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Letter from CEO, Rick Napper

The heat of the summer has hit Corinth with a vengeance and just as things heat up, MRHC is preparing to heat up as well. We are rapidly preparing for single sign-on for the Meditech system and believe this will be a long awaited improvement. We are confident that this will make utilizing the system much more user friendly. Shortly thereafter we will embark on CPOE and hopefully all of the hard work will have us better prepared for this journey.

The summer also normally brings a drop in patient volumes, which has not been the case in 2010. We have remained steady throughout the summer and have not experienced dips related to physician vacations, which is an indication of growth and improved community opinions.

We have also had new physicians to join our team, which has added to our volumes. Additional new physicians are expected to join us in August and September, just in time for the fall.

As we approach the fall, we can look forward to the MICU reopening around the middle of September with a fresh new look. We will also be offering our physicians and

patients a new service in the form of a diabetes treatment team with pharmacy, dietary, diabetes education, wound care and provider services. There is more information to follow on this so stay tuned.

Yes, summer is coming to a close and lots of things are happening. As always our physicians continue to be at the core of MRHC's growth strategy. Thank you for using our services and providing the high quality care that you do. Thank you!

Respectfully,

Rick Napper, CEO



Vice-President, Medical Affairs
Gene Combest, MD



Vice-President of Physician Operations, Don Lloyd

There may be times
when a physician may
no longer be able to
provide patient care.

I am excited about the 3rd annual CV Symposium that the Magnolia Heart and Vascular Center's cardiologists and cardiovascular surgeons are presenting on October 22nd and 23rd. Speakers will include Dr. James C. Gilmore, Dr. Angel Rodriguez, Dr. Christina Brown, Dr. Max Hutchinson, Dr. John Prather, Dr. Kerry Morgan, Dr. Nanni Pidikiti, Dr. Emad Mohamed and Dr. Barry Bertolet. The topics all look very interesting and I believe the symposium would be rewarding for everyone. Keep your eyes peeled for further information about the symposium and the speakers in the next edition of the physician newsletter.

I would like to remind all physicians that Magnolia has recently added a PHYSICIAN Information Portal to the INTRANET site. The IT team is just getting the site going, but in the near future you can expect to see much more additional information being added to the site that should be of interest to you. We are in the process of adding the Medical BYLAWS to the intranet sites this month.

Firing Patients

Once a physician and patient relationship has commenced, the physician is obligated to provide services as long as the patient needs them and meets certain patient obligations. There may be times when a physician may no longer be able to provide patient care. If the patient is noncompliant, unreasonable, threatening or otherwise contributing to a breakdown of the relationship, the decision to terminate the relationship can be made by the physician.

Regardless of the situation, to avoid a claim of "patient abandonment", a physician must follow the appropriate steps to terminate the physician-patient relationship. A physician may not discontinue treatment of a patient as long as further treatment is medically indicated without giving the patient a reasonable notice and sufficient opportunity to make other arrangements for care. A physician who does not terminate the relationship properly may be charged with unprofessional

conduct. Appropriate steps to terminate the physician-patient relationship are listed below:

- Give the patient or patient representative written notice, which may be certified mail, return receipt requested or other proof. A copy of the letter should be placed in the patient's medical record.
- Provide the patient with a brief and valid reason for ending the relationship.
- Agreeing to continue to provide care for a reasonable period of time (at least 30 days) in order to allow the patient to obtain care from another physician.
- Provide recommendations, if possible to help the patient locate another physician of the same or like specialty.
- Offer to transfer records to the new physician upon receiving the signed authorization and medical records copying fee.

An example termination letter is listed below.

SAMPLE MEDICAL PATIENT TERMINATION LETTER

(Date of letter)

(Patient address)

Dear (Patient name):

This letter is to inform you that I will no longer be your physician and will stop providing medical care to you effective (30 days from the date of the letter).

I will continue to provide routine and emergency medical care to you for 30 days while you seek another physician.

I suggest you consult the local yellow pages or the area yellow book as soon as possible so that you may find another physician who will assume responsibility for your care.

I will be pleased to assist the physician of your choice by sending him or her a copy of your medical records.

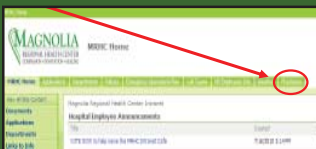
Sincerely,

(Physician name)

Instructions:

1. Retype letter and place on your office letterhead.
2. Send letter by certified mail with return receipt requested.
3. File copy of the letter and delivery receipt in patient's chart

If you have questions regarding terminating a physician-patient relationship, please contact the TSPO office at 662.287-6913.





Drug Shortages

1. Scopolamine Injection – Not available. No product in stock. Alternatives provided to anesthesia.
2. Heparin Flushes - Limited supplies are available. 10 ml vials are not available, but we have been able to get 5 ml prefilled syringes.
3. Heparin Premixed Drips - Hard to get due to changes in USP specifications for heparin. We have been able to keep adequate stock. If necessary we are also able to compound heparin drips.
4. Fosphenytoin (Cerebyx) - We are able to obtain a limited supply of this. The shortage is due to manufacturing issues in some facilities that led to increased demand of product from the remaining manufacturers. This seems to be slowly resolving.
5. Propofol (Diprivan) – Ongoing supply problems due to nation wide recall of product at the end 2009. We are able to obtain limited quantities of this product. We have been able to keep an adequate supply so far.
6. Intravenous Fat Emulsion - Supply problems due to manufacturing issues at one manufacturer. We are able to get a limited supply of 20 % lipids. The remaining manufacturer is increasing production to help meet demand for product.
7. Tobramycin Injection – Has been hard to get. We currently have adequate supplies of this product. Supply issues seem to be resolving.
8. Trimethoprim/sulfamethoxazole (Septra) Injection – Shortage created because of recent product recall of some vial sizes. There is a limited supply of this product. Our current inventory is low. Manufacturer anticipates availability of some vial sizes in July 2010.
9. Fentanyl - 100 mcg/2ml strength is temporarily unavailable.
10. Epinephrine prefilled syringes - These are temporarily unavailable due to manufacturing issues. Some product is supposed to be available by early August.
11. Dextrose Prefilled Syringes - 50 ml syringes are temporarily unavailable, but vials are still available and have been put on the Pyxis units.

Medical Trivia

Project CARESOM was established in Mississippi in 1969. Three helicopters were purchased through a federal grant and located strategically in north, central and southern areas of the state. Upon termination of the grant the program was considered a success and each of the three communities was given the opportunity to continue the helicopter operation. Only the one located in Hattiesburg did so, thereby establishing the first civilian air medical program in the United States.



E-Safety First

NAVIGATING A COURSE TO EXCELLENCE WITH BETTER COMMUNICATION

Communication can be defined as a process by which we assign and convey meaning in an attempt to create shared understanding. It is through communication that collaboration and cooperation occur, and through this collaboration that we navigate a course to excellence. In an attempt to increase communication between the hospital and medical staff, a new website has been launched with access limited to physicians only.

The new physicians' website will be full of useful information and updates for physicians practicing at MRHC. This will be the premier information portal for accessing updates and status reports on the implementation of CPOE (computerized physician order entry) and electronic ambulatory prescription management. MRHC will utilize this website to convey information of interest to physicians with such sites as: FAQs, "How To" reference material for navigating Meditech, and the link for the physician newsletter.

To complete the circle of communication,

MRHC also solicits physician feedback. On the site you will discover a link for a physician's suggestion box. You may utilize this link to make suggestions on how we can better serve the medical community. All suggestions will be answered and/or addressed in a timely manner. One of the excellent suggestions we have received was since pseudoephedrine is now by prescription, the drug and its order strings needs to be added to the T-Systems order options. This issue was immediately addressed by representatives from pharmacy, the emergency department, and T-Systems specialists. Carl Clement, Emergency Room Director then answered the suggestion on the website. Answers to anonymously entered suggestions can be viewed by clicking on the "Answers to Anonymous Suggestions" link on the physicians' home page.

Physicians may also request access to MRHC Medical Staff Privileges site by clicking on this "Link of Interest" tab. By selecting "MRHC policies", physicians are presented with all hospital policies that can be categorized in a number of ways and a search engine to make locat-

ing policies easier. Any suggestions on how this website can be improved to serve the medical staff better are welcomed.

New additions to the information technology advancements designed for physicians are the Clinical Information Portal (CIP) that will allow physicians to access their patient information remotely from their iPhone. Physician pilot testing for this project is scheduled to begin in August. Also, coming soon is a direct link from Meditech's Clinical Review into I-Site to view images without having to leave the Meditech screen.

Another innovation, Single Sign-On, will soon be piloted on 5Tower. With Imprivata Single Sign-On, a proximity badge reader will allow users to TAP their badge and enter a password only once allowing them to access applications such as Meditech and I-Site without having to enter user names and passwords for each application.

Visit the Physician's intranet site and let us know what you think. Your feedback is important in the construction of a website to fit **your** needs.

WELCOME



DR. JEREMY GRAHAM - Emergency Medicine (left)
Jeremy Graham, D.O., is an emergency medicine physician with Magnolia Regional Health Center. Dr. Graham joined MRHC's Medical Staff in June 2010. After he received his undergraduate degree from Mississippi State University and earned his medical degree from The University of the South, he then completed his residency at the University of Mississippi Medical Center in Jackson, Mississippi. Dr. Graham is a member of the American Osteopathic Association.

DR. STANER JONES - Emergency Medicine (right)
Roger Staner Jones, M.D., is an emergency medicine physician with Magnolia Regional Health Center. Dr. Jones joined MRHC's Medical Staff in June 2010. Dr. Jones received his undergraduate degree from The University of the South and earned his medical degree from St. George's University School of Medicine. He then completed his residency at the University of Mississippi Medical Center in Jackson, Mississippi. Dr. Jones is a member of the American College of Emergency Physicians.

MRHC is excited to welcome these two new physicians to our growing team!



For a complete listing of MRHC physicians, visit www.MRHC.org.



Use of Urinary Catheters in the Surgical Population

The Surgical Care Improvement Project (SCIP) indicators include a measure that recommends indwelling urinary catheters, if used, should be discontinued no later than postoperative day two. This recommendation is based on the guideline from the Centers for Disease Control and Prevention (CDC) for the prevention of catheter-associated urinary tract infections. In prefacing this guideline, the CDC states, "Urinary tract infections are the most common type of healthcare associated infections, accounting for more than 30 percent of healthcare associated infections reported by acute care hospitals. Virtually all healthcare associated urinary-tract infections (UTIs) are caused by instrumentation of the urinary tract (e.g. insertion of catheters). CAUTI has been associated with increased morbidity, mortality, hospital cost, and length of stay" (2009).

The initial consideration in indwelling catheter use should be appropriateness to the individual patient. Appropriate indications for use in the surgical patient include: acute

urinary retention or bladder outlet obstruction, strict measurement of output in critically ill patients, urologic surgery or surgery on contiguous structures of the genitourinary tract, large-volume infusions or diuretics during the intraoperative period, need for intraoperative monitoring of urinary output, and anticipated prolonged duration of surgery.

When indwelling catheters are used, they should be discontinued as soon as feasible, ideally in the PACU. The SCIP measure allows for a catheter to be left in place up to the second postoperative day, although the sooner the catheter is removed the better, preventing decreased bladder tone and increased risk of infection. External catheters are an alternative if incontinence is a consideration in the male patient. Intermittent (straight) catheterization is preferable to an indwelling device in urinary retention.

Proper aseptic technique and sterile equipment in insertion and maintenance, and early discontinuation contribute to decreasing the CAUTI rate. Currently, we see an aver-

age of two CAUTIs per quarter at MRHC. Regarding the SCIP indicator, our second quarter performance is at 88% compliance with the measure. Surgeons may find it helpful to utilize a standing order for removal of indwelling catheters in the PACU or on POD one or two, or an additional order to an existing order set. If the catheter must be maintained for more than two days, it is necessary to document the rationale.

For further information on this and other evidence-based core measure recommendations, please call the Quality Department at extension 3381.

Dr. Thomas Sweat Honored at NEMCC Corinth Library

On Friday, July 30th Dr. Thomas Sweat received a portrait prominently displayed in his honor on the wall of the NEMCC Corinth Library. Several representatives from NEMCC & MRHC attended the event. The library first opened in 2009 as the Dr. Thomas L. Sweat Library.





Risk Management

WHAT IS OUTPATIENT OBSERVATION?

The appropriate use of Observation Status is an ongoing challenge to most hospitals. The Centers for Medicare & Medicaid have noticed abuse of Observation Status in the past and therefore have set guidelines to assist physicians in determining the appropriate level of care designation for patients who need monitoring and evaluation. Observation Status continues to be an available option if the patient's clinical status and treatment meet the guidelines.

What is Observation Status?

Observation Status includes an extended period of time for assessment, monitoring, testing, and treatment by a physician and hospital staff to determine if a patient requires acute inpatient services or can be discharged.

When is Observation Status appropriate?

- Patient is stable but requires further testing and monitoring to define diagnosis, treatment, and/or management plan.
- Physician feels the patient will respond to treatment within 24 hours.
- An outpatient surgery patient who develops a complication

and because of this complication requires additional monitoring or intervention over and above what would normally be required post-operatively if the patient had not experienced the complication.

What does NOT qualify for Observation Status?

- Usual outpatient postoperative recovery time.
- Diagnostic testing.
- Continued stay for convenience of patient/family or doctor.
- Observation Status ordered before an outpatient surgery procedure.
- Patients awaiting placement in a long term care facility.

One particular area that causes confusion is the use of Observation Status following an outpatient surgical procedure. A patient should only be placed in Observation Status if there is a complication that requires monitoring and intervention beyond the 4-6 hour standard recovery period. Upon determination of a post-op complication, a "Place in Observation Status" order should be written, dated and timed, with supporting documentation regarding the medical need for this designation. Supplying the supporting documentation can be as easy as stating in the order "Place in Observation Status because....."

Can Observation Status be ordered prior to outpatient surgery?

No, since the determination is based on the patient's medical condition after surgery and must be supported by documentation in the medical record regarding what has actually occurred.

Can an outpatient surgical patient with no postoperative complications be admitted to Observation Status?

No, Observation Status is not to be used for the usual recovery time for an outpatient procedure.

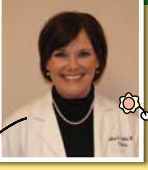
What post-op complications may warrant an order for Observation Status?

- Persistent nausea/vomiting
- Persistent fluid electrolyte imbalance
- Uncontrolled pain
- Arrhythmias
- Excessive/uncontrolled bleeding
- Psychotic behavior
- Unstable level of consciousness
- New deficit in mobility/coordination

If you would like some additional literature regarding "Observation Status," please let me know and I will gladly provide it to you.

Renee Bullard, 7673
Compliance/Risk Management

MRHC is excited to WELCOME
DR. BLAKLEY A. FOWLER to our growing team!




DR. BLAKLEY A. FOWLER - PEDIATRIC MEDICINE

BLAKLEY A. FOWLER, M.D., will join Magnolia Regional Health Center's medical staff in August 2010. Dr. Fowler received her medical degree from the University of Mississippi School of Medicine and completed her residency at Le Bonheur Children's Hospital in Memphis, Tennessee. Dr. Fowler is a member of the American Academy of Pediatrics.

DR. FOWLER WILL BEGIN SEEING PATIENTS IN AUGUST AT MAGNOLIA PEDIATRIC CLINIC.

TO SCHEDULE AN APPOINTMENT, PLEASE CALL 662.293.7390



401 Alcorn Drive, Suite 2B
Corinth, Mississippi 38834
Phone: 662.293.7390 • Fax: 662.293.7399

For a complete listing of MRHC physicians, visit www.MRHC.org.