2016 Volunteer Core Competency Handbook
Dear Volunteer Applicant:

We are delighted to have you apply to become a volunteer at either Mount Sinai St. Luke’s or Mount Sinai West Hospital. Our hard-working and dedicated volunteers play an important role at both hospitals and enrich the lives of our patients. The contributions our volunteers make to the patient experience are invaluable.

We will try to place you in a position that will reflect a combination of your skills and interests with the needs of each hospital. Remember, whatever service you perform is vital to the total experience received by our patients. We hope you find your potential volunteer experience not only personally fulfilling but deeply satisfying. Giving the gift of your time to help promote the best experience a patient and their families, escorts and visitors can have while staying in our facilities is priceless.

Mount Sinai St. Luke’s and Mount Sinai West Hospitals are committed to assuring that all staff members and volunteers are highly competent and understand the policies and procedures of the hospitals. This handbook has been designed as a resource to help volunteers develop, test and maintain their competence. Topics have been selected because of their importance to our patients and our institution. It is essential that you carefully review the handbook at the time of your application and during each calendar year thereafter. This is an institutional requirement that will help us to meet the mandates of regulatory agencies such as The Joint Commission, the Occupational Safety and Health Administration (OSHA) and the New York State Department of Health (NYSDOH).

If you have any questions about the content of the handbook and how it may apply to you, be sure to discuss these issues with the Volunteer Services Department so they may discuss it with you.

After reviewing the handbook, please complete the corresponding handbook exam; you may refer to the handbook to check for the accuracy of your answers. The exam must be submitted with your completed application packet.

We thank you for your time and interest in joining the Mount Sinai St. Luke’s and Mount Sinai West Hospital volunteer team!

*Ramona Gross*
*Assistant Director, Volunteer Services*
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Section 1

Environment of Care

- Security
- Rapid Response Team
- Fire Safety
- Emergency Management
Environment of Care

Various departments are responsible for the Environment of Care (EOC). The EOC standards, policies, plans and procedures can be found in the Environment of Care Manual.

Security

The security team is responsible for ensuring a safe environment for everyone who enters Mount Sinai St. Luke’s and Mount Sinai West.

Security is Everybody’s Business- Minimizing Security Risks

The following are security measures that have been established to eliminate or reduce risk to patients, visitors, employees and physical assets.

ID Badges

Identification badges should be worn at all times while on hospital premises. All employees (including physicians, volunteers, temps, etc.) must wear their badge at chest height with the photo clearly visible. A volunteer who loses their ID badge must report the loss to the Security Department and his/her supervisor as well as pay a $5.00 fee to replace the lost badge.

Personal Property

Please secure your personal belongings in the lockers provided by Volunteer Services. For this reason, please do not let anyone into the Volunteer Services office who does not have an ID badge. Volunteer Services is not responsible for lost or stolen items.

Security Tips

- Stay Alert – observe who is in front of you and who is behind you. Don’t be distracted by diversions.
- Beware of piggy backing! Do not let people follow you into or out of a locked unit or the Volunteer Services office
- If you notice suspicious persons or behavior, please alert Security. If you are taking a break, be sure to check in with your supervisor.
- Remember anyone can be a victim of crime at any time. This can happen to you.
- TRUST YOUR INSTINCTS – If you feel uncomfortable, walk away, consider your options and notify security or seek other help.
- Security #s - Mount Sinai West 212-523-7512 / Mount Sinai St. Luke’s 212-523-1000
- Do Not
  - Panic
  - Try to be a hero
  - Travel alone
  - Approach vehicles for any reason
  - Fail to report a crime or suspicious activity
Codes

Code Silver/Active Shooter Policy

Code Silver/Active Shooter Policy is a coordinated response to minimize personal risk of injury/harm and loss of life in the event of an Active Shooter incident. Code Silver is activated if an active shooter is on the premises, actively engaging a firearm. You will be notified via an overhead announcement Code Silver and location.

A volunteer should:

- Seek Cover and Evacuate if possible
- Shelter in Place (cover and conceal)
- Clear out hallways
- Dial 911
  - Give location
  - Give number of assailants
  - Give physical description of assailant(s)
  - Give number and type of weapons
  - Give number of potential victims and location

Once police arrive:

- Remain calm and follow officers command
- Put anything in your hands down
- Raise your hands and spread your fingers
- No screaming, yelling, or pointing
- Avoid quick motions

In addition:

- Have an escape route
- Plan ahead for the “what-if’s”
- Recognize and report any workplace violence
EMERGENCY PROCEDURES:

**Code Blue- Security Emergency**
(For immediate security response due to threatening, aggressive or violent behavior)

- For Security Emergencies at Mount Sinai St. Luke’s and Mount Sinai West
- Dial 4444
- Inform the operator of a security emergency
- REPORTING “NON-EMERGENCY” SECURITY INCIDENTS: Such as a suspicious person in the hallways
- Security representatives are available 24 hours/day:
  - **Mount Sinai St. Luke’s** 212-523-1000
  - **Mount Sinai West** 212-523-7512
- Provide your name and location of the incident
- Describe the nature of the incident
- Provide information and description

**Code Pink-Infant Abductions**

The term **Code Pink** is used to denote infant/child abduction. All hospital employees must be aware of the CODE PINK policy and their responsibility to exercise their role in response and awareness.

**Know how to respond.....**

- In the event that a newborn, infant, or child is discovered missing from the maternal infant care or pediatric unit, a **Code Pink** will be activated. The following announcement will be made over the public address system 3 times:

  "**Code Pink, (state location), all personnel must report to their assigned locations.**"

- When a **Code Pink** is announced, all staff in the hospital must be “on alert” and notify security immediately of anyone acting suspiciously. Be especially aware of persons carrying large bags or transporting an infant in arms instead of a bassinet.

- It is important to remember that **all employees and volunteers are the eyes and ears for the Security staff**. Notify security if you see anyone or anything suspicious.
**Your Role During A Code Pink**

Understand what **CODE PINK** means and actively participate in drills. The following are the appropriate general responses for all MSSL & MSW employees during a CODE PINK alert:

1. All employees play an important role during a CODE PINK alert.
   - Be aware – look around-hallways/elevator banks/fire stairs. The abductor can appear anywhere in the building in an effort to leave!
   - Call Security Emergency line at 4444 and/or security for any suspicious activity you observe.
   - All employees should make every effort to be aware of anyone behaving suspiciously - especially those who may be concealing a child in a bag or large coat, etc.
   - Provide a detailed description to Security: Height/weight/race/age/hair/clothing.
   - If the abductor is encountered, attempt to maintain a visual of the abductor, alert Security and other employees in the area, then wait for Security.
   - Always wear your Hospital ID. Maternal Child Health employees have a special access ID which contains an image of a blue bear.
   - Watch for “tailgaters” or “piggybackers” as you travel in or out of any locked unit that has newborns, infants or children.

**CODE HICS**

An event is determined a disaster if the event has an effect on St. Luke’s - West Hospital Center’s ability to maintain a ‘safe environment of care’ for patients and staff. Any event that threatens that ability can trigger SLRHC to activate our emergency response plans (Code HICS plan.)

SLRHC categorizes a disaster/emergency in one of two ways: Internal (fire inside the hospital) or external (a blizzard that hampers staff’s ability to report to work; or a pandemic influenza outbreak.)

The Code HICS is activated by senior administration on duty and the staff and volunteers are notified by:
   - a series of four fire alarm bells followed by,
   - an overhead announcement: ‘Code HICS is activated’

**If VOLUNTEERS are on assignment** when a Code HICS is activated:
   - Report to your supervisor for direction
   - End all telephone calls that are not an emergency

**If VOLUNTEERS are home**, and hear about the event on the media call the Continuum Prepares Hotline: (877) 518-1878 and call the Volunteer Office for further instruction.
Rapid Response Team

In an effort to make health care safer and more effective, Mount Sinai St. Luke's and Mount Sinai West joined the Institute for Healthcare Improvement’s 100,000 Lives Campaign in 2005. One of the interventions, proven to decrease hospital mortality rates, is the implementation of a Rapid Response Team.

The Rapid Response Team (RRT) — known by some as the Medical Emergency Team — is a team of clinicians who bring critical care expertise to the bedside. Team members include a Pulmonary/Critical Care Fellow, Hospitalist, or a Dept. of Medicine house staff, a Nurse Manager/Administrator, and a Respiratory Therapist.

The RRT can be initiated 24 hours a day by hospital staff or volunteers by calling 234444 and stating that a Rapid Response Team is needed. The RRT does not replace the patient’s primary care team, but can be called if assistance is needed or more than 1 stat page is needed to assemble a team to respond to a crisis.

Other criteria for initiating the RRT:

- A fall, injury, or illness for non-inpatients or staff in any area of the hospital that requires medical assistance. If staff determines that a non-inpatient can be transported to the ED without the need for a RRT page, the unit staff will contact the ED in advance. A Registered Nurse, NA or provider (MD/PA/NP) may accompany the person.
Fire Prevention

The Fire Safety Plan familiarizes employees with procedures to follow in the event of a fire. When procedures are followed, employees will minimize injuries and loss of life among patients, visitors and personnel. (Refer to the Fire Risk Plan in your Environment of Care Manual for additional information, EC 02.03.01, and EC 02.03.035.)

It is the policy of MSSL&MSW to provide a healthy and smoke-free environment for all who enter our facilities. Smoking is prohibited in all areas of MSSL & MSW including but not limited to:

- New York State Clean Indoor Air Act and New York City Local Law 47 bans smoking by hospital entrance doors
- Smoking is permitted only away from all buildings in areas specifically designated and posted as smoking areas. All tobacco residues must be placed in an appropriate ash can or other waste receptacle located outside of non-smoking areas.

Fire Safety

Fire hazards arise from unsafe conditions and practices. Every employee has a responsibility and vested interest in maintaining a safe hospital environment.

7 Tips for Hospital Fire Safety

1. Never yell “Fire!” - It can cause fear and panic. Use the phrase “Code Red” to alert other employees in the area.

2. Smoke Barrier Doors - The hallway doors should close automatically when there is a fire alarm. Ensure there are no equipment, instruments or other items blocking the doors that would prevent them from closing. All patient room doors should also be closed by employees with a quick word of explanation to the patients. (Note: doors are not considered closed until you hear the latch click in place.)

3. Horizontal Evacuation to Area of Refuge - The first phase of evacuation is moving patients to the other side of the smoke barrier doors or the area of the refuge on the same floor.
4. **Vertical Evacuation** - Moving patients to a lower floor can be dangerous. It should be done only when ordered by Fire Department personnel or the hospital safety designee.

5. **Elevators** - Never use elevators during a fire alarm situation. Use elevators only when directed by the Fire Department.

6. **Oxygen Shut Off** - The oxygen shut off valve should only be turned off when directed by the Nurse Manager or designee on the floor.

7. **Storage** - Do not store anything within 18 inches of the height of a sprinkler head.
Your Role In Fire Safety
It is important that you and all staff are prepared to respond to fires and other emergencies.

Everyone has a role and responsibility in the event of a fire emergency which may involve the removing of patients and others, sounding the alarm, or extinguishing a fire. All staff and volunteers should know the following:

- MSSLM&SW Fire Emergency Plan/Evacuation procedures
- The location of alarm pull/call boxes
- The location of and how to use a fire extinguisher

Please follow the direction of your unit supervisor in the event of a fire.

When you are on your unit or department, please walk around and become familiar with the location of important fire prevention items:

1. Stairwells
2. Manual fire alarm pull stations
3. Fire alarm code charts (know your area’s fire alarm code and the general building codes)
4. Portable fire extinguishers (determine the type of extinguisher for your area, and read the directions on the side of the extinguisher)
5. Smoke and fire barrier doors
6. Medical gas shut off valves and note the area or room(s) they control (remember medical valves can only be shut upon the direction of unit’s nurse-in-charge)

IT IS EVERYONE’S RESPONSIBILITY TO LISTEN AND RESPOND APPROPRIATELY TO FIRE ALARM ACTIVATION.

In the event of a fire: Ambulatory patients are evacuated first.
Whenever a fire alarm is activated, remember to implement RACE.

R.A.C.E.
This easy to remember acronym is our procedure in the case of a fire. Every employee is trained to recognize and respond appropriately in the case of a fire using this acronym.

R - RESCUE / REMOVE persons in danger
A - ALARM pull the alarm and then dial: 4444
C - CONTAIN / CONFINE fire and close doors
E - EXTINGUISH if possible and/or EVACUATE
Fire Extinguishers

A fire extinguisher is an active fire protection device used to extinguish or control small fires, often in emergency situations. It is not intended for use on an out-of-control fire, such as one which has reached the ceiling, endangers the user (i.e., no escape route, smoke, explosion hazard, etc.), or otherwise requires the expertise of the fire department. Portable fire extinguishers are conveniently located throughout the hospital in cabinets along the corridors. The location of extinguishers are noted by signs adhered to the wall. The extinguisher or cabinet must be clearly seen from the corridor.

- **Water Extinguisher – Use on Class A fires**
  - Contained in the shiny, silver-colored container.
  - Used for **Class A fires only** – ordinary combustibles such as wood, paper, linen, clothing, mattresses, plastic, furniture, and waste containers.
  - Do **not** use on electrical equipment, Class C, or flammable liquid, Class B fires.

- **Carbon dioxide extinguisher – Use on Class B and C fires**
  - Contained in a red metal container which has a large cone shaped nozzle.
  - Used for **Class B fires** which involve flammable liquids such as oils, greases, chemicals, flammable gases, xylene, alcohol, and plastics.
  - Used for **Class C fires** which involve electrical equipment, medical equipment, electrical wiring, fuse box, or circuit breakers.
  - It can be used on electrical equipment without receiving an electrical shock.

- **Wet chemical extinguisher – Use on Class K - cooking fires**
  - Contained in the shiny, silver-colored container. This container is shorter, and slightly wider than the water extinguishers.
  - These extinguishers are marked for use on grease, hot oil, or cooking fires.
  - These extinguishers are located only in kitchen areas within 15 feet of the cooking equipment.
  - Used for **Class K fires only** – Cooking fire, grease, hot oil, deep fat fryers, etc.
Dry chemical extinguisher – This all-purpose extinguisher can be used on Class A, B, or C fires

- Contained in a red container marked “dry chemical”.
- Can be used on ALL TYPES OF FIRES.

To use a fire extinguisher- we use the acronym P.A.S.S.

P- Pull the pin. The pin is in place to prevent the accidental discharge of the fire extinguisher.

A- Aim the nozzle at the base of the fire. The nozzle is usually clipped to the side of the extinguisher.

S- Squeeze the handle. Use firm pressure when squeezing the two handles located on top of the extinguisher.

S- Spray onto the fire using the nozzle. Spray at the base of the fire in a sweeping motion.

Note: Do not pull the pin until you intend to use the extinguisher. All fire extinguishers have a seal to keep the pin place. When pulling the pin give a twist to break the seal. This will allow the pin to be removed. Squeeze the handle to release the extinguishing agent.
Emergency Management

Emergency Management ensures an effective response to disasters or emergencies affecting the environment of care. Emergency Management has coordinated resources and responsibilities for dealing with all aspects of emergencies, both on and off-site.
Section 2

Infection Control

Infection Control Program

Employee Health Service
**Infection Control**

The Department of Infection Control is responsible for conducting surveillance of hospital-acquired infections; investigating and controlling outbreaks or infection clusters among patients, staff and volunteers; and evaluating new and existing infection control products and devices.

**What are Standard Precautions?**

Using Standard Precautions reduces the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. In hospitals Standard Precautions apply to:

- Blood
- All body fluids, secretions and excretions, except sweat, regardless of whether or not they contain visible blood
- Non-intact skin
- Mucous membranes

All hospital employees must use Standard Precautions when caring for all patients. You follow Standard Precautions when you:

- Use protective barriers to reduce the risk of exposure.
- Prevent injuries by needles, scalpels and other sharps by handling and disposing of them properly.
- Report all needle injuries and mucous membrane exposures as an incident.
- Obtain the Hepatitis B vaccine if your work puts you at risk to come into contact with blood and body fluids

**Hand Hygiene/Hand Washing**

Hand hygiene remains the single most important way to prevent the spread of an infection for both patients and employees. The Hand Hygiene Guidelines developed by the Centers for Disease (CDC) recommend that healthcare workers wash their hands or use an alcohol-based hand wash (as long as their hands are not visibly soiled) to routinely clean their hands between patient contact. Understanding and practicing the principles and guidelines of Standard Precautions are essential for all healthcare workers.
Hand hygiene/ Hand washing cont’d

You should always wash your hands:

- If hands are visibly soiled
- At start of shift
- Before and after every patient contact
- After leaving a patient’s room
- After removing gloves
- After blowing your nose
- After handling garbage

- Before and after eating
- If hands are sticky from repeated Purell use
- After coughing or sneezing into your hands
- After using public restrooms

The proper way to wash your hands is as follows:

- Wet your hands with clean running water and apply soap. Use warm water if it is available.

- Rub hands together to make lather and scrub all surfaces, making sure to clean between fingers and under fingernails. Point fingers downward when washing.
  - Continue rubbing hands for 20 seconds, or about the time it takes to sing the “ABC’s” or Happy Birthday song.

- Pointing fingers downward rinse hands well under running water.

- Dry your hands using a paper towel or air dryer. If possible, use a paper towel to turn off the faucet and open door if exiting a room.

If soap and clean water are not available, use an alcohol-based hand sanitizer to clean your hands.

- Apply product to the palm of one hand.
- Rub hands together.
- Rub the product over all surfaces of hands and fingers until hands are dry.
- Do not dry or wipe hands with paper towel.
REMEMBER: Alcohol based hand rubs can only be used up to 6 times in a row without washing one’s hands. After the sixth usage you must wash your hands.

Artificial Fingernails
Volunteers may not wear artificial fingernails or extenders since they are proven risk factors for colonization of organisms of the hand. As per MSSL&MSW dress code policy, nail length should be short enough to allow for thorough cleaning underneath the nails and not cause gloves to tear.

Respiratory Etiquette
Cover your nose or mouth when sneezing or coughing with a tissue or into upper sleeve.

Personal Protective Equipment (PPE)
PPE is primarily described as items worn to protect the skin, eyes, nose, and throat of an employee from pathogens, blood, and other bodily fluids. Although volunteers are not allowed to come into direct contact with patients who require PPE, the information below is still required knowledge for volunteers. Remember PPE is one time use only (Except N95 particulate respirators/masks used for Airborne Precautions). PPE must be removed if penetrated with any blood or body fluids!

PPE to be worn when caring for all patients include:
- **Gloves** - to protect hands if there is a chance of exposure to blood or body fluids. Always remove after use, discard, and wash hands immediately.
- **Mask** - to protect the mouth if there is a chance of airborne exposure or blood splatter into the mouth.
- **Eyewear** - to protect eyes if there is a chance of blood splatter into the eyes.
- **Gown** - to protect clothes from soiling from blood or bodily fluids. *These gowns are not to be worn outside of a patient’s room.*
  - PPE must be removed before leaving a patient’s room.
**Vaccination-Get the Flu shot**

Vaccination is generally considered to be the most effective and cost-effective method of preventing infectious diseases.

**Influenza Vaccination**
The vaccine can either be live but weakened forms of pathogens (bacteria or viruses) or killed or inactivated forms of these pathogens. The common virus Influenza (‘flu’) is a contagious disease. It is easily spread from one person to another. The flu vaccine is recommended for everyone six months and older. It is especially recommended for anyone who lives with or cares for people at risk for influenza-related complications, such as health care providers.

Volunteers are required to receive influenza vaccination on an annual basis. Volunteers who do not receive the influenza vaccination for various reasons such as religion or personal beliefs, are required to sign a declination form at Employee Health Services. If a declination has been signed, volunteers may be asked not to report to service during the flu season.

**General Vaccination**
Employee Health Service provides the following vaccinations related to Infection Prevention:

- Hepatitis B
- Mumps
- Rubella
- Pertussis
- Varicella
- Tetanus
- Influenza

**Transmission Based Precautions**

Transmission Based Precautions are designed for patients documented or suspected to be infected with a highly transmissible or epidemiologically important pathogen for which additional precautions beyond Standard Precautions are needed to interrupt the spread of the infection.

1. **Airborne Precautions** (e.g. TB, measles)
2. **Droplet Precautions** – (e.g. rubella, influenza, adenovirus)
3. **Contact Precautions** - (e.g. multi-drug resistant organisms, draining wounds, diarrhea)

Due to liability reasons, volunteers are not allowed to enter Precaution/Isolation rooms. **Staff who request a volunteer to enter isolation rooms should be directed to the Volunteer Services Office.**
What do you do if you experience a needlestick or blood exposure?

If you experience a needle stick or blood exposure:

1. Wash the affected site.
2. Contact your volunteer supervisor and the Volunteer Services Office.
3. During the week, Employee Health Services provides the post needle stick (HBV/HIV) protocol. Late hours, weekend, and holiday exposure incidents, as well as needle stick or blood exposure occurring at the RH site, will be directed to the Emergency Department (ED). The Blood/Body Fluid Exposure Category Worksheet is used to manage the exposure incident.
4. Exposure evaluation includes a review of hepatitis B vaccine status, serologic testing or prophylaxis as indicated, and hepatitis C screening.
5. If the source is positive or at high risk for HIV infection, a decision regarding antiviral prophylaxis should be made immediately. If prophylaxis is elected it should be started as soon as possible, preferably within one hour.
6. When initial management is done in the ED, an evaluation will follow at Employee Health Service at the SL site on the next business day to review blood tests and provide continuity of care.
7. The number at Employee Health Service is 212 523-2342. If you call this number, you will be told what to do in case of a needle stick.
The Employee Health/Occupational Medicine Division provides the following services related to infection control:

- Vaccinations for hepatitis B, mumps, rubella, varicella, tetanus and influenza.
- Annual testing of all employees and volunteers for tuberculosis (PPD). Testing may be done more frequently in certain areas depending upon risk of transmission of TB.
- Treatment and follow-up of bloodborne pathogen exposure (e.g. needlestick).
- Treatment and follow-up of communicable disease exposure.
Section 3

Patients’ Rights

- Cultural Competency
- Financial Assistance
- Patient Rights
- Recycling Confidential Information

- Language Assistance
- Patient’s Bill of Rights
- Advance Directives
- Pain
Cultural Competency

The workforce of Mount Sinai St. Luke's and Mount Sinai West and the patient population we serve represent many nationalities, races, religious and cultural beliefs. These differences can impact the quality of our communication, the quality of our work environment and the quality of patient care.

Every volunteer is expected to develop a basic level of cultural competency, enabling him or her to work effectively in cross-cultural situations.

Valuing Workplace Diversity

Although workplace diversity is geared toward staff, volunteers are also encouraged to create an inclusive work environment at Mount Sinai St. Luke's and Mount Sinai West, by:

- Showing respect for one another
- Engaging in open and respectful discussions about cultural, racial or other differences
- Constructively address misunderstandings and conflict

Volunteers are also encouraged to respectfully address negative behaviors that may occur in the workplace such as:

- Remarks perceived as offensive or demeaning
- Unresolved cultural misunderstanding or disagreements
- Judging cultural beliefs of others
- Active exclusion of others

Diversity Vision:
To create an inclusive environment where everyone values and respects each other’s contributions to the workplace.

Providing Culturally Competent Care

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
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<tbody>
<tr>
<td>Patients have different religious and cultural beliefs about health care.</td>
<td>Develop skills to better hear what people from different cultures want to communicate to you.</td>
</tr>
<tr>
<td>Patients in some ethnic groups can be at greater risk to some diseases than other ethnic groups.</td>
<td>Learn about the cultures you serve and use that knowledge to provide a culturally competent approach to each patient.</td>
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</tbody>
</table>
Deaf patients and patients with Limited English Proficiency (LEP) must have access to medical information in their preferred language.

Contact Patient Relations or the Diversity and Inclusion Office to obtain interpreter services and documents

Utilize interpreter services properly

8. Language Assistance for Persons with Limited English Proficiency (LEP)

To eliminate language as a barrier to quality health care, the Language Assistance Program provides free trained interpreters for limited English proficiency and deaf patients. Aside from this being part of our policy and mission to provide excellent medical care for the communities we serve, it keeps us compliant with the Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency.” When interpreting vital information, accuracy is crucial to ensuring that patients are fully informed and able to make decisions about their healthcare. Family members or minors may be able to have a conversation in foreign language, but may not be able to interpret medical information.

Our resources in providing medical interpretation may include:

- Staff/ certified volunteer interpreters
- Sign Language Interpreter
- Language cards and posters
- Over the phone interpretations
- American Sign Language (ASL) Videoconference rovers
- Easy Listeners and amplifiers
- Written Translations
- Telecommunications Device for the Deaf (TDD/TTY)

How Do I Know if a Patient Needs an Interpreter?

Upon admission, staff will assess the patient’s language needs. Appropriate phrasing to determine a patient’s needs should be utilized at all times. The following examples of statements are considered appropriate and respectful:

“What language do you feel most comfortable speaking?”
“Do you need a medical interpreter?” and “In what language?”

Please note, volunteers may not translate medical information, regardless of fluency, even if requested by staff. All medical translation must be made by a certified and trained medical interpreter.

DO NOT ASK! - “Do you speak English?” or “Do you understand English?”
What is the procedure to get an interpreter?

Monday through Friday between 9:00 AM and 5:00 PM at Mount Sinai St. Luke's call:
- For Spanish Interpreters only page 3-3853
- For other languages call extension 23-2187

Monday through Friday between 9:00 AM and 5:00 PM at Mount Sinai West call:
- For Spanish Interpreters only page 3-7155
- For other languages call extension 23-2187

At all other times or if the interpreter is not available
- Call the over-the-phone interpretation service at extension 36-5096

What services are available for deaf and hard of hearing patients?
- Monday-Friday 9:00 AM to 5:00 PM, to schedule an ASL interpreter (at least 24 hrs. in advance) or for emergency and walk-in requests call 23-2187
- All other times 23-5678

ASL Videoconference rovers and sound amplifiers are located at the ED and at the Admitting Department.

8. Language Assistance for Persons with Limited English Proficiency (LEP) cont’d

Refusing Hospital Interpreter

By federal law, all non-English speaking patients MUST be offered a free interpreter. If the patient chooses to use a family member, the medical record MUST contain documentation that an interpreter was offered and the patient has chosen to use a family member.

Under no circumstances is anyone under the age of 16 to be used as an interpreter except in an emergency. This must be documented in the medical record.
Keep in mind that while it is helpful to learn about different cultures, we do not treat cultures; we treat individuals.

Our Diversity Mission:
To treat each patient as an individual within their own cultural context.

For more information, please contact Pamela Abner, Chief Administrative Officer, Office of Diversity and Inclusion, at 212-523-3204, or Shana Dacon, Diversity Program Manager at 212-636-8980.
Hospital Financial Assistance

Mount Sinai St. Luke's and Mount Sinai West help the uninsured or the underinsured through our financial assistance policy. Those patients who lack health insurance or the financial resources to pay for quality health care services have the opportunity to apply for financial assistance.

Patients inquiring about Hospital Financial Assistance for in-patient services should be directed to the Department of Financial Counseling (DFC). Patients inquiring about Hospital Financial Assistance for out-patient services should be directed to the HEAL Center. Eligibility for discounts, and/or payment plans will be made by DFC. If a patient needs access or information about any of our Financial Assistance Programs, please direct them to one of the following locations:

<table>
<thead>
<tr>
<th>Mount Sinai West HEAL Program</th>
<th>Mount Sinai St. Luke's HEAL Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000 Tenth Avenue at 59th Street</td>
<td>1111 Amsterdam Avenue</td>
</tr>
<tr>
<td>Room 1M12</td>
<td>Room Clark 108</td>
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<tr>
<td>New York, NY 10019</td>
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<td>Fax: (212) 636-3806</td>
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<tr>
<th>Mount Sinai West DFC Program</th>
<th>Mount Sinai St. Luke's DFC Division</th>
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<tr>
<td>1000 Tenth Avenue at 58th Street</td>
<td>1111 Amsterdam Avenue</td>
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<td>Room 2J</td>
<td>Room B150</td>
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<td>Phone: (212) 523-7816</td>
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New York State Patients’ Bill of Rights

These regulations exist to help ensure the quality and safety of a patient’s hospital care. Patients receive a copy of the Patients’ Bill of Rights upon admission to the hospital. They are posted in

- Patients’ waiting room areas
- Outpatient/Ambulatory Departments
- Admitting Office
- Emergency Departments
- Inpatient Units
- Other public locations throughout the hospital

PATIENTS’ BILL OF RIGHTS

As a patient in a hospital in New York State, you have the right, consistent with law, to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.

2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment or age.

3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

4. Receive emergency care if you need it.

5. Be informed of the name and position of the doctor who will be in charge of your care in the hospital.

6. Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.

7. A no smoking room.

8. Receive complete information about your diagnosis, treatment and prognosis.

9. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

10. Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet “Do Not Resuscitate Orders - A Guide for Patients and Families.”

11. Refuse treatment and be told what effect this may have on your health.

12. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

13. Privacy while in the hospital and confidentiality of all information and records regarding your care.

14. Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.

15. Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

16. Receive an itemized bill and explanation of all charges.

17. Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital’s response, you can complain to the New York State Health Department. The hospital must provide you with the Health Department telephone number.

18. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.

19. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.

Public Health Law (PHL) 2803 (l) (g) Patients’ Rights, 10NYCRR, 405.7, 405.7 (a) (l), 405.7 (a) (2)
Patients’ Rights

The Patient Representative Department is the liaison between patients, their families, and hospital employees. They assist patients and their families in obtaining information, understanding hospital policies and procedures, exercising their rights under the law, and resolving problems and concerns. They are the vehicle by which patients may voice their grievances and recommend changes in hospital policy.

Mount Sinai St. Luke’s 212-523-3700
Mount Sinai West 212-253-7225

Patients’ Bill of Rights

Each patient in a hospital in New York State has rights under the law; they are described in the Patients’ Bill of Rights on the previous page. A patient is viewed as an equal partner in the healthcare process. There are eight categories in the Patients’ Bill of Rights:

1. Access to Medical Care

- EMTALA- Emergency Medical Treatment & Active Labor Act- To ensure public access to emergency services regardless of ability to pay.

- The Joint Commission- (formerly known as JCAHO) - Its mission is "To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations".

- ADA -The Americans with Disabilities Act gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, access to healthcare, employment, transportation, state and local government services, and telecommunications.

2. Patient Autonomy

Patients have the right to make decisions about their medical care without their health care provider trying to influence their decision. Patient autonomy does allow for health care providers to educate patients but does not allow the health care provider to make the decision for the patient. Patients also have the right to:

- a complete understanding of the diagnosis and treatment
- refuse treatment and know the consequences
- considerate and respectful care, without discrimination

Patients in return are encouraged to:

- Provide accurate information about their past and current medical history.
- Ask for an explanation if they do not understand what is being told to them.
- Provide feedback to the hospital on services provided.

3. Right to know with whom they are Interacting during their Health Care

Patients have the right to know the name, title, and position of members of their care team and name of physician in charge of care – All staff and volunteers must wear their ID in a manner that shows their name and photograph.
4. Access to a Safe Environment of Care

Patients have the right to a secure, smoke-free setting, and policies and procedures that support patient care.

5. Privacy and Confidentiality

All hospital staff and volunteers have the responsibility to protect patients’ confidentiality at all times. The Patients’ Bill of Rights ensures patient confidentiality.

- Do not discuss any patient information with other patients, relatives and friends of the patient (unless officially authorized), visitors to the hospital, representatives of the news media, your own relatives, friends, and or neighbors.
- Do not discuss any patient information in public areas such as elevators, cafeteria, hallways, or on the jitneys.
- Be sure to speak in a low voice in private/appropriate areas when discussing patient information.
- Do not share computer access codes or passwords with anyone.
- Patients’ records are released only with their written authorization or as otherwise required by law. Release forms are available in Medical Records.
- Medical records must be secured on the patient care units to prevent unauthorized access. Do not leave records unattended.
- Do not turn or access computer terminals with the screen facing in a direction where there is public access.
- Do not write medical information on white boards that can be seen by the public. In accordance with HIPAA, volunteers are prohibited to access and convey medical information in a public manner.
- Be sure to discard paper with patient information in locked receptacles.

*New York State has passed a law guaranteeing confidentiality to all persons related to HIV status and HIV testing. If HIV information is released without proper authorization, the individual can be charged with a misdemeanor and fined up to $5000.

6. Grievance Process

The Grievance Process exists to respond to, investigate, and resolve concerns expressed by hospital patients, visitors and community members. Should patients voice or share concerns with volunteers, please contact Volunteer Services. The Volunteer Services office will convey any questions or concerns to Patient Relations who can provide patients with follow-up information including the number for the NYS Health Department, 800-804-5447.
7. Advance Directives

An **Advance Directive** is a legally recognized document that expresses a person’s wishes regarding medical treatment that he/she would or would not want in the event that he/she loses the ability or capacity to make or communicate those decisions. Patients can make their wishes known in advance through a legal form known as an advance directive. Every patient who enters MSSL&MSW must receive information and counseling, if needed, concerning use of **ADVANCE DIRECTIVES**.

As part of the admission process, the patient is given a packet containing the booklet, **Your Rights as a Hospitalized Patient**, which contains the NY State Healthcare Proxy (available on every patient care unit). Out-patients receive a packet with the Patients’ Bill of Rights and the Health Care Proxy. The information in this booklet is reviewed with the patient and the patient is then given an opportunity to discuss their questions and concerns with a staff member.

*Examples of Advance Directives include:*

- **Health Care Proxy**: A document in which a patient appoints a legally authorized surrogate decision-maker, called the health care agent, in the event the patient loses the ability to make his/her wishes known.

- **Living Will**: A document patients can use to express their treatment preferences to be followed when they have lost their ability to be involved in the treatment decision-making process.

- **Oral Advance Directive**: A spoken statement made by the patient, prior to loss of decision-making capacity, which clearly reflects the patient’s preferences about specific treatment options. Any oral statements made by a patient during their hospitalization must be fully documented in the medical record.

- **Do Not Resuscitate (DNR) Order**: Patients and their surrogate decision makers also have the right to ask for a DNR order if they would not want cardiopulmonary resuscitation attempted in the event they experience a cardiac or pulmonary arrest. Consent for a DNR order is given by the patient, health care proxy agent or next of kin when a patient has lost decision-making capacity. This consent for the DNR order is obtained by the attending physician, and must be reassessed every 7 days while a patient is hospitalized. A non-hospital DNR can be obtained for discharged patients.

New York State Law requires that all hospitalized patients be given the opportunity to complete an advance directive. The **Health Care Proxy** is given to each patient on admission. The Patient Representative can provide a patient with information regarding the Health Care Proxy or any other advance directive.

The Patient Representative is also a resource for Hospital Center staff who have questions about specific advance directives brought in by patients or about advance directives in general. Please note, volunteers are not allowed to counsel or guide patients regarding this information. If approached, please forward any inquiries to Patient Representatives or the appropriate staff on the unit.

*Key points regarding advance directives:*

- Adults in New York State have the right to accept or refuse medical treatment, including life-sustaining treatment.
• Advance directives become a permanent part of the medical record. The hospital must ensure that the patient’s wishes are carried out to the extent permitted by law.
Ethics Committee

The Ethics Committee advises and offers support and consultation for patients, families and staff when any of these individuals feel there is an ethical dilemma related to patient care. Committee members include doctors, nurses, social workers, an attorney, a chaplain, a medical ethics professional, and a member of the community. The scope of the Ethics Committee involvement includes:

- Adherence to advance directives
- Dispute resolution in implementing Do Not Resuscitate Orders
- Recommending policies and procedures regarding the resolution of ethical issues
- Providing feedback to the hospital on services provided
- Information and education on ethical issues

To contact the **Ethics Committee** for an issue at Mount Sinai St. Luke's and Mount Sinai West:

**Contact the Social Worker assigned to that nursing unit.**
# Recycling Confidential Information

## How Mount Sinai St. Luke's and Mount Sinai West Recycle Protected Health Information (PHI) Securely

The Health Insurance Portability and Accountability Act (HIPAA) of The Federal Office of Civil Rights require health care facilities to establish written policies and procedures for implementation of privacy and security measures. In other words, our patients have a right to the privacy of their health information. So if we throw away any office paper that contains protected health information (PHI), we have to ensure its security and ultimate destruction.

### Locked versus unlocked bins

Unlocked recycling bins are used for paper recycling in those areas that are inaccessible to patients and public. Whether paper waste is newspaper, magazines, junk mail or Protected Health Information (PHI), all paper recyclables go into a blue recycling bin. Locked bins are for the same exact material, that is, both Personal Health Information and regular paper recyclables, but the locked bins are in final storage areas and in areas that are accessible to patients/visitors.

## What is Protected Health Information (PHI)?

What is the definition of confidential waste?

Protected Health Information is anything that contains:

- Patient Name and/or address
- Names of relatives
- Names of employer(s)
- Birth date
- Telephone number
- Fax number
- Email address
- Social security number
- Medical record number
- Health plan beneficiary number
- Account number
- Certificate and/or license number
- Any vehicle or device serial number
- Web URL
- Internet protocol address
- Finger or voice print
- Photographic images
- Any other unique identifying number, characteristic or code (whether generally available in the public realm or not.)

## For More Information...

The HIPAA-compliant recycling policy is found in the *Environment of Care Manual* under Section – Hazardous Materials and Waste Management

For pick-up requests, in-service information or for additional bins contact Environmental Services:

- Mount Sinai West – 212-523-7001

### Locked recycling containers cannot be opened to retrieve items accidently placed inside!
Pain

Many of our patients who come to our facilities have pain. **ALL** employees and volunteers, not just patient care providers, have a role to play in effective pain management.

**What Is Pain?**

* Pain is whatever the person experiencing the pain says it is. It is important to remember that we all experience pain differently.
* Pain may be expressed differently within different cultures.
* Pain is personal and can vary in intensity and severity.
* Pain can be acute (e.g., after an operation, fracture, or with an infection) or chronic (e.g., long term pain associated with cancer or persistent back pain).
* Pain can be expressed in different ways such as verbally (saying “It hurts!” or moaning) and non-verbally (crying or grimacing).

**Some Tips for Assisting Our Patients in Pain**

* All employees and volunteers can promote a healing environment for our patients by limiting noise, clutter, and disruption.
* If you see or hear someone in pain, alert the patient care providers immediately.
* Patient care providers may use various pain rating scales to help the patient assess his/her pain. There are scales available for children and patients who do not speak English. Documents with pictures of faces indicating how much pain a patient is in are available to use:
Section 4

Performance Improvement/
Risk Management

- Quality Improvement
- Core Measures
- Occurrence Reporting
- Employee Accident Reporting
- Teamwork
Core Measures

There is an increased demand by the public for accountability and transparency in health care delivery. Therefore the federal government and other regulatory agencies have developed performance measures to see how well a hospital is caring for its patients.

The Joint Commission (JC) and the Center for Medicare Services (CMS) have started the ORYX Core Measure Initiative to help hospitals measure their performance and ultimately, to improve the care they provide. As part of the ORYX Initiative, Joint Commission-accredited hospitals, such as the Mount Sinai St. Luke's and Mount Sinai West, must collect and report data on specific performance measures. These performance measures are based on treatments that are evidence based.

The ORYX Core Measures Initiative allows The Joint Commission and CMS to review data trends and to work with hospitals as they use the information to improve patient care.

Currently, accredited hospitals collect and submit performance data on the following:

1. Acute MI (heart attack)
2. Heart Failure
3. Community Acquired Pneumonia
4. Surgical Care Improvement Project
5. Immunization
6. ED arrival to Admission time
7. ED arrival to Discharge time

The performance of MSSL&MSW is measured and compared to all other institutions in the above seven areas. It is important to note that our funding will be related to our performance in these areas (Pay-for-Performance).

Results of data collected are publicly reported and may be reviewed by healthcare consumers on two web sites:

**The Joint Commission:**
www.thejointcommission.org (click on Quality Check)

**U.S. Department of Health & Human Services:**
www.hospitalcompare.hhs.gov
Professional Misconduct & Impaired Health Professional

Professional misconduct is behavior by physicians, nurses or volunteers or staff which violates professional standards of conduct and puts patients at risk. Any employee or volunteer who believes he or she has observed professional misconduct must report it to the persons listed below.

Some of the main examples of professional misconduct include:

- Engaging in substance abuse or practicing the profession while impaired by alcohol, drugs, physical disability or mental disability
- Verbally or physically harassing, abusing, or intimidating a patient or associate
- Refusing to care for a person because of race, color, religion, national origin, sexual orientation, age, sex, or ability to pay
- Breaching confidentiality
- Failing to tell the patient who will be involved in their non-emergency procedure or surgery
- Performing services which have not been authorized
- Abandoning or neglecting a patient
- Failing to maintain proper patient records
- Engaging in fraudulent activity in obtaining a license or in practice
- Permitting or aiding an unlicensed professional to perform activities that only a licensed professional can do
- Making false reports or failing to file reports
- Failing to give patients copies of documents which they request or failing to help them fill out insurance forms.

The decision about whether professional misconduct has occurred is made by the Legal Department in consultation with hospital administration. If any employee observes or suspects professional misconduct on the part of any professional, that employee must immediately report the circumstance and the facts upon which it is based to any of the following:

- His/her supervisor
- Risk Management Department
- Legal Department
- Department Chair of the provider (physicians, dentists, podiatrists, house staff)
- Corporate Compliance Hotline (1-800-692-2353)

Any supervisor who receives a report of professional misconduct or provider impairment must promptly relay it to anyone mentioned above.
Employee Accident Reporting

If you are injured while on duty or you contract an illness as a result of your employment, you should do the following:

- Report the incident immediately to your supervisor (including sharps or needle stick injuries, and TB conversions).
- With your supervisor, complete the “Employee Accident Report” form (#30010).
- Print hard and write legibly (this is a multi-part form).
- Request a copy of this form and keep for your own records.
- Submit the form within 48 hours to Human Resources for prompt response and evaluation.
Section 5

Patient Safety

- Patient Safety
- Colors Of Safety
  - 2016 National Patient Safety Goals
  - Fall Prevention Program
Patient Safety

MSSL & MSW are committed to providing safe, high quality patient care. Maintaining an environment that ensures safety for patients, families, visitors, employees and volunteers is critical. To accomplish this, MSSL&MSW not only have to have safety systems in place, but also need the participation of all employees and volunteers in recognizing and reporting risks and concerns related to patient and employee safety, and medical/healthcare errors. This reporting hopefully will effect changes that raise the bar for patient and employee safety at MSSL&MSW.

What is already in place at MSSL & MSW to ensure patient, employee and volunteer safety?

- Policies and Procedures: Administrative, Departmental, Environment of Care, Human Resources, Attending and House Staff
- Competency Assurance Programs
- Hospital wide and department specific training programs
- Corporate Compliance Program
- Risk Management Programs
- Quality Improvement Programs
- Employee Health Service Programs
- Facilities Management Programs
- Security, Engineering, Biomedical, Engineering, Safety, Waste Management
- Emergency Preparedness Programs
- Infection Control Programs
- Patient Relations Program
- Medication Use Safety Improvement Committee (MUSIC)
- Safe Babies/Safe Haven Program

If an employee or volunteer has a suggestion related to reducing or eliminating a potential unsafe condition or practice, what can be done?

- Speak with his/her manager, program supervisor or Volunteer Services office.
- Call the Quality Improvement Department at 212-523-2158.
- Submit ideas in writing related to reducing blood exposures to Dr. Bruce Polsky, Infection Control Committee.
- For unsafe conditions, contact Yvonne Guariglia, Chair, Environment of Care Committee, at 212-523-2050.

If an employee causes or witnesses an event that causes harm or has a potential to cause harm or has any concerns about the safety or quality of the care provided, what can be done?

- Speak with his/her manager, program supervisor or Volunteer Services office.
- Contact the Risk Management Department (212-523-5663).
- Contact the Corporate Compliance Office or the Corporate Compliance Helpline.
- Contact the Quality Improvement Department (212-523-2158).
WHAT ROLE DO ALL EMPLOYEES, PHYSICIANS AND VOLUNTEERS PLAY IN PROMOTING PATIENT AND STAFF SAFETY?

- Strict adherence to ALL MSSL&MSW policies and procedures
- Reporting of potential or actual unsafe conditions or practices
- Completing and forwarding Occurrence Reporting Forms to Risk Management and Quality Improvement Departments.
2016 National Patient Safety Goals

Medical errors are one of the nation’s leading causes of death and injury. A report by the Institute of Medicine estimates that as many as 44,000 to 98,000 people die each year as the result of medical errors. Beginning in 2003, The Joint Commission has enforced national patient safety goals for healthcare organizations to increase patient safety.

The following are the six national patient safety goals and one universal protocol for 2016.

1. Improve the Accuracy of Patient Identification
   - Use at least two patient identifiers (neither to be the patient’s room number) whenever administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures. Containers used for blood and other specimens are labeled in the presence of the patient.
   - Eliminate transfusion errors related to patient misidentification.

   **HOW DO MSSL&MSW ACCOMPLISH THIS GOAL?**
   ▪ We use patient name and date of birth to confirm the correct patient.

2. Improve the Effectiveness of Communication among Caregivers
   - Report critical results of tests and diagnostic procedures on a timely basis.

   **HOW DO MSSL&MSW ACCOMPLISH THIS GOAL?**
   Administrative Policy, A2-121: Critical Test Results requires that all results of critical tests or values are to be reported to the appropriate provider as soon as possible but no longer than one hour from the time it is received.

3. Improve the Safety of Using Medications
   - Label all medications, medication containers (e.g. syringes, medicine cups, basins), or other solutions on or off the sterile field in perioperative and other procedural settings.
   - Maintain and communicate accurate patient medication information.

   **HOW DO MSSL&MSW ACCOMPLISH THIS GOAL?**
   ▪ Staff in the perioperative and procedural settings labels all medications containers used on the sterile field.
   ▪ Refer to Perioperative Services Policy: Medication on the Sterile Field.
   ▪ Administrative Policy, A2-130: Medication Reconciliation requires that patients’ current medications are reviewed upon admission and compared to those ordered while under the care of the organization to identify and resolve any discrepancies. A list of medications that the patient should be taking is provided at time of discharge.
### 4. Reduce the Risk of Health Care-Associated Infections
- Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or CDC hand hygiene guidelines.

**HOW DO MSSL&MSW ACCOMPLISH THIS GOAL?**
- The Infection Control Dept. has placed alcohol-based hand cleansing solutions in designated patient care service areas.
- Signs are posted as a reminder to wash hands, and literature on the importance of hand hygiene is distributed to patients.
- The Hand Hygiene Team monitors compliance with hand washing and provides feedback to staff.

### 5. The Organization Identifies Safety Risks Inherent In its Patient Population
- The organization identifies patients at risk for suicide. (Applicable to patients being treated for emotional or behavioral disorders only.)

**HOW DO MSSL&MSW ACCOMPLISH THIS GOAL?**
- All patients admitted for emotional or behavioral disorders (on behavioral units) are assessed throughout their hospital stay for suicide risk. Interventions are implemented based on risk criteria.
- Patients on the general inpatient (non-behavioral) unit are assessed on admission and regularly thereafter for suicidal history or ideation.

### 6. Improve the Safety of Clinical Alarm Systems
- The organization establishes alarm system safety as a priority.
- Identify the most important alarm signals to manage.

**HOW DO MSSL&MSW ACCOMPLISH THIS GOAL?**
- The Department of Patient Care Services has developed guidelines for Alarm Management which are integrated into device and equipment-specific policies (e.g., CC-C06, P-5, RT-9001).
This is a Universal Protocol:

**ELIMINATE WRONG-SITE, WRONG-PROCEDURE AND WRONG-PATIENT PROCEDURES**

- Conduct a **pre-procedure verification process**.
- **Mark the procedure site** for procedures involving right/left distinction, multiple structures, or multiple level, the intended site must be marked such that the mark is visible after the patient has been prepped and draped.
- Implement **Time-Out** immediately before starting the procedure to confirm:
  - Correct patient
  - Correct side/site
  - Accurate procedure consent form
  - Agreement on the procedure to be done
  - Correct patient position
  - Relevant images and results are properly labeled and displayed
  - The need to administer antibiotics or fluids for irrigation purposes
  - Safety precautions based on patient history or medication use

**HOW DO MSSL&MSW ACCOMPLISH THIS GOAL?**

- Prior to the start of any procedure, an on-going process of information gathering and verification is conducted by involved team members.
- A “time-out” is used prior to start of the procedure to confirm correct patient, procedure, and site.
- Site is marked with the procedurals’ INITIALS for all procedures involving laterality (Right, Left), level (e.g.: Spine) and multiple structures (e.g.: Finger).
- Refer to Administrative Policy, **A2-133: Universal Protocol**.
Patient Fall Prevention Program

All patients are at risk for falling. In order to create an environment of safety for our patients, ALL HOSPITAL EMPLOYEES, not just patient care providers, have a role in preventing patient falls.

What Is the Hospital’s Fall Prevention Program?

- On admission and at regular intervals during the hospital stay, nurses identify patients at risk for falling using a Fall Risk Assessment tool.
- Patients and family are provided with education to prevent falls.
- All patients are instructed to use the call light for assistance.
- All patients are instructed to wear non-slip footwear.
- Increased monitoring of patients who are identified at moderate or high risk for falling. These patients will be identified with the following:
  - Yellow armband placed on wrist
  - Yellow non-skid socks
  - Yellow name tag at room door
  - Yellow “Fall Risk” sign placed over patient’s bed or on room door
  - Yellow “Fall Risk” sticker placed on front of chart

The purpose of the program is to educate ALL HOSPITAL STAFF to increase awareness of patients who are at risk for falling.

Why Is This Important?

Adverse events associated with falls may include cuts or bruises, bone fractures, head injuries, and fear of falling again. Injuries resulting from a fall may lead to a longer hospital stay.

What Is My Responsibility In Preventing Patient Falls?

ALL HOSPITAL EMPLOYEES AND VOLUNTEERS are to be aware of their responsibility in preventing patient falls from occurring. REMEMBER:

- If patient is at risk for falling or needs help, request assistance for the patient and stay with them until help arrives.
- Communicate unsafe situations (e.g., liquid on floor, broken equipment, furniture blocking pathway to the bathroom) to the charge nurse or Nurse Manager/Supervisor.
**Colors of Safety**

**Color-Coded Patient Alert Condition ID Bands**

As part of a national effort to enhance patient safety, Mount Sinai St. Luke's and Mount Sinai West are using pre-printed, color-coded patient wristbands that alert staff members to certain patient conditions.

Color-coded wristbands allow us to quickly communicate important information among staff regarding these patient alert conditions:

- **RED means Allergy Alert.** Red alerts us to stop and look in the medical record to find out information on the patient’s allergies, so we can provide safe care.

- **YELLOW means Fall Risk.** Yellow alerts us that the patient may need extra assistance when walking or transferring to prevent falls. Patients assessed at risk for falls may also be wearing yellow slipper socks and have yellow Fall Risk Stickers on the medical record and on the room name tag outside the patient’s door.
Section 6

Customer Service

- HCAHPS
- AIDET

Standards of Customer Care
**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**

CMS requires all hospitals who receive Medicare reimbursement to participate in a publicly reporting patient satisfaction survey called HCAHPS. The HCAHPS surveys are distributed to patients by an outside agency called the Press Ganey who collects and organizes the scores. Managers at Mount Sinai St. Luke’s and Mount Sinai West, keep track of our scores.

There are 7 areas that are measured:

- Nurse Communication
- Doctor Communication
- Cleanliness and quiet of the hospital environment
- Responsiveness of hospital staff
- Pain Management
- Communication about medicines
- Discharge Information

The **Language of Caring** is a hospital-wide program that promotes caring communication between caregivers and patients and among co-workers. Below are the Language of Caring communication skills that are expected to be practiced by MSSL&MSW employees:

- Heart-Head-Heart Communication
- The Practice of Presence
- Acknowledging Feelings
- Showing Caring Non-verbally
- Positive Intent
- The Blameless Apology
- The Gift of Positive Regard
- The Caring Broken Record
Standards of Customer Care

Standard #1: We will make our patients and their families feel welcomed.
- Welcome patients and visitors and inquire how we can help
- Introduce ourselves using name and title
- We will explain to the patient our role in his/her care during individual encounters
- Wear our hospital ID badge at chest height with name and picture visible
- Establish eye contact and smile when speaking to patients, visitors, and colleagues
- Respond promptly to inquiries or problems
- Offer assistance to individuals who are disabled or may be confused with the surroundings

Standard #2: Whenever we have a patient or employee interaction, we will act in a professional manner and we will dress professionally to communicate that visibly.
- Greet a patient using his/her formal name, unless invited to call him/her differently
- Always knock before entering a room and asking permission to enter
- Welcome, assist and orient new volunteers (if applicable)

Standard #3: We will maintain a peaceful, calm and healing environment.
- Speak in a quiet tone of voice
- Provide a blanket to ensure a patient’s comfort
- Offer assistance when needed and possible
- Ask “Is there anything else I can do for you?” when leaving a patient room

Standard #4: We will keep our personal frustrations separate.
- We will speak positively of MSSL & MSW and of our colleagues when speaking to patients, visitors, and fellow volunteers
- Keep staff gossip and personal matters out of a patient’s hearing
- If necessary, conduct a private discussion with fellow volunteers identifying and clarifying possible miscommunication
- Help others with our “know how” and ask for help when we need it
- Always link problem identification with problem solving suggestions
- Reach out to Volunteer Services office for support and guidance
Standards of Customer Care *cont’d*

**Standard #5:** We will relieve the fears and anxieties of our patients by listening, answering questions and explaining procedures.
- Repeat a patient’s request or concern so he/she knows we understand
- Communicate in a clear, easy to understand manner
- Inform a patient of the time of a test or procedure
- Give honest reasons for any delay without causing unnecessary anxiety
- Maintain eye contact when talking and listening
- Always try to go that “extra step”

**Standard #6:** We will acknowledge when we have failed to meet their expectations and apologize sincerely for inconveniences.
- Apologize for all delays – even though we may not be responsible for them
- Recognize and stay calm when a patient is upset and ask what we can do to help

**Standard #7:** We will ask colleagues how we can help.
- We will welcome and assist new employees
- We will assist fellow volunteers whenever possible
- We will help others with our “know-how” and ask for help when we need it

**AIDET for Admissions and change of shift**

<table>
<thead>
<tr>
<th>A</th>
<th>Acknowledge your patient by naming them (e.g., “Hello Mrs. Jones, welcome to Mount Sinai St. Luke’s Hospital or Mount Sinai West Hospital.”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Introduce yourself with your name and telling the patient who you are and what you do. Introducing staff and fellow volunteers will help transition care. For example, you could say, “You are in good hands with Miss Jones, your PCA. She always gives excellent patient care.”</td>
</tr>
<tr>
<td>D</td>
<td>Duration How long will the procedure take? How long will the patient wait? How long till results arrive? Discuss the patient’s expectations of a great hospital stay and convey any necessary information to the patient’s clinical team. Provide the patient with an estimation of wait time for procedures and discharge. .</td>
</tr>
<tr>
<td>E</td>
<td>Explanation and write on white boards: Educate patients to our goals for them that include their white board concerns. Ask “Is there anything else I can do for you?” before leaving the patient’s room.</td>
</tr>
<tr>
<td>T</td>
<td>Thank you Thank family for their assistance. Thank them for choosing our hospital.</td>
</tr>
</tbody>
</table>
Hourly Rounding with the 5 “T’s”

For each of the 5 T’s, here are some possible questions to ask your patient:

TELEVISION
“Hi Mrs. Johnson. Do you know how the television works? I will be more than happy to show you how to use the remote and settings.”

TELEPHONE
“Do you need assistance using the telephone? You can make local calls.”

TRAY
Trays should be no further than arms-length from the patient. If they are, bring the tray within arms-length. “Can you reach the tray? Is this a comfortable distance for you? Here is your water and I am moving your TV button close so you can reach it. Is there anything else you need that I can get for you now?”

TISSUES – placed nearby on the tray
“Here are your tissues. Should you need any additional boxes, please let me know. Feel free to have the nurse page me so I can bring them to you.”

TRASH
“Has your trash been emptied? Feel free to let the staff know if it hasn’t or doesn’t get emptied. I will be happy to report that as well while I am volunteering.”
Section 7

Population Specific Care
Patients who come for care at MSSL&MSW represent a great variety of populations. Therefore, our employees and volunteers must be able to interact with the many different populations we serve. But what does population really mean? Population can be defined many ways. The Joint Commission states that population can be defined by the following:

- **Age** (e.g., pediatrics, adult, elderly)
- **Health status/disease process** (e.g., diabetics, cardiac patients, surgical patients)
- **Cultural/Spiritual** (e.g., Christian, Jewish, Muslim, Hispanic, Chinese)
  - **Functional Status** (e.g. limited mobility, deaf, visually impaired, developmentally disabled)
  - **Equipment used in treating the population** (e.g. Fetal monitor, telemetry, ventilator)
Section 8

Corporate Compliance

Eight Elements of Corporate Compliance Program

- HIPAA
- Code of Conduct
- Non-Retaliation
- Office of Corporate Compliance
  - Fraud and Abuse
  - EMTALA
Corporate Compliance

What Is Corporate Compliance?

There are many definitions as to what constitutes a Corporate Compliance Program. On a basic level it is about the commitment of Mount Sinai Beth Israel, Mount Sinai Beth Israel Brooklyn, Mount Sinai St. Luke's and Mount Sinai West (collectively, “Hospitals”) to operate and assure compliance with and conform to all applicable federal, state and local laws, rules and regulations, as well as policies and standards set by the government, insurance programs and other payers (i.e. Medicare and Medicaid). Additionally, the Hospitals, as providers of health care, are part of an organization that promotes integrity and ethical behavior through all levels of the organization.

Corporate Compliance - Introduction

We have established a Corporate Compliance Program in accordance with guidance set forth by the Office of Inspector General of the United States Department of Health & Human Services, as well as by legislation enacted by the state of New York.

The purpose of the Corporate Compliance Program is to prevent, detect and investigate violations of law. This also includes fraudulent and unethical behavior, as well. The hospital is committed to educating and training staff and volunteers to comply with the laws, as well as encouraging them to ask questions or seek advice to ensure that they conduct hospital business in a lawful and ethical manner.

Corporate Compliance - Health Care Origins

New York State

In addition to the guidance promulgated by the federal Department of Health & Human Services Office of the Inspector General (OIG), New York State, through its Office of the Medicaid Inspector General (OMIG), requires that its hospitals implement corporate compliance programs as well. Essentially, the requirements of the New York and the federal OIG are very similar in scope with certain variations. The OIG and the OMIG require that hospital compliance programs contain certain essential elements (see below – the Eight (8) elements of a Corporate Compliance Program). The OMIG regulations also list certain specific risk areas that a compliance program must address. They include billing, payments, medical necessity and quality of care, governance, mandatory reporting, credentialing and having certain policies and procedures, inclusive of a policy addressing non-intimidation and non-retaliation. Additionally, the OMIG requires that hospitals certify on an annual basis that they have established and implemented an effective compliance program that meets the OMIG’s standards.
The Risks of Non-Compliance

Healthcare organizations that are not in compliance with government laws and regulations face severe penalties that could result in monetary settlements, mandated supervised compliance programs (through corporate integrity agreements), exclusion from government healthcare programs (i.e. Medicare, Medicaid), and possible criminal prosecution and incarceration for intentional and egregious acts.

Organizations suspected of fraud and abuse must deal with extensive government audits and reviews. These investigations usually result in costly civil monetary settlements and can disrupt routine hospital operations.

Fraud and Abuse

The terms fraud and abuse are often used in regard to Corporate Compliance Programs. The following are their definitions together with examples:

**Fraud** - is an intentional deception or misrepresentation which the individual or entity knows to be false or does not believe to be true and results in some unauthorized benefit. The most frequent kind of fraud arises from a false statement or misrepresentation that relates to payment from a health care program (i.e. Medicare, Medicaid, Empire Blue Cross, etc.) Fraud also includes reckless disregard for compliance with laws, rules and regulations. Examples of healthcare fraud may include the following:

- Incorrect reporting of diagnoses or procedures to maximize reimbursements
- Billing for services, supplies or equipment that were not rendered
- Disguising non-covered or non-chargeable services/supplies/equipment as covered items
- Deliberate double billing of payors and/or patients

**Abuse** - is used to describe incidents or practices of providers, physicians, or suppliers of services which, although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices, that directly or indirectly result in unnecessary costs to the government health care programs, improper reimbursement, or payment for services that fail to meet professionally recognized standards of care or which are medically unnecessary. One type of abuse to which healthcare payors are particularly vulnerable is overutilization of medical and healthcare services. Abuse may include the following:

- Excessive charges for services or supplies
- Claims for services not medically necessary
- Improper billing practices (i.e. billing Medicare instead of another third party payor)

The Eight (8) Elements of a Corporate Compliance Program

The Office of Inspector General’s (“OIG”) compliance guidance for the hospital industry and the New York State Office of the Medicaid Inspector General, recommend that Corporate Compliance programs contain the following eight (8) elements for every Corporate Compliance Program:

1.- Establishment of Standards of Conduct

This element represents the Code of Conduct that demonstrates our commitment to abiding to the relevant laws and regulations of federal and state government and federal and New York State healthcare program requirements. Further, to provide additional guidance, Corporate Compliance specific policies and procedures have been developed which are available to all staff, and which address certain identified risk areas. These Policies and Procedures, as well as the Code of Conduct, are contained in the Corporate Compliance section on the Hospitals’ Intranet web site.
2-Designation of Corporate Compliance Officer and Compliance Committee
Frank Cino, Senior Vice President, serves as the Chief Compliance Officer. Louis I. Schenkel is the Vice President for Compliance. They are responsible for the development, operation and oversight of the Corporate Compliance Program. Mr. Schenkel’s office telephone number is (212) 523-2162.

The Hospitals Compliance Oversight Committee, which is a multi-disciplinary committee comprised of senior leadership assists in the design, implementation and operation of the Corporate Compliance Program.

3- Training and Education
All newly hired staff and volunteers receive a copy of the Code of Conduct and Corporate Compliance education and training at orientation.

4- Reporting Channels- Effective Lines of Communication
Open and effective communication enhances an organization’s ability to identify and respond to compliance concerns and issues.

All staff and volunteers have a duty to report suspected or actual violations of federal, state or local laws, rules, regulations policies and procedures or the Code of Conduct to their supervisor, either in writing, by telephone or in person. All staff and volunteers are encouraged to make reports through their administrative chain of command. Volunteers should contact Volunteer Services or the Office of Corporate Compliance directly at (212) 241-9391. Anonymous reporting of violations may be made via the toll-free Corporate Compliance Helpline: 1-800-853-9212. There will be no reprisals or any retaliation against employees for good faith reporting.

5- Enforcement of Disciplinary Standards
All staff and volunteers are accountable for complying with the standards of the Corporate Compliance Program. By enforcing disciplinary standards, the organization helps to create an institutional culture that emphasizes ethical behavior.

Disciplinary actions may be taken for:
- Violating the Code of Conduct or other laws and regulations
- Failing to report a violation of the Code of Conduct or cooperate in an investigation
- Retaliation against an individual for reporting a violation or possible violation of the Code of Conduct
- Deliberately making a false report of a violation of the Code of Conduct

The extent of disciplinary action utilized will depend on the nature, severity and frequency of the violation. The Chief Compliance Officer is authorized to recommend, in consultation with appropriate management staff, as necessary, appropriate discipline, up to and including termination.

6-Auditing and Monitoring
We are committed to an ongoing evaluation process. Monitoring and auditing activities are conducted under the auspices of the Chief Compliance Officer. Audits are designed to address compliance with laws, regulations and policies governing, among other things, coding, reimbursement, documentation, medical necessity and other areas that may be deemed as high-risk areas. Issues for audit are also based on publications such as OIG Special Fraud Alerts and the annual OIG and OMIG Work Plans. Reports of audits are made to the Compliance Oversight Committee and the Audit and Compliance Committee of the Board of Trustees.
7- Responding to Detected Offenses and Implementing Corrective Action Initiatives
All reported violations will be promptly, thoroughly and confidentially investigated by the Corporate Compliance Officer. Hospital staff and volunteers are required to cooperate with any investigation conducted in response to a report concerning compliance issues. Appropriate follow-up will be made to correct the issue and prevent recurrence.

8- Non-Retaliation
All hospital staff and volunteers have a duty and responsibility to report suspected or actual violations of laws, regulations, policies and procedures and the Corporate Compliance Program Code of Conduct, without fear of retaliation, retribution or intimidation. Retaliation against any staff member or volunteer, who seeks advice, raises a concern or reports an ethical or corporate compliance issue in good faith will not be tolerated.

The Office of Corporate Compliance
The Office of Corporate Compliance’s mission is to promote adherence to appropriate standards of business conduct and to ensure conformance to applicable federal, state and local laws and regulations, as well promoting integrity and ethical behavior throughout the organization. The Office of Corporate Compliance strives to ensure organizational compliance with the eight (8) elements of an effective Corporate Compliance Program.

Code of Conduct
Our Corporate Compliance Code of Conduct has been adopted by the Board of Trustees to provide standards by which trustees, employees, physicians, volunteers and other affiliated entities will conduct themselves in order to protect and promote organization-wide integrity and to enhance our ability to achieve its mission. The Code of Conduct is an encompassing foundation document based on the principles outlined in the Mission Statements of the Hospitals and in accordance with organizational values based on integrity and trust. It also contains resources to help resolve any questions about appropriate conduct in the workplace. The Code of Conduct applies to all Hospital staff, including board members, physicians and vendors and sets forth our commitment to comply with all federal and state laws and regulations, inclusive of an emphasis on preventing fraud and abuse.

All staff and volunteers receive the Code of Conduct and are required to sign an acknowledgement that they will abide by it during their service.

The Code of Conduct addresses many issues relating to lawful and ethical behavior. Some of these issues include:

- Patients’ Rights
- Workplace Practices
- Conflict of Interest
- Billing/Reimbursement
- Confidentiality

Further, other fundamental provisions contained in the Code of Conduct include:
• The hospitals’ commitment to full compliance with all federal and state healthcare program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements.
• The requirement that all staff are expected to report suspected or actual violations of any federal and state healthcare program requirements or of applicable laws and regulations or the Code of Conduct, through the respective associate’s administrative chain of command or directly to the Corporate Compliance Office.
• The right of all employees to make confidential and/or anonymous disclosures of any identified issues or questions associated with hospital policies, practices, applicable laws and regulations or the Code of Conduct, through their respective administrative chain of command, to the Corporate Compliance Office or to the toll-free Corporate Compliance Helpline. All such reports will be in accordance with the hospital's non-retaliation policy.
• The possible disciplinary consequences to our hospitals, staff and volunteers of failure to comply with federal healthcare program requirements as well as the failure to report such non-compliance.

**Non-Retaliation**

It is the policy of the hospitals that all staff have a duty and responsibility to report suspected or actual violations of laws, regulations, policies, procedures and the Code of Conduct, without fear of retaliation. We do not tolerate or condone retaliation against staff for good faith reporting of concerns or violations. Any associate who commits or condones any form of retaliation or retribution will be subject to disciplinary action, up to and including termination.

**EMTALA**

EMTALA is an acronym for the Emergency Medical Treatment & Active Labor Act. It is a federal law that became effective in 1986 and is sometimes referred to as the “Anti-Dumping Law”. Its primary purpose is to ensure emergency care for anyone who requires it regardless of his/her ability to pay or insurance coverage.

**What is Our Commitment?**

Our Hospitals are committed to providing quality emergency medical services to all patients who present at any of our Emergency Departments (or in the case of a pregnant woman presenting at the labor/delivery area) regardless of their payor status.

**Basic EMTALA Obligations**

1- Provide an appropriate Medical Screening Examination (“MSE”) (an MSE is more than just triaging a patient) to determine whether an emergency condition exists
2- Provide any necessary **stabilizing treatment**, including treatment for pregnant women and their unborn child

3- Provide an appropriate **transfer** to another facility, if necessary, regardless of the patient’s ability to pay

**Other Key Points**

- It is a violation of EMTALA to delay a Medical Screening Examination to inquire about a patient’s payor or insurance status. After an MSE has been conducted by qualified medical personnel (i.e. physician) to determine if an emergency condition exists, insurance and other payment information may then be obtained from a patient

- Hospitals that violate EMTALA can be fined up to $50,000 per violation

- Our Hospitals’ Emergency Departments and labor/delivery suites have required signage which states that patients have the right to a Medical Screening Examination, Stabilizing Treatment and a Transfer, if necessary

If you have any questions about EMTALA, speak to your supervisor, the Patient Relations Department or the Office of Corporate Compliance.

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**Your Role in Corporate Compliance**

- **Become familiar with and abide by the Code of Conduct** - You are expected to read and understand and abide by the Code of Conduct. If you have any questions about the Code of Conduct ask your supervisor or the Corporate Compliance Office.

- **Know and comply with applicable laws and regulations** - You are expected to be familiar with laws that apply to your specific service/position description and level of responsibility. If you are not sure about whether a law or standard applies, ask your supervisor.

- **Assume and take individual responsibility** - Corporate Compliance is everyone’s business. Don’t assume someone else is doing or not doing something about an issue. Step forward and tell someone about a concern or issue you may know of.

- **Report in good faith suspected or actual violations of laws, regulations or the Code of Conduct using the administrative chain of command.**
• **Understand the consequences of non-compliance** – failure to comply with laws and regulations or the Code of Conduct could pose serious risks to employees as well as to our Hospitals.

• **Ask questions** - If you don’t know something or want answers to your questions, just ask; if you have doubts about the legal or ethical implications of a situation, ask your supervisor or the Corporate Compliance Office.

• **Lead by example** - be a leader and role model of lawful and ethical behavior…”One Way…the Right Way”

**Compliance is Everyone’s Responsibility!**

**HIPAA**

**General**

HIPAA stands for a federal law called the Health Insurance Portability and Accountability Act. This law, among other purposes, was created to protect the privacy and security of patient healthcare information, which is considered Protected Health Information (“PHI”). It also established uniform standards for electronic billing and the computerized transfer of healthcare information.

**Protected Health Information (PHI)**

PHI includes any information (i.e. oral, recorded on paper, or sent electronically) that is unique to a patient and by itself can identify that person in regard to their physical or mental health, services rendered or payment for those services, including personal information connecting the patient to the records. Some examples of PHI include:

- Name
- Address
- Social security number
- Telephone number
- Medical record number
- E-mail address
- Hospital admission date
- Discharge date, etc.

Generally, PHI cannot be used or disclosed by staff without a patient’s consent or authorization, unless it is for “TPO”. TPO stands for Treatment, Payment and Operations.

**Treatment**- refers to how the Hospital and its health care providers manage, coordinate or provide health care. This includes consulting with other health care providers or patient referrals.
**Payment** refers to the activities necessary for the Hospital and its health care providers to obtain payment for rendered services.

**Operations** refers to the administrative, financial, legal and quality improvement activities necessary to support Hospital functions relating to treatment and payment.

**Notice of Privacy Practices**

The HIPAA law requires that all patients be provided with the written Notice of Privacy Practices ("NPP") when utilizing Hospital health services for the first time. The NPP informs patients of their rights regarding the use and disclosure of PHI as well as our legal obligations to safeguard the PHI. Patients are asked to sign an acknowledgement form noting their receipt of the NPP.

**Minimum Necessary Rule**

The HIPAA regulations require the Hospital to take reasonable steps to limit the use and disclosure of PHI. The least amount of PHI required for volunteers to provide service in their role effectively is considered "minimum necessary". Volunteers need to be careful in terms of how they use and share PHI if they come across it.

**Business Associates**

Under HIPAA, when we share patient information with contracted vendors such as transcription services or billing companies, they become "business associates" and must also follow HIPAA rules. Our "business associate agreements" (contracts) with these vendors must include an acknowledgement of HIPAA compliance.

**Privacy Officer/HIPAA Security**

The hospital has appointed a Privacy Officer, Louis Schenkel, who has overall responsibility for ensuring compliance to the HIPAA regulations. Among the Privacy Officer’s HIPAA duties are the drafting of policies and procedures. These policies are posted on the Hospital Intranet web site.

The Privacy Officer is also responsible for investigating and acting upon privacy complaints. Similar to Corporate Compliance issues, employees and others may not be retaliated against for making good faith reports of privacy violations.

If you have any questions or concerns about compliance with the HIPAA Privacy Rule, speak to your supervisor or the Privacy Officer, who can be contacted at (212) 523-2162 or (212) 241-4669.

For questions or issues relating to the security component of HIPAA, please contact Raymond Shelton, who can be reached at (212) 523-7019.

**Your Role in HIPAA**

- Ensure that PHI is not disclosed improperly
- Do not discuss PHI in elevators or in public areas such as cafeterias where your conversations may be overheard
- Protect and do not share computer passwords
- Make good faith reports of HIPAA violations to the Privacy Officer
HIPAA Case Scenario # 1
You work in the Medical Records Department and a certain physician requests medical records of patients that she is not involved with. Is she allowed to do this?

Answer:
No. Only the attending, covering or consulting physicians may have access to patient medical records. “PHI”- Protected Health Information, can only be released for the purposes of “TPO”- Treatment, Payment or Operations. Patients are entitled to expect confidentiality, the protection of their privacy and the release of PHI only to authorized parties. This physician should be reported to your supervisor or to the Corporate Compliance Office.

HIPAA Case Scenario # 2
You are a physical therapist who just found out that your favorite teacher from high school is in the Emergency Department arriving via ambulance after a car accident. She had X-rays taken and her husband has asked you to get the results since you know the radiology supervisor and the Emergency Department physician is busy with another patient. Should you do this?

Answer:
No. Even though you have the ability to get the X-ray results, this patient’s PHI has nothing to do with your job, nor is it related to TPO. If you obtain the results from the radiology supervisor, both of you will be violating HIPAA, the Code of Conduct, and subjecting the hospital to the risk of liability for breaching the patient’s right to confidentiality and privacy.