORMATION

The following section contains information about the confidentiality of Methodist Information, including but not limited to patient health information, business information and personnel records.

Confidential Business Information
Physicians, allied health professionals and/or employees must not give confidential or proprietary business information to unauthorized persons, such as competitors, suppliers or outside contractors without proper authorization. Physicians, allied health professionals and/or employees must not use Methodist information obtained by reason of their employment with the intent to cause financial gain to themselves or unfair advantage to other people. Examples of confidential business information include, but are not limited to, pricing and cost data, information pertaining to acquisitions, divestitures, affiliations and mergers, financial data, pay scales, strategic plans, marketing strategies, supplier and subcontractor information and research data.

Confidentiality and Information Security
Methodist maintains a strict policy of confidentiality to safeguard the privacy and confidentiality of data pertaining to patients, employees and business information related to its operations. This policy applies to all physicians, allied health professionals and/or employees, associates and business partners who are authorized to have access to confidential information.

This confidentiality policy serves as a basis for the establishment of standards and security controls for information owned by, or in the custody of, Methodist regardless of its form (oral, paper-based and electronic) or storage media. It is applicable to all types of information used by Methodist, including, but not limited to: patient health information; patient demographic information; patient financial information; research information; personal information about physicians, employees and other caregivers; peer review information; information about payors; business records including financial, personnel records, practice patterns, strategic plans, and similar information; any discoveries, inventions, ideas, methods or programs that have not been publicly disclosed; computer software; and, any other information that has been marked "confidential."

Safeguarding confidential and proprietary information is not only a legal requirement, but also an important ethical obligation. The responsibility for maintaining confidentiality of information lies with the individual entrusted with the information. By signing a Confidentiality and Information Security Agreement the physician, allied health professional and/or employee or associate agrees to abide by the confidentiality policies and procedures for keeping information and information systems secure. Access to information systems and proprietary data is a privilege extended at the discretion of Methodist and Methodist retains the right and authority to revoke or restrict such privileges at any time.

Medical and Billing Records
Methodist strives to maintain all paper and electronic data, including medical records and financial reports, in a secure manner and in a safe location for the length of time required by law. Information contained in records, contracts, billing statements or other documents must not be altered or falsified. Only authorized persons may access medical and billing records.

Passwords
Methodist physicians, allied health professionals and/or employees are required to keep passwords secret and are instructed not to share it (them) with anyone except for technical maintenance or as directed by management for legitimate business purposes. Methodist physicians, allied health professionals and/or employees are also required to change their password if it has been divulged or if it is suspected to be known by others.

DISCIPLINARY ACTION

The following section contains information about disciplinary action that may be taken in response to violations of the law or Methodist standards.

Penalties for Non-compliance
Everyone is equally responsible for maintaining high standards of lawful behavior. Legal and regulatory compliance violations will lead to disciplinary action that may include termination of privileges and may involve governmental civil and/or criminal prosecution, in addition to exclusion from participation in Medicare and other federal health care program business.

Progressive Correction
All physicians, allied health professionals and/or employees have the responsibility to follow standards such as those established by law, policies, procedures, departmental practices and job descriptions. Each physician, allied health professional and/or employee also has the responsibility to report to management any violation of such standards.

Credentials Verification
Credentials will be verified for each physician and/or allied health professionals prior to approval at The Methodist Hospital in accordance with the Medical Staff Bylaws.

WORKPLACE BEHAVIOR

The following section contains information to serve as a guide and reference for all physicians, allied health professionals and employees, including management, in carrying out their duties in a consistent and equitable manner.

Alcohol and Drugs in the Workplace
As part of Methodist's commitment to safeguarding the health of physicians, allied health professionals and/or employees, providing a safe place for to work, and supplying our customers with the highest quality patient care and service possible, Methodist prohibits the unlawful manufacture, distribution, use or possession of alcohol, drugs or other controlled substances on its premises or worksites. Methodist encourages prevention and treatment of substance abuse through education, counseling and rehabilitation programs.

Distribution and Solicitation
No solicitation of employees and/ or distribution of literature will be permitted within Methodist property or on Methodist premises. Methodist reserves the right to regulate any solicitation or distribution activities (including the selling of products or services) by any nonemployee, organization or employee which disrupts or interferes with the normal work activity of Methodist employees. Any organization (on its own or through its employee supporters) or any nonemployee violating this policy shall be asked to leave the premises.

Electronic Communications Systems Use
Methodist policy regarding the use and monitoring of communications systems includes electronic and telephone communications systems, including but not limited to mail, e-mail, courier services, telephone systems, answering machines, voice mail, fax machines, video equipment and tapes, tape recorders and recordings, pagers, cellular telephones, computer networks, and computer directories and files. Methodist technology and/or equipment should be used for business purposes only and all communications and stored information transmitted, received, or contained in the Methodist information systems are the property of Methodist.

Communications that may defame Methodist, physicians, allied health professionals, employees, customers, vendors, or competitors as well as offensive, harassing, vulgar, obscene, or threatening communications are prohibited.

Physician/Allied Health Identification
Physicians and/or allied health professionals are required to wear an identification badge while on duty. The badge is provided to you by Methodist and must be worn in a visible location with the picture side of the badge displayed. Generally, no decorations or jewelry may be attached to the badge; however, an official service pin may be affixed to the badge without obstructing the picture, name identification or the magnetic badge reader, if applicable.

WORKPLACE BEHAVIOR, continued

Equitable Treatment
Physicians and/or allied health professionals are provided an avenue to voice their concerns should they feel they have been treated inequitably and their disputes cannot be resolved through normal day-to-day problem solving channels. Any such actions are to be reported to the President/CEO, senior management, or departmental chairpersons. Concerns of unfair, unsafe or unlawful treatment will be investigated promptly, thoroughly, securely and kept confidential. There will be no retaliation against any person who exercises his or her right to resolve conflicts in this manner.

Harassment
Methodist is committed to providing a work environment free from all forms of harassment, exploitation or intimidation, including sexual, racial and/or religious harassment. Each member of the Methodist community is responsible for fostering mutual respect, for being familiar with this policy, and for refraining from conduct that violates this policy. This policy applies to all individuals, including employees, patients, members, visitors, members of Medical and/or House Staff, students, volunteers, physicians, allied health professionals, contractors and vendors.

Smoking/Tobacco
The Methodist Hospital is smoke/tobacco free. All tobacco products are not permitted on the property of the hospital. This includes the professional buildings and all hospital parking lots.

Weapons-Free Environment
Methodist strives to provide a safe working environment free from risk of violence with firearms and weapons. Methodist prohibits the possession of any kind of lethal weapon on its premises; this includes all concealed handguns regardless of whether a person has been issued a license to carry a concealed handgun by the Texas Department of Public Safety. Only Commissioned Law Enforcement Officers and persons granted written permission by the President and Chief Executive Officer of Methodist are permitted to carry weapons on the premises. Methodist physicians, allied health professionals and/or employees should report anyone who may be carrying a weapon to a Security Officer and/or Public Safety at The Methodist Hospital.

PATIENT RIGHTS

The following section contains information about certain basic rights of patients. In keeping with our mission, Methodist recognizes and promotes certain basic rights of patients in accordance with applicable laws, regulations and accreditation standards.

Admission, Transfer and Discharge
Methodist will not exclude or otherwise discriminate against any person on the basis of race, color, disability, national origin, age, sex, or religion from participation in, admission to, access to, or treatment in, any programs, activities or benefits.

Methodist is committed to ensuring that all patient transfers are done in a medically appropriate manner from physician to physician, as well as hospital to hospital. The transfer of a patient may not be predicated upon unreasonable discrimination based upon race, religion, national origin, age, sex, physical condition or economic status.

Methodist is committed to working together with the patient and family to formulate a discharge plan based on patient need for post-hospital care, and to provide education and instructions to the patient, the family, and/or others who will be involved in home care, and complete referrals to appropriate resources as indicated.

Emergency Medical Treatment
Methodist is committed to providing emergency medical services to individuals who present to the hospital's emergency department, without regard to condition or economic status, if the hospital has the required capability and capacity. All individuals who present with similar medical conditions will be treated consistently.

End-of-Life Decisions
Methodist recognizes the rights of patients to formulate advance directives concerning their health care. To encourage patients to take the initiative to ensure that their values are respected in end-of-life decisions and to comply with Federal and State laws, Methodist will provide patients with information concerning their rights to make decisions about medical care, including their right to request or refuse treatment and to formulate advance directives. A patient's advance directive will be honored to the extent permitted by law and within the capabilities of Methodist and its employees and medical staff. Methodist also recognizes that employees', and its medical staff, may have strongly held values and beliefs that cause a concern or conflict with some aspect of patient care. Such concerns or conflicts will be evaluated and resolved to ensure that the quality of care is not compromised.

Informed Consent
Methodist recognizes that patients have the right to be informed of their medical condition and to consent to or decline any medical service or treatment.

PATIENT RIGHTS, continued

Reporting of Suspected/Alleged Abuse or Neglect
Methodist is committed to complying with Federal and State laws for reporting alleged or suspected abuse, neglect or exploitation of patients and/or family members. To comply with applicable laws and to maintain the confidentiality of the reporter, the person who observed or has reason to suspect abuse, neglect or exploitation must make the actual call to Adult Protective Services or Child Protective Services. Social Workers are available at each Methodist entity to assist any employee making the report and with any subsequent investigations.

Research
Methodist recognizes the importance of clinical and biomedical research as part of its overall health care mission and is committed to following high ethical standards while conducting any research. However, to support the larger part of its mission to provide high quality patient care, Methodist must have the opportunity to review the impact of proposed research projects on hospital operations and patient privacy. Each Methodist employee and/or individual conducting research on behalf of Methodist or engaged in Methodist's working environment applying for and/or conducting research of any type is responsible for complying with the law and Methodist policies and procedures. Research misconduct will not be tolerated.

Before participating in a research study, patients must be fully informed of alternative services that might prove beneficial to them. All potential risks, discomforts, expected benefits and alternatives must be completely explained to the patients in a manner they can understand. All patients and staff have the right to refuse to participate in research without compromising any other services or functions. A patient's treatment will not be affected by his/her refusal to participate in a research study.

Right to Protected Health Information
Methodist recognizes that patients have rights, with certain exceptions provided by law, with respect to the health information that is created about them at Methodist. These rights are set forth in Methodist's Notice of Privacy Practices and Methodist's policies and procedures. If you have questions or need information regarding your legal duties or privacy practices, please contact The Methodist Hospital's Entity Business Practices Officer, Vicki Brownewell, 713 441 4922.

Access
Patients have the right to review and receive a copy of their health information contained within Methodist's designated record set (generally, this is the patient's medical record and billing record).

Accounting of Disclosures
Patients have the right to request a list of disclosures that Methodist has made of the patient's health information, with the exception of disclosures made for treatment, payment or health care operations, those authorized by the patient and certain other disclosures.

Amendment
Patients have the right to request an amendment of their health information if the patient feels that the health information that Methodist has is incorrect or incomplete.

PATIENT RIGHTS, continued

Complaint
Patients have the right to file a complaint with Methodist or the Secretary of the United States Department of Health and Human Services if the patient believes that his/her health information privacy rights have been violated.

Confidential Communications
Patients have the right to request that Methodist communicate health information to them by an alternate means or location other than their home address and telephone number. Requests for alternate communications should also be communicated by the patient to all of their health care providers, including their private physician. Methodist shall strive to accommodate the patient's request for alternate communications.

Notice of Privacy Practices
Patients have the right to receive a paper copy of the Notice of Privacy Practices. Methodist reserves the right to change the Notice of Privacy Practices, including the right to make new provisions effective for all health information that is currently maintained, as well as any information received by Methodist in the future.

Restrictions
Patients have the right to request that Methodist restrict the use or disclosure of the patient's health information for treatment, payment or health care operations. Methodist is not required to agree to the patient's request for certain restrictions. If Methodist does agree to a restriction, the request will be granted unless the information is needed to provide emergency medical treatment to the patient.

The Methodist Hospital System

TMH Texas Medical Center Campus

EMERGENCY NUMBERS

REPORTING A FIRE:

Alkek Fire 3300	**Annex Fire 3300**	**Dunn Fire 3300**	**Fondren/Brown Fire 3300**
Main Fire 3300	**Neurosensory Fire 3300**	**West Pavilion Fire 3300**	
Medical Towers Fire 9-911	**Scurlock Fire 9-911**	**Smith Fire 9-911**	**Warehouse Fire 9-911**

1. **Dial the fire extension or telephone number**
2. **identify yourself**
3. **Give location of fire or smoke**
4. **Describe what is burning**

713-790-4258 CODE BLUE
713-441-4246 SECURITY
713-441-4246 SPILLS
713-441-1016 Emergency Room
713-441-1036 Environmental Safety
713-790-2201 Page Operator
713-441-2381 Pastoral Services
713-441-2151 Public Safety

From Meridian Telephone using 5 Digit Dialing

8+3300 FIRE
8+4258 CODE BLUE
1+4246 SECURITY
1+4246 SPILLS
1+1016 Emergency Room
1+1036 Environmental Safety
8+2201 Page Operator
1+2381 Pastoral Services
1+4246 Public Safety

Poison Control 1-800-764-7661

Television / Radio Stations that TMH uses for Weather and Closure Announcements are:

Channel 13 and KTRH 740 AM

SAFETY

Safety is a top priority of Methodist and we commit substantial resources to providing the safest possible physical environment for all. The success of our safety program depends on employee, physician and allied health professional's commitment to safety. You can help promote safety by focusing on these key areas:

- Awareness - You are expected to be aware of fire, disaster, and safety policies and procedures.
- Prevention - It is up to you to look for unsafe conditions, report them, and see that they are corrected.
- Preparedness - When an emergency does arise, you must know how to act to prevent or reduce injuries damage and loss.

Accidents and Injury Reporting
If you see anyone injured, give assistance and get help. Always report any accidents, injuries or unusual incidents to the charge nurse, nursing director senior management and/or President/CEO immediately.

Environmental Management
The mission of Methodist reflects a social responsibility to the community to protect the environment and minimize the environmental impact of its operations. Methodist strives to comply with environmental laws and regulations and will implement other appropriate environmental strategies that do not unreasonably increase the cost of health care.

Fire Plan
While Methodist buildings have been constructed to be as safe as possible, effective response to any fire depends in great measure on preparedness. In the event of a fire or fire drill, you should know and carry out appropriate procedures.
Fire safety and prevention are responsibilities of all employees. An easy to remember acronym, RACE, is a guide that helps prevent panic and avoid catastrophe in a fire emergency.

RESCUE. Rescue anyone in immediate danger.
ALARM. Pull the nearest fire alarm. Pull stations are usually located near elevators and stairwells and nurses stations. Call an emergency number such as 911 or your entity's internal emergency number.
CONTAIN. Contain fire and smoke by closing doors.
EXTINGUISH. Extinguish the fire if it can be done safely.

Safety Training
Trained and motivated employees are Methodist's greatest resource. Methodist conducts a comprehensive safety training program that is continuously monitored for its effectiveness. Safety training for employees includes orientation programs for corporate-wide and departmental safety information and procedures. Each Methodist entity is uniquely specialized and varied in terms of procedures, equipment and materials. Recognizing these individual conditions, each department conducts safety orientation to familiarize its employees with safety policies and procedures particular to the area.

Severe Weather and Emergencies
In case disaster strikes or threatens Methodist or the community, each individual department has a disaster plan that employees are to review and be prepared to follow. Should this occur, please see the Nursing Director/Supervisor on the unit, the President/CEO, senior management, and/or departmental chairperson on how you may assist in this circumstance.

Hospital Codes

For all hospital codes, the hospital operator is to be notified by calling ext. 14246.

Dr. Pyro: This code means fire. Please respond by removing all items and equipment in hallways, close all doors and windows. Remember to R.A.C.E. – Rescue, Alarm, Contain, Extinguish, if you find a fire. In the event of a true fire, personnel not assigned to assist directly with a fire incident will remain on their units. Personnel may be assigned to front entrance, Emergency Department entrance, employee/physician entrances, loading dock entrance and any public entrance to prevent entry into the building. NO VISITORS WILL BE ALLOWED TO ENTER THE HOSPITAL DURING A TRUE FIRE EMERGENCY. If the relocation or evacuation becomes necessary, follow evacuation plan of the hospital.

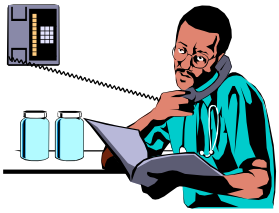
Dr. Pink: This code indicates that there is an infant/child abduction. Observe all exits, hallways and elevators throughout the hospital. When a Code Adam has been initiated, the PBX operator will provide information regarding the department or area the child was last seen, age of the child, skin and hair color, and description of clothes the child was wearing.

Code Orange: In the event a bomb threat is received, the individual answering the call, will immediately call 14246. The recipients of the call will note/document: the exact time of the call, when the call was terminated, exact words of the caller, any distinguishing background noises. At no time will this information be shared with fellow medical staff members or hospital personnel, patients or visitors after it is called to the operator by calling 14246.

Chemical Spills: Report all chemical spills by calling the hospital operator at 14246. Evacuate and secure the area. If on hospital property, the hospital's HAZMAT team will respond to large spills and spills of unknown substances.

Disaster Instructions for Physicians: If called to respond to a hospital disaster, report to the Physician Staging Area, Dunn OR Waiting Room, D399. Physician Disaster Information Line is 713-441-DOCS.

Disaster Alerts:	**Code 99 – Management**	Management standby for info.
	Code 99 – Triage	ER Disaster Group activation.
	Code 99 – STAT	Staff report to department, await instructions.



THE METHODIST HOSPITAL SYSTEM DICTATION INSTRUCTIONS

DIAL: ***713-441-4211*** or ***1-888-481-4626***

Enter the Staff Physician's ID and Press #

To Dictate — Press 1

To Listen — Press 2

Enter the Facility Code (if requested) **and Press #**

1 – The Methodist Hospital
2 -- Methodist Sugar Land Hospital
3 – Methodist Willowbrook Hospital

Enter the Report Type & Press #

1 – H&P	5 – Delivery Note
2 – Consultation	6 – Death Summary
3 – Operative Report	7 – Code Blue
13 – To use Operative Template	
4 – Discharge Summary	

Keypad Functions

1 – Play (listen)

2 – Record

3 – Short Rewind

4 – Fast Forward to End

5 – Disconnect

6 – Pause

7 – Rewind to Beginning

8 – End report, begin new document

#9 – to mark STAT

Enter the Patient's 13-digit Encounter Number & Press #

Begin Dictating – Please remember to state the following:

- State physician name (responsible for signing report)
- ***Identify type of report***
- ***Say and spell the patient's name***
- Patient's complete 13-digit Encounter Number
- ***Give dates of Admission, Discharge, Operative and/or Consult date***
- Give name and credentials of person dictating if other than staff physician (this will be indicated at the end of the report as "Dictated by:_____")

JOB NUMBER - Upon completion of dictation **Press 5 or 8** (as in keypad functions).

You will be given a **"Confirmation Number"** for verification of dictation.

STAT DICTATION - Call 713-441-0050 to notify if a report is to be transcribed STAT.
Give: Confirmation Number, patient's name and Encounter number.

Once a report is transcribed it will be available in the Physician Portal for signature.

*TO LISTEN TO A DICTATED REPORT***Please see wallet Dictation card for Listening Instructions**

HIM GENERAL INFORMATION

LOCATION

The Health Information Department (HIM) is located on the first floor of the Main Building (M1-001), between the Market Place Cafeteria and the Emergency Room.

HOURS OF OPERATION

Monday through Friday - 7:00 a.m. to 11:30 p.m.,
Weekends and Holidays (Excluding Thanksgiving & Christmas Day) - 8:00 a.m. to 4:30 p.m.

TELEPHONE NUMBERS

713.441.2401 Medical Records main
713.441.0942 HPF assistance
713.441.4211 Dictation system
713.441.0050 Dictation assistance

MEDICAL RECORD ACCESS

All medical record information is regarded as confidential and available only to authorized users. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

Hospital medical records are available in these media systems:

Horizon Patient Folder (HPF)*

HPF contains real-time results from Radiology, Laboratory, and dictated reports. Once a patient is discharged, the paper chart is scanned into HPF and MethOD entries are electronically transmitted to HPF.

Records of discharged patients are sent to the HIM Department on the day of discharge for scanning into HPF. Records may not be held on the nursing units post-discharge. The complete medical record is available in HPF approximately 48 hours after discharge.

HPF contains all medical records from July 2004 to present.

HPF is considered The Methodist Hospital's legal medical record.

Horizon Physician Portal (HPP)*

HPP is another way to access the same information as in Horizon Patient Folder, but makes the patient records accessible from remote locations for chart completion.

MethOD

MethOD is an electronic clinical documentation system for Orders, Vital Signs, and Nursing Notes. Radiology and Laboratory results, and physician dictated reports are also viewable real-time in MethOD.

Paper Based Medical Records

Medical records prior to July 2004 are stored off-site in hard copy, microfilm, or electronic media and may be requested by contacting the HIM Department.

*Document Imaging

DOCUMENTATION GUIDELINES

GENERAL GUIDELINES

Entries in the Medical Records: All entries in the patient's medical record shall be made only by duly authorized persons functioning within their sphere of competence as outlined in Hospital and Medical Staff policies. **All entries in the patient's medical record shall be legible, accurately dated and timed, and individually signed.** A Practitioner may have a designated Practitioner sign on his behalf in accordance with applicable policies and procedures of the Hospital and Medical Staff. Signature shall be defined as establishing authorship by means of written signatures, identifiable initials, or computer key. **The use of rubber stamp signatures is not allowed.**

If an error in written documentation is made, the error should be lightly scored through, signed and dated. *Liquid paper and labels should not be used to cover incorrect or revised documentation.*

To amend an authenticated handwritten entry in the medical record, an addendum, which provides the reason for the amendment, may be either written or dictated, and then signed and dated.

Entries by medical students must be co-signed by a Medical Staff member or a resident.

Information regarding the content of reports - H&P, Operative Report, and Discharge Summary may be found below and on the TMH Intranet at **www.methodistdocs.com**, under "Medical Records Documentation".

HISTORY AND PHYSICAL EXAMINATION

1. History and physical reports must be completed within 24 hours of admission and prior to invasive or high-risk procedures.

2. Reports completed within thirty (30) days prior to the admission may be used provided the H&P is relevant to the admission AND includes an admission note completed with 24 hours of admission documenting any updates to the History and Physical report. For outpatient services, a History and Physical may be completed within 30 days prior to the admission as long as an update note is completed the same day, but prior to the invasive or high-risk procedures.

3. History and physical reports completed more than thirty (30) days prior to the admission CANNOT be used.

4. Every admission to the Rehabilitation Center, Psychiatry, Skilled Nursing Facility and Hospice is considered a separate admission and requires that a medical history and physical examination be completed within seven (7) days before admission and no later than 24 hours following admission.

A complete History and Physical must contain all elements in bold

CHIEF COMPLAINT: Concise statement describing the symptom, problem, condition, diagnosis, or other factors that is the reason for the encounter.

HISTORY OF PRESENT ILLNESS: symptoms/complaints**:**

- Location "where"
- Quality or sensation ex. Sharp, dull, shooting
- Severity of illness
- Duration of complaints, onset to present
- Timing, pattern or frequency
- Context (circumstances associated with symptoms
- Modifying factors (to obtain relief and results)
- Associated signs and symptoms

REVIEW OF SYSTEMS: Document all systems inventoried. The systems are:

- Constitutional (weight loss, fever, etc)
- Ears, Nose, Mouth Throat
- Eyes
- Respiratory
- Neurological
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Endocrine
- Allergy/Immunological
- Integumentary (skin and/or breast)
- Hematology/Lymphatic
- Psychiatric

Past History: Medications, allergies, illnesses, injuries, operations, hospitalizations, dietary status.

Family History: A review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk.

Social History: Marital status, occupation, drug, alcohol, and tobacco use.

PHYSICAL EXAMINATION: Document all systems/body areas examined. The systems are:

- Constitutional (vital signs, general app.)
- Ears, Nose, Mouth Throat
- Eyes
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Respiratory
- Musculoskeletal
- Neurological
- Skin
- Hematology/Lymphatic/Immunological
- Psychiatric
- Body Areas: dictate each body area examined: head/face, neck, chest (breast/axilla), abdomen, genitalia (groin/buttocks), back including spine and each extremity

ADMITTING DIAGNOSIS OR IMPRESSION

COURSE OF ACTION PLANNED FOR PATIENT

OPERATIVE REPORT

1. A preoperative diagnosis must be recorded and authenticated prior to surgery by the individual who is responsible for the patient.

2. The operative report should be recorded immediately after surgery, but no later than 24 hours after surgery.

3. A non-rotating resident may dictate and sign the report, however, the staff physician must ALWAYS authenticate the report. If dictated by a rotating resident, or the staff physician, only the staff physician's signature will appear on the report.

The Operative Report should contain the following elements if applicable, ALL elements in bold must be documented

Patient Account Number

Date of Admission

Date of Procedure

PRIMARY SURGEON

ASSISTANT(S) (If there were no assistants, indicate none)

Pre-operative diagnosis (or indications for the procedure)

POST-OPERATIVE DIAGNOSIS

Title of operation

Anesthesia administered

ESTIMATED BLOOD LOSS (If there was no blood loss, indicate none)

SPECIMENS (If no specimens were removed, indicate none)

FINDINGS

DESCRIPTION OF PROCEDURE (should include any complications, transfusions, prosthetic devices, grafts, tissues, transplants, implants, or explants.)

POST-PROCEDURE/POST-OPERATIVE NOTE

1. A post-operative note should be **immediately recorded after the procedure** which contains sufficient and pertinent information for use by any practitioner who may attend to the patient.

A complete Post-Operative Note must contain all of the following elements:

PRIMARY SURGEON

ASSISTANT(S) (If there were no assistants, indicate none)

POST-OPERATIVE DIAGNOSIS

TITLE OF OPERATION

ESTIMATED BLOOD LOSS (If there was no blood loss, indicate none

SPECIMENS (If no specimens were removed, indicate none)

FINDINGS

The Post-Operative Note/Post-Procedure Note **should also reflect** any complications, transfusions, prosthetic devices, grafts, tissues, transplants, implants, or explants.)

PHYSICIANS ORDERS

1. All written physician orders must be signed, dated and **timed**.

2. Verbal and telephone orders are to be signed with date and time within 48 hours. Medical staff members are responsible for authenticating unsigned resident and fellow orders.

PROGRESS NOTES

1. A Progress Note should be written within 24 hours of admission, then daily thereafter for critical patients with difficulty in diagnosis or management of the clinical problem. For all other hospital patients, a Progress Note should be written at least every 48 hours. For Skilled Nursing Facility patients, there should be a Progress Note at least every seven (7) days.

2. Progress Notes should reflect:
   - Pertinent chronological report of the patient's course of hospitalization
   - Any change in the patient's condition
   - Any complicating factor in the course of the disease
   - Patient's response to treatment interventions
   - Patient's treatment plans

CONSULTATION REPORT

1. The Consultation Report should reflect an examination of the patient and review of the patient's medical record.
2. The report, which may be handwritten or dictated, should include the consultant's findings, diagnosis (es) and recommendation(s).

DISCHARGE SUMMARY

1. A Discharge summary is required for hospitalizations with a length of stay longer than forty-eight (48) hours.

2. For inpatient deaths, regardless of the length of stay, a "Death Summary" is required which provides the same information indicated above with the exception of final disposition and discharge instructions. Code Blue Notes are not acceptable as a discharge/death summary.

3. Discharge summaries MUST be completed WITHOUT the use of abbreviations within thirty (30) days of the date of discharge of the patient.

The Discharge Summary should:

- Identify the patient by name and account number;
- Provide the dates of admission and discharge and the name of the attending physician;
- State the final diagnoses (principal diagnosis, conditions present on admission and conditions and complications that arose during the patient's stay);
- Address the reason for the patient's admission;
- Address pertinent physical findings and findings from laboratory, imaging, and other diagnostic studies;
- Summarize the patient's hospital course, the medical and surgical treatment provided and the patient's response to treatment;
- Describe the patient's condition or functional status on discharge (in terms that permit a measurable comparison with the condition on admission, avoiding use of vague terminology such as "improved");
- State the patient's final disposition (i.e. discharged home, to nursing facility, to another acute care facility); and
- State pertinent instructions given to the patient and/or family regarding medications, status at discharge, diet, follow-up care and physical activity.

4. A final progress note may be substituted for a discharge summary for:
   - Uncomplicated hospitalization with a length of stay not exceeding 48 hours
   - Uncomplicated delivery
   - Normal newborn

5. The final Progress Note or Physicians' Orders **should include pertinent instructions to the patient and/or family** regarding medications, diet, follow-up care and physical activity if a discharge summary is not provided.

The Methodist Hospital

Completion of Medical Records
(as outlined in section C7 of "Rules and Regulations")

The patient's medical record shall be completed at the time of discharge. Following discharge, the Medical Record Department shall advise the Practitioner of any deficiencies in the medical record and give the Practitioner ample opportunity to complete the record. If, however, the record remains incomplete thirty (30) days after discharge, the record shall be declared delinquent and shall result in the suspension of the Practitioner's privileges to book patients for elective admissions, diagnostic testing, and elective surgical procedures. Suspension of such privileges as a result of delinquent medical records remains in effect until the Practitioner provides proof that the delinquent medical records have been completed.

Upon the second suspension for delinquent medical records within a six (6) month period, all of the Practitioner's clinical privileges at the Hospital shall be suspended. The suspension will remain in effect until the Practitioner providers proof that the delinquent medical records have been completed. Suspension of Staff membership as a result of delinquent medical records shall not constitute a professional review action and shall not give rise to a right of review pursuant to the Fair Hearing Plan.

Upon a third suspension for delinquent medical records within a six (6) month period, the Practitioner shall, in addition to being suspended from the exercise of all clinical privileges at the Hospital, be deemed to have voluntarily resigned his Medical Staff membership and clinical privileges. Before such action is finalized, the Practitioner will be invited or may ask to appear before the Record Committee at its next regularly scheduled meeting to explain any extenuating circumstances or to provide any information that would demonstrate that any of the three suspensions were improperly administered.

A voluntary resignation as a result of three (3) suspensions shall not constitute a professional review action and shall not give rise to a right of review pursuant to the Fair Hearing Plan. Reinstatement of a Practitioner's privileges shall be made only upon submission of a new application, and such application shall be processed without preference as an application for initial appointment.

The incomplete record(s) of a Practitioner who is permanently or protractedly unavailable shall be referred to the Record Committee and declared complete for purposes of filing. Each record will contain an appropriate explanation for the permanent filing.

The Methodist Hospital System

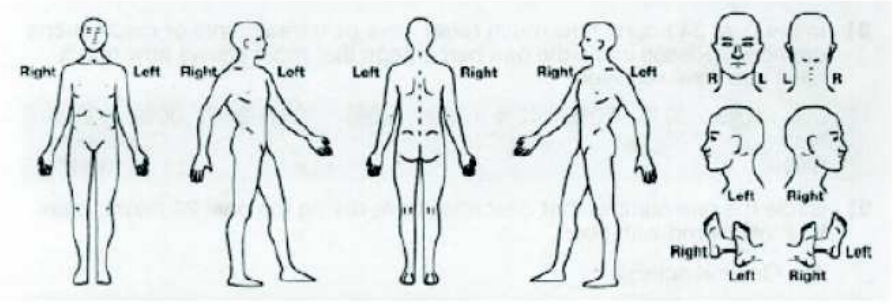
Pain Management Pocket Card

The goal of pain management is the relief of pain, not the administration of interventions

To be used as a guide only. Healthcare professionals should use the most recent evidence and clinical judgment to individualize therapy to each patient. Contact the Drug Information Center, 713-441-4190, for further assistance.

Initial Pain Assessment Tool

Evaluate ALL sources of pain and existence and effectiveness of home care regimen, including non-pharmacologic means of pain control



For EACH source of pain, determine:

Intensity: Patient rates the pain. Scale used: _____
Present:_____ Worst pain gets:_____ Best pain gets:_____
Acceptable level of pain:_____

- **Quality:** (Use patient's own words, e.g., prick, ache, burn, throb pull, sharp) _____
- **Onset, duration, variations, rhythms, breakthrough pain:** _____
- **Manner of expressing pain (preferred pain scale):** _____
- **What relieves the pain?**_____
- **What causes or increases the pain?**_____
- **What has been tried that did not work?**_____
- **Effects of pain:** (function, quality of life) _____
- **Physical activity**_____

Accompanying symptoms (e.g., nausea)_____
Sleep disturbance (describe) _____ Appetite interference _____
Relationship with others (e.g., irritability)_____
Emotional upset/instability (e.g., anger, suicidal, crying) _____
Concentration impairment_____ Other_____
Current Pain Regimen at home: _____
Prescribing physician or therapist: Name_____ Phone _____

PAIN INTENSITY RATING SCALES

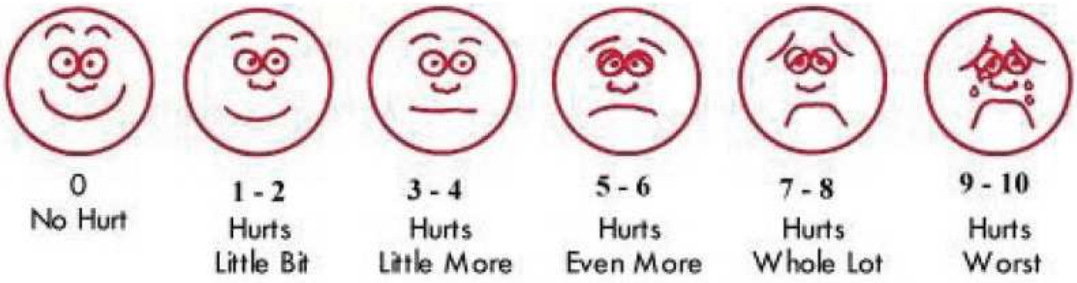
Visual Analogue Scales

0
No Pain

10
Worst

Directions: Ask the patient to indicate on a 10 cm line where the pain is in relation to the two extremes. Measure from the left hand side to the mark in cm to obtain the rating, #cm = pain score.

Pain Faces Scale



Step	Severity of Pain	Functional Losses	Pain Rating
1	Mild	Mood, Relationships	1-3
2	Moderate	Sleep, Ambulation	4-6
3	Severe	Normal thought process, daily activities	7-10

Basic Principles of Pain Management

The goal of pain management is the relief of pain, not the administration of interventions

1. Reassess after each intervention until pain is under control, then at least daily.
2. Around the clock (ATC) pain requires ATC pain medication.
3. Breakthrough pain medication should be available for all ATC regimens.
4. Diagnosing the type of pain is critical to effective pain management.
5. Non-pharmacologic interventions [e.g., heat, cold, massage, distraction (consider befriender volunteer)] can be combined with all treatment regimens.
6. If it would hurt you, it will hurt the patient.
7. If the patient is groaning or agitated, suspect and rule out pain first.
8. There is no maximum dose with pure opioid analgesics (morphine, oxycodone, hydromorphone). Titrate to adequate pain relief or unmanageable side effects.
9. Avoid using multiple opioids or NSAIDS simultaneously whenever possible.
10. Side effects of opioids are anticipated; provide prn remedies at start of therapy.
11. Aggressive acute pain management prevents the development of chronic pain- Do it for your patient and for yourself!

DEFINITIONS:

Addiction: A persistent pattern of dysfunctional opioid use that may involve any or all of the following: a) loss of control over the use of opioids, b) adverse consequences associated with the use of opioids, c) preoccupation with obtaining opioids, despite the presence of adequate analgesia (Compton et al., 1998)

Tolerance: A form of neuroadaptation to the effects of long-term opioid use that is indicated by the need for increasing or more frequent doses of the medication to achieve the initial effects of the drug. Tolerance may occur to the analgesic effects of opioids and to the unwanted side effects, such as respiratory depression, sedation, or nausea, but not to constipation. Tolerance alone does *not* imply addiction.

Dependence: A physical state in which abrupt cessation of the opioid or administration of an opioid antagonist results in a withdrawal syndrome. Physical dependence is an expected occurrence in all individuals in the presence of continuous use of opioids. It does *not* imply addiction.

Pseudoaddiction: A set of behaviors a person exhibits when undertreated for pain to obtain medication for adequate pain relief (Weissman & Haddox, 1989). The behaviors extinguish when the pain is adequately relieved.

Breakthrough Pain: Pain that increases above the pain addressed by the ongoing analgesics. Includes incident pain and end of dose failure. (Pasero et al., 1999b, p162)

Nociceptive Pain: Acute pain in soft tissue, bones, viscera. Generally described as achy, sharp, crampy.

Neuropathic Pain: Pain from disordered nerve function anywhere in the neuraxis (brain, spinal cord, peripheral nerves). Often described as shooting, numb, tingly, drilling/boring, itchy.

Neuropathic Pain: Anticonvulsants and Antidepressants

Generic (Brand)	Start Dose	Max Dose/Day	Routes of Admin	Relative Cost/Dose	Comments
Gabapentin (Neurontin®)	300 mg titrate	3600mg/day	PO	+	Few ADRs, drug interactions. Can increase dose rapidly. High doses can affect mood
Carbamazepine (Tegretol®)	200-300 mg	1200mg/day	PO	+	Monitor CBC
Phenytoin (Dilantin®)	100 mg TID, titrate	600mg/day	PO	+	Need good oral hygiene
Lidocaine (Lidoderm®)	Apply to area		Topical gel or patch	+++	No systemic toxicity. Indication: Post-herpetic neuralgia
Desipramine (Norpramin®)	75 mg/day	300 mg/day	PO	+	Less anticholinergic effect compared to other TCAs
Amitriptyline (Elavil®)	10-25 mg	200mg/day	PO	+	strong anticholinergic effect; EKG for doses above 100 mg
Nortriptyline (Pamelor®)	10 mg	150 mg	PO	+	EKG for doses above 100 mg

Relative Cost: + $1-3, ++ $3-5, +++ $5-10, ++++ $10-20, +++++ >$20/ dose

Recommended starting doses. *Titrate* to achieve effective pain control

Mild Nociceptive Pain

Generic (Brand)	Start Dose	Max Dose/Day	Route of Admin	Relative Cost/Dose	Comments
Ibuprofen (Advil®, Motrin®)	200-800 mg	3200 mg	PO q 6 hrs	+	Good for musculoskeletal pain, inflammation, co-analgesic w/ opioids
Acetaminophen (Tylenol®)	325- 650 mg	4000 mg Elderly: 2600 mg	PO q 4 hrs	+	Caution combination products, ⇑ Cr, ⇑ LFTs

Moderate Nociceptive Pain

Generic (Brand)	Start Dose	Max Dose/Day	Route of Admin	Relative Cost/Dose	Comments
Oxycodone-Acetaminophen (Percocet®)	5/325 mg – 10/650 mg	4000 mg of acetaminophen	PO q 6hrs	+	More potent than 5 mg morphine
Oxycodone-Aspirin (Percodan®)	5/325 mg	4000 mg of acetaminophen	PO q 6hrs	+	More potent than 5 mg morphine
Hydrocodone-Acetaminophen (Vicodin®,Lortab®)	5 mg/500 mg-7.5 mg/500 mg	4000 mg of acetaminophen	PO q 6hrs	+	
Hydrocodone-Acetaminophen (Norco®)	10 mg/325 mg	4000 mg of acetaminophen	PO q 6hrs	+	Less acetaminophen content per mg hydrocodone than Vicodin®/Lortab®

Severe Pain - Mixed

Generic (Brand)	Start Dose	Max Dose	Routes of Admin	Relative Cost/Dose	Comments
Immediate acting - oral					
Morphine sulfate	5 mg		PO q 3 hrs	+	Caution in increased Cr, history of hallucinations
Oxycodone (Roxicodone®)	5 mg		PO q 4hrs	+	Few active metabolites
Fentanyl (Actiq®)	200 mcg	No more than 6 units initially	Place between cheek and lower gum for 15 minutes	++++	Indicated for breakthrough cancer pain, contraindicated in acute or postoperative pain, NOT for opioid-naive pts
Hydromorphone (Dilaudid®)	2 mg		PO q 3 hrs	+	Few active metabolites. VERY potent
Methadone (Dolophine®)				+	Good for mixed, nociceptive and neuropathic pain; good for cancer and other non-cancer chronic pain; contact pharmacy for assistance with dosing

Relative Cost: + $1-3, ++ $3-5, +++ $5-10, ++++ $10-20, +++++ >$20/ dose

Severe Pain – Mixed (Continued)

Generic (Brand)	Start Dose	Max Dose	Routes of Admin	Relative Cost/Dose	Comments
Long acting-Oral/Transdermal					
Morphine sulfate (MS Contin®)	Total 24 hr oral dose IR Morphine, divide dose by 2		PO q12hrs Some pts require q8hrs dosing	+	Differing brands have differing durations of action. **DO NOT CRUSH, CHEW, BREAK.** Patient must swallow whole.
Oxycodone (OxyContin®)	Total 24 hr oral dose IR oxycodone, divide dose by 2. Opioid naïve pts: 10 mg		PO q 12 hrs	++	Can be used in patients who were already on this prior to surgery. **DO NOT CRUSH, CHEW, BREAK.** Patient must swallow whole.
Fentanyl (Duragesic®)	25 – 100 mcg/hr	800 mcg/hr	Transdermal q 48-72 hrs	+++++ (increases with dose)	**8-12 hr onset.** Indicated in chronic, stable pain. **DO NOT CUT PATCH. Need breakthrough doses of immediate release meds at initiation.**
Parenteral					
Morphine sulfate	4 mg		IV q 3hrs	+	Reduce dose in renal dysfunction, reduce dose by 50% in fragile or elderly, seizure disorder
Fentanyl (Sublimaze®)	20-50 mcg		IV q 1-2 hrs	+	Short duration of action. Pt may require PCA for ATC pain management
Hydromorphone (Dilaudid®)	0.5 mg-1 mg		IV q 3 hrs	+	Least # metabolites, very potent (good for pts on high dose opioids)
Methadone (Dolophine®)				+	Good for mixed, nociceptive and neuropathic pain; good for cancer and other non-cancer chronic pain; contact pharmacy for assistance with dosing

To Convert from Another Opioid to Morphine (multiply by conversion factor in table)

From Oral	To Oral Morphine (mg)	From Parenteral	To Parenteral Morphine (mg)
Hydromorphone	4	Hydromorphone	6.7
Oxycodone	2	Fentanyl *(mcg)*	0.1
Hydrocodone	0.15-1		

Foley KM. NEJM 1985, 313: 84-95

Equianalgesic Doses of Opioid Analgesics

Oral/Rectal (mg)	Analgesic	Parenteral (mg)
4	**Hydromorphone**	1.5
15	**Morphine**[a]	5
10	**Oxycodone**	-

Levy MH. NEJM. 1996; 335: 1124-1132

a Ratio of oral: parenteral route 3:1 is recommended for chronic pain, ratio of oral: parenteral route 6:1 is recommended for acute pain. Due to first pass effect of the liver, oral doses are routinely higher than parenteral to achieve the same clinical result.

Management of Common Adverse Effects of Opioids

Effect	Treatment
Sedation	Allow patient to rest unless sedation is bothersome to the patient or there is poor respiratory function. If needed, decrease opioid dose; if respiratory depression, use naloxone (see below); consider adding psychostimulant if persistent and dose cannot be reduced due to severity of pain.
Insomnia	Switch to different opioid to reduce metabolite accumulation.
Delirium/Hallucinations, Seizures	Reduce dose or switch to a different opioid
Pruritis	Oral antihistamine
Gastric stasis	Metoclopramide
Constipation	Patient's preferred LAXATIVE agent (not stool softener alone). Senokot S (sennosides, docusate), Dulcolax® supp, Lactulose, Sorbitol. For magnesium containing products (e.g.,Mg citrate, Milk of Magnesia, Fleets enema) use CAUTION for patients with ⇑ Cr and/or dehydration. DO NOT USE Polyethylene Glycol for patients who are dehydrated.
Nausea/Vomiting	Anti-dopaminergic: Metoclopramide, haloperidol (low dose 1-2mg). Antihistamines (H1); Hydroxizine. Anti-serotonin, e.g., ondansetron (Zofran®) Indic: Post-anesthesia and Chemo-related nausea. Single dose ONLY. Sea Bands (acupressure). Combine different mechanisms of action for additive effect.
Urinary retention	Crede's maneuver. If no response, straight cath.
Severe respiratory depression	Not a common side effect. **Stop all sedatives, opioids**. Stimulate patient. Give DILUTED naloxone 0.1 mg, may repeat q 2 minutes, call MD

Relative Cost: + $1-3, ++ $3-5, +++ $5-10, ++++ $10-20, +++++ >$20/ dose

Short-term, acute pain, second-line agents:
Mixed Agonist/Antagonists: Contraindicated for patients on mu opioids, chronic pain therapy.
There is no evidence that use of these agents in preference to other opioids prevents addiction.

Brand Names	Start Dose	Max Dose/Day	Routes of Admin	Relative Cost/Dose	Comments
Buprenorphine (Buprenex®)	0.3 mg		IV q 6 hrs	++	Elderly: start at 0.15 mg q 6 hours
Nalbuphine (Nubain®)	10 mg	160 mg	IV q 3-6 hrs	+	
Butorphanol (Stadol®)	1 mg	16 mg	IV q 4 hrs	+++	

Visceral and Miscellaneous pain: Corticosteroids

Generic Names	Start Dose	Max Dose/day	Routes of Admin	Relative Cost/Dose	Comments
Prednisone	40-100 mg		PO	+	Indicated for visceral or neuropathic pain, ⇑ ICP, ⇓ appetite, ⇓ mood. Can cause hallucinations, ⇑ BP, immune suppression, ⇑ blood glucose
Dexamethasone	16-96 mg		PO, IV	PO + IV ++++	

To Convert to Transdermal Fentanyl (Duragesic®)

Transdermal fentanyl should be **reserved for patients with chronic stable pain.**
Conversion factors are unreliable; cautiously follow the package insert, copied below.

The following chart should only be used for converting oral morphine to fentanyl patch:

Oral 24-hour Morphine (mg/day)	Fentanyl patch dose (MCG/hr)
45-134	25
135-224	50
225-314	75
315-404	100
405-494	125
495-584	150
585-674	175
675-764	200
765-854	225
855-944	250
945-1034	275
1035-1124	300

- It may be necessary to provide patients with breakthrough pain doses of an immediate release or parenteral opioid during the initiation of transdermal fentanyl
- Increase patch dose based on breakthrough medication used during the initial 3 day period
- Do not titrate patch more often than every 2 days
- If rotating off transdermal patch, remove patch and start new opioid 12 hours later. Breakthrough medication may be needed during this time period.

Oral and Parenteral Opioid Analgesic Equivalences and Relative Potency of Drugs Compared with Morphine

Class	Generic Name (Brand Name)	Parenteral (mg)	Oral (mg)	Conversion Factor (IV to PO)	Duration (hours)
Opioid Agonists	***Short acting-Oral***				
	Codeine	130	200	1.5	3-4
	Hydrocodone-Acetaminophen (Vicodin®, Lortab®, Norco®)	-	30	-	3-5
	Morphine immediate release	10	30	3	3-4
	Oxycodone-Acetaminophen (Percocet®)				3-4
	Oxycodone-Aspirin (Percodan®)				3-4
	Oxycodone immediate release (Roxicodone®)	-	15	-	3-5
	Tramadol (Ultram®)	-	50-100	-	3-7
	Short acting-Intravenous				
	Fentanyl		-	-	1
	Hydromorphone (Dilaudid®)	1.5	7.5	5	2-3
	Morphine	10	30	3	3-4
	Long acting-Oral				
	Morphine controlled release (Kadian®)				24
	Controlled release (OxyContin®)		20		12
Partial Agonists	Buprenorphine (Buprenex®)	0.3	-	-	6-8
Mixed Agonist-Antagonist[2]	Pentazocine (Talwin®) (NF)	60	180	3	2-3
	Nalbuphine (Nubain®)	10	-	-	4-6
	Butorphanol (Stadol®)	2	-	-	4-6

1 Opioid combined with non-opioid. Non-opioid dosage must be limited due to possible toxic effects
2 Agents should NOT be used in combination with opioid agonist drugs

Adapted Foley KM. NEJM 1985, 313: 84-95
NF-Nonformulary agent, Please convert patient to formulary alternative.

Practice Guideline:
CHRONIC PAIN
Target Population: Infant/Child/Adult

GOALS/OUTCOMES

A. Reverse, prevent and/or modify defining characteristics and related/risk factors.
B. Patient/family/S.O. will have knowledge related to **Chronic Pain** and it's potential impact on present/future lifestyle and health status.
1. **State personal related/risk factors and defining characteristics.**
2. **State how related/risk factors and defining characteristics can be modified, reversed or prevented.**
3. **State the name, purpose, dosage, route, scheduling, potential food/herb/drug interactions, major side effects, importance of taking medications and impact of missing medications.**
4. **Demonstrate/state safe and effective use of medical equipment/supplies.**
5. **State appropriate resources for support (e.g., physician, pharmacist).**
6. **Describe current level of pain using age appropriate scale, and compare to desired level; reports subtle Δ pain.**
7. **State appropriate self-advocacy techniques (e.g., communicate need for pain medication).**
8. **Identify factors that aggravate or relieve pain (e.g., activity, positioning).**
9. **Demonstrate appropriate use of pain control measures (e.g., imagery, relaxation, meditation, positioning, pharmacologic activity modification measures).**
10. **Verbalize steps to regain/maintain/manage lifestyle, integrating pain management measures.**
11. **State how family/SO can participate in pain management plan.**
12. **State relationship of chronic pain to sleep/rest, ADLs, and stress level.**

INTERVENTIONS/PROCESS

- Collaborate with resources for the continuum of care (e.g., pain clinic, chaplain/clergy, social worker, child life specialist, pharmacist).
- Assess, monitor and document the defining characteristics, related/risk factors.
- Plan and document mutually developed goals.
- Implement appropriate interventions as follows and document:

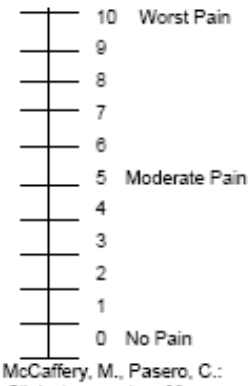
1. **Evaluate pain using identified tool/self report (pain character, location, intensity, frequency/duration) or physiologic/behavioral indicators and correlate to patient's desired pain level, expected pain progression, personal/cultural factors influencing pain perception (cognition, emotions, coping) and aggravating/relieving factors.**
2. **Explore pain perception, its effect on lifestyle (e.g., self-care, sleep, appetite, mood, cognitive function, role relationships, personal goals achievement, self esteem/image, perception of time). Acknowledge with patient that he/she is the expert regarding his/her own pain.**
3. **Explore the effectiveness of previously used pain management measures and mutually integrate effective measures into current pain management plan.**
4. **Investigate effectiveness and use of non-pharmacologic methods of pain management:**
   - **Modify/inhibit perception of pain (e.g., humor, visualization, guided imagery, breathing exercises, progressive relaxation, distraction/diversional activity, TENS).**
   - **Stimulate/block pain gates (e.g., pressure, massage, heat, cold, cutaneous stimulation either in affected or contralateral area).**
   - **Modify self image and outlook on pain control (e.g., positive thinking).**
6. **Investigate effectiveness of pharmacologic methods of pain management, as well as side effects (e.g., constipation). Incorporate measures to enhance effectiveness and/or minimize side effects (e.g., concomitant bowel program).**
7. **Avoid abrupt withdrawal of medication capable of causing physical dependency if taken over period of time.**
8. **Assist/support patient/family in developing and using a pain management plan including selected techniques (pharmacologic/ non-pharmacologic) which can be integrated into his/her lifestyle to maximize functional status.**

<u>Knowledge Deficit</u>

- Refer to Independent Guideline "Knowledge Deficit".
- Assess and document, readiness/ability to learn, learning needs/preferences and knowledge/skill level regarding related factors, risk factors and defining characteristics.
- Discuss how related factors, risk factors and defining characteristics may be modified.
- Instruct and/or discuss each factors listed under goals and outcomes section of **Chronic Pain** guideline.
- **Evaluate and document** effectiveness of teaching interventions progress toward goals and outcomes related to **Chronic Pain**.

Add individualized interventions specific to the patient/family/ S.O. in the plan of care.

Wong-Baker FACES Pain Rating Scale
From Wong, D.L., Hockenberry-Eaton, M., Wilson, D., Winkelstein, M.L., Schwartz, P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.



From McCaffery, M., Pasero, C.: Pain: Clinical manual, p. 63. Copyright 1999, Mosby, Inc.

Practice Guideline: CHRONIC PAIN

DEFINITION: Chronic pain is persistent, and, therefore, disruptive to normal living (e.g., sleep, work, social activity). Unlike acute pain, chronic pain no longer serves a protective purpose, and has a negative impact on health and function. There are two primary types of chronic pain:

Chronic Pain	• Pain extends beyond period of healing • Often initiated by injury • Cause may not be apparent in some cases
A. Chronic Cancer (Malignant) Pain	• Includes pain caused by cancer, as well as by related painful diagnostic procedures or treatments • Acute and chronic components, as well as multiple etiologies • Limited in duration
B. Chronic Non-Cancer (Non-Malignant) Pain	• Persistent pain not related to cancer • Causes include acute injury that leads to chronic pain, as well as various chronic conditions • Cause may not be discernable, therefore, pain may be considered the disease itself • May or may not have well-defined characteristics/patterns • Duration and severity may impact daily activities, which may contribute to psychological, social, and work issues.

RELATED/RISK FACTORS

PERSONAL

Stress, anxiety, fear, guilt, depression, grieving, powerlessness
Perception/past experiences with pain
Cultural responses
Spirituality
Knowledge deficit
Monotony, fatigue, boredom, loneliness
Impaired communication (e.g., infants, children, adults with cognitive impairment, language)
Underreporting
Disbelief of others
Dietary habits (e.g., caffeine, stimulants)
Teething
Fear (e.g., addiction, discomfort)

TREATMENT RELATED

Operations and other invasive diagnostic or therapeutic procedures
Toxicities of chemotherapy & radiation
Surgery
Procedures (e.g., cast, tube, bandages, venipuncture)
Position (e.g., stirrups, hard surface, immobile)
Inadequate control with pain medications (e.g., not given around the clock)
Under treatment of pain

ENVIRONMENTAL

Weather extremes (e.g., cold, hot, damp)
Bright lights
Loud noises

PHYSIOLOGICAL

Nociceptive Pain: caused by ongoing activation of A-δ and C-nociceptors in response to a noxious stimulus).

Somatic Pain: arises from bone, joint, muscle, skin or connective tissue

Superficial:
- external mechanical, chemical or thermal events (e.g., sunburn, chemical or thermal burns, cuts, contusions of skin); dermatological disorders; sharp, prickling, burning; well localized

Deep:
- overuse strain; mechanical injury; cramping; ischemia; inflammation (e.g., arthritis, tendonitis); dull, aching, cramping; localized or diffuse radiating

Visceral Pain: arises from visceral organs
- organ distension (e.g., bladder distension); muscle spasm (e.g., colic); ischemia (e.g., peptic ulcer disease, sickle cell disease); inflammation (e.g., appendicitis, pancrentitis); deep aching or sharp stabbing; well or poorly localized

Neuropathic Pain (reflects nervous system injury or impairment)

Peripherally Generated Pain
- Painful Mononeuropathies (e.g., nerve root compression, nerve entrapment, trigeminal neuralgia)
- Painful Polyneuropathies (e.g., diabetic neuropathy, toxins, infection, autoimmune diseases)

Centrally Generated Pain
- Deafferentation Pain (e.g., phantom pain, burning below level of spinal cord lesion)
- Sympathetically Maintained Pain (e.g., reflex sympathetic dystrophy/causalgia)

DEFINING CHARACTERISTICS (Signs & Symptoms)

Verbalization or observed behavior of pain/discomfort experienced for a prolonged period of time.
Altered ability to perform previous level of ADL/physical activity
Δ sleep pattern (e.g., awakens with pain, short sleep cycle, insomnia)
Fatigue
Weakness
Guarding behavior (e.g., positioning, protective/guarding, posturing/movement, rubbing, limp
Anorexia, cachexia
Muscle spasm
↑ psychological distress (e.g., depression, anxiety, anger, guilt)
↓ concentration, altered time perception (clock watching)
Tense expression, or flat affect
Fear of re-injury
Self focusing, questions meaning of pain
Social withdrawal, feeling of not belonging
Additional symptoms may be associated with patient's specific system dysfunction or etiological circumstance

SYSTEMIC EFFECTS OF UNRELIEVED PAIN

SYSTEM	EFFECTS OF UNRELIEVED PAIN
Endocrine	↑ adrenocorticoptrophic hormone (ACTH), ↑ cortisol, ↑ antidiuretic hormone (ADH), ↑ epinephrine, ↑ norepinephrine, ↑ growth hormone (GH), ↑ catecholamines, ↑ rennin, ↑ angiotensin II, ↑ aldosterone, ↑ glucagon, ↑ interleukin-1, ↓ insulin, ↓ testosterone
Metabolic	Gluconeogenisis, hepatic glycogenalysis, hyperglycemia, glucose intolerance, insulin resistance, muscle protein catabolism, ↑ lipolysis
Cardiovascular	↑ heart rate, ↑ cardiac output, ↑ peripheral vascular resistance, ↑ systemic vascular resistance, hypertension, ↑ coronary vascular resistance, ↑ myocardial oxygen consumption, hypercoagulation, deep vein thrombosis
Respiratory	↓ flows and volumes, atelectasis, shunting, hypoxemia, ↓ cough, sputum retention, infection
Genitourinary	↓ urinary output, urinary retention, fluid overload, hypokalemia
Gastrointestinal	↓ gastric and bowel motility
Musculoskeletal	Muscle spasm, impaired muscle function, fatigue, immobility
Cognitive	Reduction in cognitive function, mental confusion
Immune	Depression of immune response
Developmental	↑ behavioral and physiologic responses to pain, altered temperaments, higher somatization, infant distress behavior; possible altered development of the pain system, ↑ vulnerability to stress disorders, addictive behavior, and anxiety states
Future pain	Debilitating chronic pain syndromes: postmastectomy pain, postthoracotomy pain, phantom pain, postherpetic neuralgia
Quality of life	Sleeplessness, anxiety, fear, hopelessness, ↑ thoughts of suicide

X00489; Rev. 10/03

Methodist The Methodist Hospital

Restraint Facts for Members of the Medical Staff
(Source: Methodist Hospital Policy Patient Care/Patient Safety (PC/PS) 26)

- The Methodist Hospital (TMH) is committed to creating an environment which limits the use of restraints to clinically appropriate situations, ensures patient safety, respects patient rights and dignity, and allows for patient and family participation, when appropriate.

- A restraint is any manual method, physical or mechanical device, material or equipment attached or adjacent to the patient's body that restricts movement or immobilizes/reduces the ability of a patient to move his or her arms, legs, body or head freely. Examples of restraints include:
  - ankle or soft wrist restraint
  - a vest
  - tied mittens
  - chest belt
  - enclosure bed
  - four side rails
  - physical holds

- A restraint or seclusion is used only to protect patients, staff or others from harm and only after less restrictive measures were deemed ineffective. TMH does not permit restraint or seclusion for purposes such as coercion, discipline, convenience or retaliation.

- Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.

- Use of restraints or seclusion must be ordered by the physician or by a Nurse Practitioner or Physician's Assistant functioning as the agent of the physician.

- Restraints used for non-violent and violent behavior are time limited. The initial restraint/seclusion order must be obtained within one hour of application and may be by telephone or written and indicate the type of restraint used. This information is present on the order form.

- Renewal for non-violent restraints is daily and for violent restraint and seclusion is based on the age of the patient. This information is present on the order form.

- If the order is received from a physician other than the responsible physician, the responsible physician must be notified as soon as possible, but no longer than 24 hours after initiating restraint/seclusion.

- Nursing will monitor the patient to assess the need to continue the restraint/seclusion. The use of restraint or seclusion must be discontinued as soon as possible based on an individualized assessment and re-evaluation.

- The death of a patient associated with the use of restraint or seclusion must be reported to CMS in accordance with the Conditions of Participation. The date and time the death was reported to CMS is documented in the patient's medical record. Risk Management and Performance Improvement are responsible for the reporting.

Methodist The Methodist Hospital

LEADING MEDICINE℠

April 7, 2010

To: The Methodist Hospital Medical Staff
The Methodist Hospital Employees

The Methodist Hospital Practitioner Health Committee of the Medical Staff is charged, among other things, with addressing physician health as it relates to patient safety; educating the Medical Staff and employees regarding illness and impairment recognition issues specific to Practitioners; and encouraging self-referral. The American Medical Association (AMA) defines an impaired physician as "*a physician who is unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deterioration through the aging process or loss of motor skills or excessive use or abuse of drugs including alcohol*."

To that end, this is to remind you that should you observe or suspect impairment of a practitioner in the hospital setting that you believe jeopardizes patient care, the Practitioner Health Committee is available by calling 713-441-1537. This will connect you to the answering service of the Chair of the Committee. Please identify that you are calling about an impaired practitioner issue. This message will be retrieved only by a member of the Committee and will be completely confidential.

Please be assured that the Committee evaluates the credibility of all complaints, allegations, and concerns, determining whether a physician problem is best addressed through a disciplinary measure or via the physician-health route, always monitoring the affected Practitioner and the safety of patients until the rehabilitation or any disciplinary process is complete.

Any time you wish to contact a member of the Practitioner Health Committee individually and directly, you are welcome to do so as follows:

- Ranjit C. Chacko, M.D., Chair
- Michael J. Feltovich, M.D.
- James N. Flack, M.D.
- John P. Lauzon, Jr., M.D.
- Paul E. Schulz, M.D.
- C. Richard Stasney, M.D.

Sincerely,

Ranjit C. Chacko, M.D.
Chair
Practitioner Health Committee
RCJ:mgw

TMH BIOMEDICAL ETHICS CONSULTATION SERVICE

On call (24 hours/day, 7 days/week) PAGE: **713-404-7904**
Available to Patients, Families, Medical and Hospital Staff, and Students
For more information: www.tmh.tmc.edu/biomedicalethics/ConsultationService.htm

Contexts for Consultation
Source: TMH Procedure PC09
Appropriate contexts for consultation would include:

Withholding or Withdrawing Life-Sustaining Treatment

Sources: Advance Directives Act (Chapter 166, Texas Health & Safety Code); TMH Protocol PR02, PR05

General Principles

- Competent adult patients may accept or refuse life-sustaining treatment, either at the time or by means of an Advance Directive.
- If the patient is pregnant, the Biomedical Ethics Consultation Service should be consulted.

Key Definitions

Qualified patient: A patient with a terminal or irreversible condition that has been diagnosed and certified in writing by the responsible physician.

- ***Irreversible condition***: A condition, injury or illness that a) may be treated but is never cured or eliminated; b) leaves a person unable to care or make decisions for the person's own self; and c) without life-sustaining treatment provided in accordance with the prevailing standard of medical care is fatal.
- ***Terminal condition***: An incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Life-sustaining treatment: Treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as CPR, mechanical breathing machines, kidney dialysis treatment, and artificial nutrition and hydration. The term does not include performance of a medical procedure considered to be necessary to provide comfort care or any other medical care provided to alleviate a patient's pain.

Qualified Patient without a Directive and Incompetent or Incapable of Communication

- A legal guardian or an agent appointed under a Medical Power of Attorney may make treatment decisions for the patient, including a decision to withdraw or withhold life-sustaining treatment.
- If there is no guardian or agent, the responsible physician may make the decision with *one* person from one of the following categories, in order of priority: a) spouse; b) reasonably available adult children; c) parents; or d) nearest relative.
- If no surrogate is available, the responsible physician may make the decision with the concurrence of another physician not involved in the treatment of the patient.
- Treatment decisions must be based on what the patient would have wanted, if known, and if not known, on the surrogate's judgment of the patient's best interests.
  - Decisions must be documented in the patient record, preferably using the Categories of Life- Sustaining Treatment Order Form, and signed by the responsible physician.
- Absence of a Directive does not create a presumption against a decision to withhold or withdraw treatment.

Medically Inappropriate Decisions About Life-Sustaining Treatment

- When the responsible physician believes a patient or surrogate's decision about life-sustaining treatment is medically inappropriate, he/she should discuss carefully with the decision-maker the nature of the ailment, treatment options, prognosis, reasons why the decision is medically inappropriate, and transfer options.
- Before the Biomedical Ethics Committee can review a case, the responsible physician must request an ethics consult, give the decision-maker a copy of TMH Protocol 05, and obtain a second medical opinion from a physician who has examined the patient.

The Methodist Hospital

Acronym Decoder - The Methodist Hospital System

ADA	Americans with Disabilities Act - law governing handicap accessibility
AOD	Admission, Observation and Discharge units within Perioperative Services
API	Payroll system
BP	Business Practices (compliance and ethics)
CPE	Center for Professional Excellence
CMI	Case Mix Index
CMPI	Care Management and Performance Improvement
CTC	Computer Training Center
EAP	Employee Assistance Program
ED	Emergency Department
EIS	Employee Information System
EOC	Executive on Call
EPSi	Enterprise Performance System, Inc. (web-based budgeting software)
FMLA	Family and Medical Leave Act- law governing employee leave
FTE	Full Time Equivalent Employee
HBSI	Tool used for benchmarking hospital operational and financial performance
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIS	Hospital Information System- employee records
HLT	Hospital Leadership Team- comprised of VP's who report to the CEO
HR	Human Resources
ICARE	Integrity, Compassion, Accountability, Respect, Excellence
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LOS	Length of stay
LTD	Long Term Disability
MGJ	Mary Gibbs Jones Building – TMH Campus
NEPA	National Environmental Policy Act
OD	Organizational Development
OR	Operating Room
OSHA	Occupational Safety and Health Administration
PACU	Post Anesthesia Care Unit
PHI	Protected Health Information (especially as pertains to HIPAA)
PMM	Pathways Material Management- purchasing system
SJ or SJMH	San Jacinto Methodist Hospital
SL	Methodist Sugar Land Hospital
STD	Short-Term Disability
TMH	The Methodist Hospital
TMHS	The Methodist Hospital System
TMHPO	The Methodist Hospital Physicians Organization
TMHRI	The Methodist Hospital Research Institute
UOS	Units of Service (used for benchmarking purposes)
WB	Methodist Willowbrook Hospital
WP	West Pavilion

"A to Z" Department Guide

Accounting
Leads financial statement audits, Bond Reporting and Annual Charity Care Reporting, leads preparation of timely and accurate financial statements and budget reports, assists with budget, reimbursement, manages accumulation and reporting of operating statistics, manages processes to reconcile and analyze general ledger accounts, coordinates payment of legal fees for all entities except SJMH, maintains Department ID Number hierarchy for all entities except SJMH, completes ad hoc reports to support budget, tax, reimbursement and operating entity needs.

Benefits
Responsible for designing and implementing and managing medical/dental plans, fringe benefits, managing retirement plans, short term and long term disability, workers' compensation, paid time off, family medical leave/leave of absence, subsidized parking, transportation needs, and tuition reimbursement. 713-441-2124.

Budgeting and Compliance
Coordinates the annual budget process, leads Federal and State income tax reporting for all entities except SJMH, leads preparation of Medicare/ Medicaid/ Champus cost reports for all hospitals except SJMH, leads FEMA project, manages cost report audits, maintains models to value accounts receivable, and to estimate Medicare settlements, tracks Baylor costs and coordinates annual support budget, and manages accounting and reporting for restricted, physician and endowment funds.

Center for Professional Excellence (CPE)
Administers the nursing support system- developing and generating operational reports, automated staffing systems, data and information. Disseminates TMH Nursing Initiatives in the global arena that promotes relationship - centered care. Mission is to achieve excellence in patient care by developing professional nursing practice through education, research, leadership and consultation with the interdisciplinary healthcare team. Check the extensive CPE website on the intranet for the latest information about programs and support resources.

Community Benefits
The Methodist Hospital Community Benefits Program was established in 1994. Methodist funds a charity care program for its own patients, independent clinics and other nonprofit organizations to assist individuals and families in poverty and crisis. Working collaboratively with others allows us to optimize health care dollars for the benefit of the entire community. In 2002, Methodist contributed $225 million to Community Benefit programs, including $47.2 million to care for the poor in the greater Houston area. Program Coordinator: Monica Burns-King, 713-441-1517.

Compensation
Administers the base salary program, manages the incentive pay programs, manages Merit Process/Guidelines, advises and consults with management on pay-related issues, and ensures overall integrity of all pay programs. Utilizes market data to establish the compensation structure. Your assigned ER Generalist is your first point of contact for compensation information; however, you can also reach Compensation directly at 713-394-6698.

Employee Relations (ER)
Seeks to develop and retain a safe, skilled, motivated, and productive work force through effective partnerships with client groups. All members of management have a designated Generalist who is the first point of contact to:

- Interpret human resources policies and procedures and applicable laws;
- Serve as a liaison between your department and specific HR services including Recruiting/Staffing, Compensation, Benefits, Organization Development, and Payroll; and
- Deliver training on such topics as performance management, human resources policies and procedures, and regulatory compliance (EEO, OFCCP, ADA, FMLA, etc.)

Weekend Generalist assistance for TMH is available by paging: 281-735-9980. Employee Relations services will continue to evolve based on client needs and expectations.

Employee Wellness Services
Our goal at Methodist Wellness Services (MWS) is to create an environment for Methodist Hospital employees that supports and promotes wellness. By offering innovative and educational programs, we will help employees reduce lifestyle factors while helping to attract and retain excellent employees. We offer programs such as yoga, tai chi and pilates classes, a walking program, massage therapy and weight loss as well as a fitness center with showers and dressing rooms available. Massage Therapists can be scheduled on your unit to relieve your employees' stress at your request. Our New Directions® Medical Weight Management Program is available to employees as well as to community members who have 50 or more pounds to lose. This is a structured modified-fasting diet program, which is high in protein and low in calories and has produced outstanding results for many participants. As a part of Methodist Wellness Services, the Employee Clinic, provides post-offer physicals, TB tests and flu shots for employees. MWS and the fitness center are located in the Smith Tower, suite 583 and the Employee Clinic is located in the Scurlock basement, first floor. For more information on our programs please call 713-394-6079.

Facility Management Services
FMS is a multifaceted department that services and maintains over 2.2 million square feet. FMS is comprised of these subsections: Building Services, Design and Construction, the Maintenance Shops, Public Safety, and Service Communications. The "One-Call" number for most building service issues is 713-441-4246.

Flex Team- Nursing Support Services
In order to meet our variable staffing needs without relying on outside agencies, the Methodist Hospital has our own Nursing Support "Flex Team" comprised of 150 RN's, PCA's, and Unit Secretaries that work when you need staff. These employees are not benefited and make premium pay to be available when you need staff. There are currently multiple options for RN's with varied requirements and pay scale from $37.00-$75.00 per hour. In addition, the Nursing Support staff administers the TAP program. TAP is a temporary assignment by a flex team member on a particular unit for a scheduled period of time (one week to 90 days). Nursing Support operates 24/7 and coordinates staffing needs and the scheduling of the flex team. See our website on the intranet for more information
www.tmh.tmc.edu/tmh/methodistnursing/slines/units/Staffingoffice/Default.htm

Human Resources
"One HR" provides service and support for management and staff to all hospitals for benefits, compensation, payroll, employee information system, process improvement, employee records, employee relations, recruitment, and training and development. Human Resources is available to answer all management and staff questions in person or by email and to solve issues on a timely basis. They may be contacted at 713-441-2124.

Information Technology Services
The Information Technology mission is to establish an innovative, integrated environment through the advancement of information technology solutions and services. IT supports clinical systems for patient care, corporate employee systems, and financial systems; and provide internal and external customer support (including computer training classes and coaching), and information systems security. The Help Desk is your best single point of contact for assistance with computer problems and questions. The Help Desk hours are from 7:00 AM to 5:00 PM. The number is 832-667-5600.

International Services
Each year, Methodist treats more than 4,500 international patients from over 70 countries, especially Latin America and the Middle East. Methodist also maintains affiliations with more than 25 hospitals throughout Latin America, Europe and the Middle East. The International Services department assists international patients with the selection of a Methodist affiliated physician and coordinates with the physician's office regarding patients' clinical needs; and coordinates all logistical aspects of their stay including transportation, accommodations, appointment scheduling, translation services, and consolidated billing. 713-790-5696

Managed Care
Operational liaisons for each entity contract with managed care companies in Acute Care, Transplant, mental health, VNA, pharmacy, and international. Managed Care also develops physician market strategy and direct employer contracting. The managed care department negotiates the agreements, but once these agreements are effective, it becomes a team effort with other hospital departments to ensure a smooth process for patients through the 'business portion' of their hospital care. This includes admitting, pre-certification, case management, discharge planning, billing, and collections.

Methodist DeBakey Heart Center
The Methodist DeBakey Heart Center (MDHC) is a partnership between The Methodist Hospital and Baylor College of Medicine. MDHC combines research, prevention, and diagnostic care, surgery and rehabilitation services in a coordinated multi-disciplinary program with one focus: delivering compassionate, effective care and treatment to patients with heart disease. Patient care teams provide the full range of cardiac care, ensuring high-quality care and satisfaction to those served. Although it does not have distinct walls to separate it within the Methodist Hospital, MDHC has over 700 employees and more than 75 physicians. The Center has 10 operating rooms, 9 catheterization labs, 154 acute care beds, 48 ICU beds and 30 transplant beds. The Methodist DeBakey Heart Center's (MDHC) vision is to become the benchmark heart center of the world. The mission is "through research, education, and a full continuum of patient care, provide effective and efficient, compassionate cardiovascular care to the satisfaction of those we serve."

Organizational Development
Organizational Development exists to support and advance organization and individual performance effectiveness to meet the business objectives of Methodist. We achieve this by providing consulting, learning services and collaborative human resource development. This includes:

- Consultation and advice to develop and implement solutions to organizational needs
- Delivery of training to increase the competency of the work force
- Identification of strategic approaches for effective supervision, performance management, problem solving, and conflict management;
- Conducting organizational assessments to enhance operational effectiveness, improving teamwork, and aligning structural and human resources components

Payroll / Employee Information System (EIS)
Payroll / EIS manage the payroll process, manage employee information data and personnel records, respond to employee/management inquiries, and design, revamp and implement HR processes. Questions about Payroll are most quickly addressed by calling 713-441-1148 or visiting our service center at Medical Towers 17th floor.

Performance Improvement
The Decision Support and Performance Improvement Division at The Methodist Hospital provides Care Management activities, facilitation and coordination of performance improvement activities, and data and statistical support to departments throughout the hospital. The information supplied by the staff within the Decision Support Department offers administrators a basis for making decisions related to budget, utilization, performance improvement, as well as improving the quality of patient care. Director: Debra Preston 713-441-4621. Intranet home page: http://www.tmh.tmc.edu/dept/dspi/dspi_default.htm

Purchasing
The Department's mission is to have the right supply in the right place at the right time at the right price. The Department is responsible for identifying opportunities to improve cost-effectiveness, value, and quality of supplies and equipment for the institution through Product Standardization Committees comprised of multiple user departments and focus group meetings. The main telephone number of Purchasing Services is 713-790-3081. Intranet home page: http://www.tmh.tmc.edu/dept/purchasing/nov2.htm

Recruitment
Part of the "One HR" Team, recruitment partners with entity leadership to provide recruitment and retention services including strategy, sourcing, screening, referrals, on boarding, and reporting. The goal is to lower the vacancy rate by finding quality people. The recruiting office is located at 6500 Fannin, Suite 903, and their hours are 7:30 am –5 pm. Contact Recruiting at 713-441-5009. Recruiters will help you identify and be responsive to your candidates, validate Job Descriptions, and understand Behavioral Interviewing.

Spiritual Care
The Department of Spiritual Care and Education is committed to providing the finest spiritual care coupled with healing skill, compassion, and respect for human dignity. Consistent with our hospital's belief that sound educational programs enhance the quality of patient care, the Department of Spiritual Care and Education offers a fully accredited Clinical Pastoral Education (CPE) program within a multi-disciplinary setting. Our purpose is to provide an explicit witness to the Holy One, in a spirit of respect for, and appreciation of, our religious and cultural diversity. We do this through Institutional Ministry, Pastoral Care Ministry to Patients and Staff, and the Wesley Ministry. For more information or to talk with us, call (713) 441-2381.

Strategic Planning, Marketing and Communications
The Marketing Department is responsible for TMH media relations and the Internet site **(**www.methodisthealth.com). This department is also responsible for internal communications, special event planning, corporate communications, and marketing efforts including developing sport sponsorship relationships and promoting service lines. If you have questions about Methodist graphic standards, and need a logo or template, please access the Methodist Identity Manager site at www.monigle.net/mhsidm (username: methodist; password: brand).

Volunteer Services
Opportunities in volunteer services are available through The Methodist Hospital Auxiliary, the Methodist Hospital Service Corps, and Caring Friends. The Auxiliary raises funds to purchase capital equipment for the Hospital through the Gift Shop and Thrift Shop, and the Service Corps assists patients, families, and visitors by working in 16 designated areas of the hospital. Caring Friends provides non-clinical assistance to patients and families during peak hours of operation. For more information, contact Donna Field or Gloria Palmberg at 713-441-3351.

INSTRUCTIONS TO ACCESS THE: Methodistdocs/Physician Portal Site

From the TMH Intranet Homepage, click on the link named, “Methodistdocs/Physician Portal” to the right of the screen.

Here, you will be able to review additional information on the following orientation checklist items:

- Core Measures
- Formulary
- Dictation Instructions
- Medical Record Documentation Requirements
- Medical Record Completion Requirements
- Guidelines for Medical Records Forms
- Instructions for Accessing Patient Record Applications
- Pain Management Pocket Card
- Information on the TMH Eppright Center

INSTRUCTIONS TO ACCESS THE: Medical Staff Services Intranet Site

From the TMH Intranet Homepage, click on the link named, “The Methodist Hospital (Medical Center)” on the left of the screen. Then select “Medical Staff Services.”

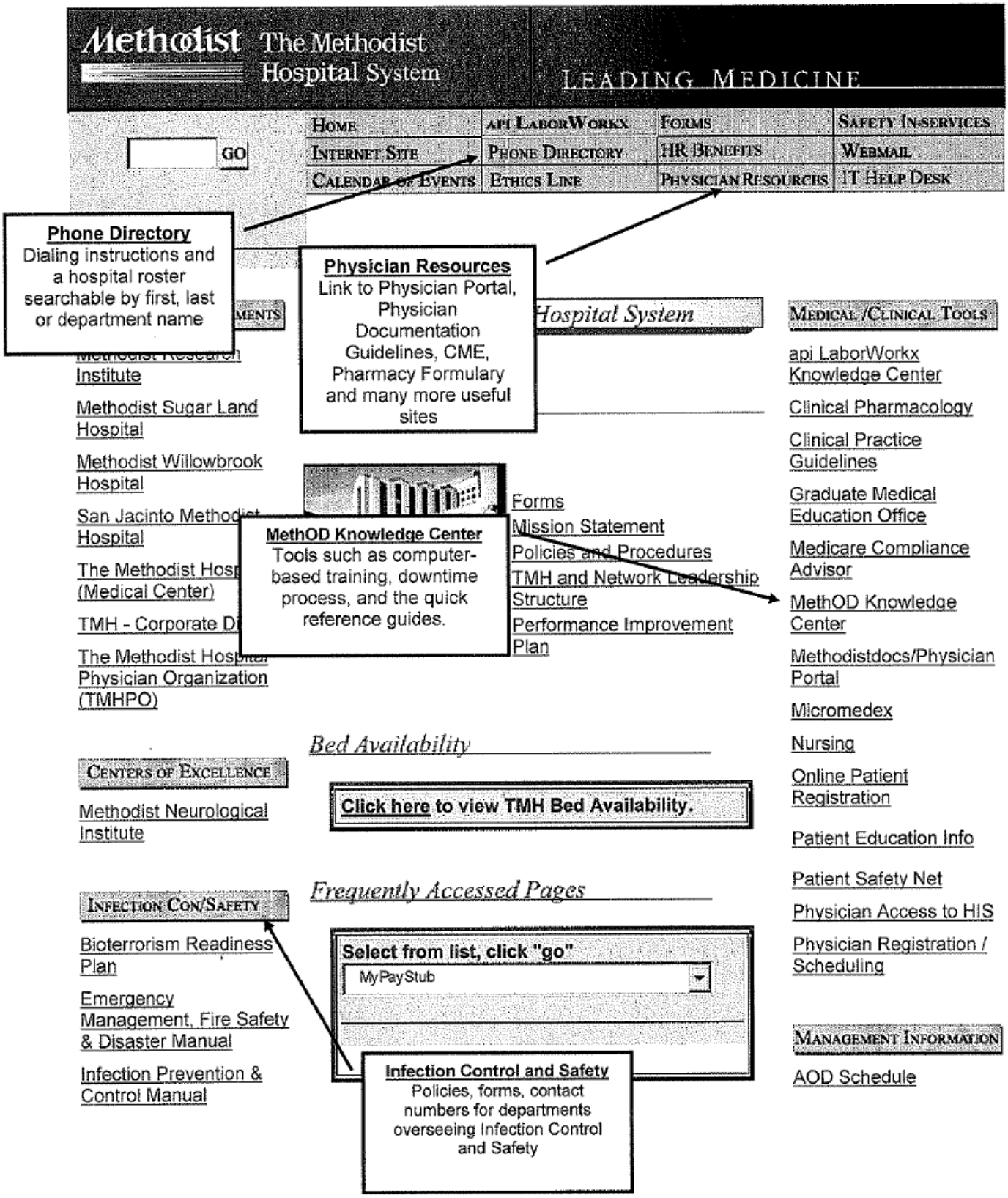
Here, you will be able to review additional information on the following orientation checklist items:

- Medical Staff Bylaws
- Rules & Regulations
- Allied Health Professional Manual
- Fair Hearing
- Special Interview Procedure
- Guiding Principles
- Standing Medical Staff Committee List
- Practitioner Health Committee – Recognizing an Impaired Practitioner
- Physicians Credentialed to be Intensivists
- Code of Conduct Policy
- Focused and Ongoing Professional Practice Evaluation (FPPE/OPPE) Policy
- TMHS Library Services
- Call Schedules

Please call Medical Staff Services at 713-441-2194 for any questions or concerns about accessing this information.

Highlights of the Intranet

The Methodist Hospital intranet site is available from any computer in the hospital system. The content of the site is constantly being upgraded. The following screen shots will help you locate areas that you will find useful.



NEW PRACTITIONER ORIENTATION
ACKNOWLEDGEMENT
(Medical Staff Members)

I acknowledge that Medical Staff Services has reviewed and/or made available to me the items listed below prior to my first patient encounter at The Methodist Hospital:

- Facility Overview: mission, vision and ICARE values
- Computer system access code and Confidentiality Agreement
- Medical Staff Organization Chart
- General Overview: Medical Staff structure, department meeting requirements, Bylaws, Rules & Regulations, Fair Hearing Plan, Special Interview process, quality review, Committees, etc.
- Compliance and Ethics
- Confidentiality
- Disciplinary Action
- Workplace Behavior/Code of Conduct
- Patient Rights
- Safety
- Hospital Codes
- Pain Management (Pocket Card and Practice Guideline for Treating Chronic Pain)
- Focused and Ongoing Professional Practice Evaluation (FPPE/OPPE) Policy and Procedure
- Biomedical Ethics Consultation Service
- Practitioner-specific clinical privileges (approved for TMH)
- Medical Records documentation requirements (Medical Staff Rules C1-10)
- Dictation instructions
- Identification badge
- Practitioner Health Committee- Recognizing an Impaired Practitioner
- Community Resource Library overview & contact
- Phone Directory

_____
Practitioner Printed Name

_____ _____
Practitioner Signature Date

**Return to Medical Staff Services prior to receiving identification badge and first patient contact at TMH.*