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## Letter from CEO, Rick Napper

As all of you know, Congress has passed legislation to reform health-care. Although the full magnitude of the bill is yet to be determined, I would like for each of you know my thoughts regarding the impact of this legislation on MRHC.

First and foremost, the hospital inpatient/outpatient and inpatient psychiatric facilities will face a reduction in market basket adjustments equal to 3% from 2010 through 2019 and a decrease to productivity gains of 1.4% per year beginning in 2012.

Second, the government will create an Independent Medicare Commission to operate as follows:

- The Commission will submit proposals for the redirection of Medicare cost growth
- The Commission cannot ration care, increase revenue or change benefits
- The Commission's first proposal is expected in 2014
- The Commission will recommend

quality improvements and constrain costs growth in the private sector

- If the growth of Medicare does not decrease the Commission must make recommendations on how to eliminate growth

Third, this legislation does not include any fix to the current physician payment issues. Physician payment (SGR) will require separate legislation. Additional legislation will be required to avert a 21% reduction in physician payment. Medicare/Medicaid disproportionate share hospital (DSH) will incur a 75% decrease in 2015 for Medicare and Medicaid will decrease proportionately to the Medicaid insured patients. Beginning in 2013 inpatient hospitals will begin to recognize payment increases or decreases directly related to pay for performance measures that will be directly connected to HCAHPS data. Physicians will experience pay for performance beginning in 2011 for reporting and 2015 based on the data collected.

These are a few of the key issues facing healthcare. I want everyone to understand that over the last 36 months MRHC has diligently prepared for the changes of healthcare reform. I do not want to disregard the seriousness of this issue, but I also know that through our vision, strategic plan and focus on excellence, we are positioned to absorb the impending changes. It will take every employee's maximum effort and a constant team effort to overcome the hurdles our government placed before us. I will continue to keep you updated and will communicate changes as they occur. We are one community, one hospital, one team and we have one focus – our patients.

Respectfully,

Rick Napper, CEO

Attention Medical Staff  
"Breast Cancer:  
Diagnosis, Evaluation,  
Treatment"



The West Clinic and our Cancer Center are co-sponsoring a Grand Rounds April 13, 2010 from 12:00PM - 1:30PM on breast cancer. This features some of our expert clinicians and should be an excellent review. Topics will include the most recent recommendations related to breast imaging, the diagnosis of breast cancer and treatment modality. Indications presented by: Sylvia Richey, M.D., Bert Duncan, M.D., Graham Sexton, M.D.

April 13, 2010

12:00 noon

Conference Center

Lunch provided

RSVP-Jenessa Taylor ext-1142



## Vice-President of Physician Operations, Don Lloyd

P4P programs use financial incentives to stimulate improvement in the quality of care and stimulate reductions in costs.

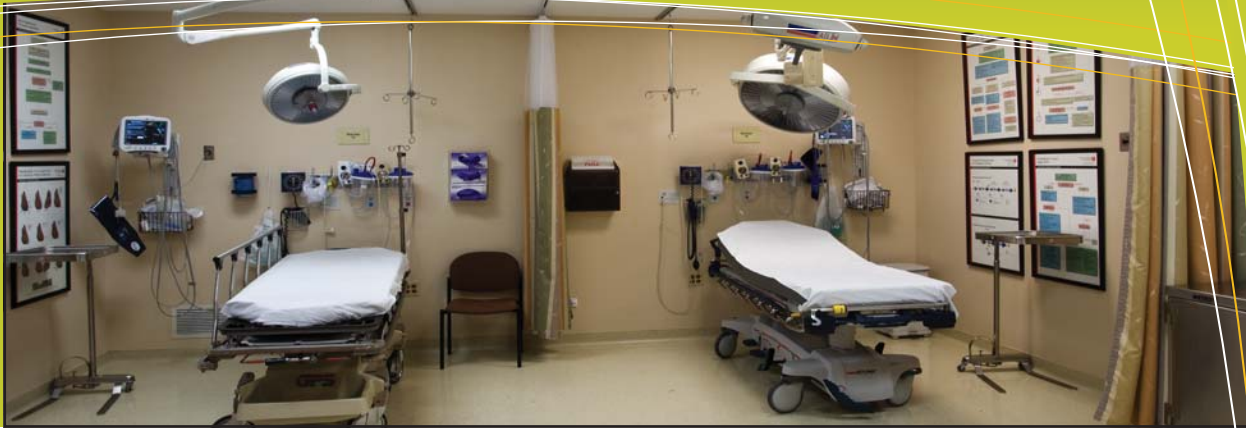
### Pay-4-Performance

P4P programs use financial incentives to stimulate improvement in the quality of care and stimulate reductions in costs. To achieve these goals, P4P programs use a variety of performance measures, including clinical processes of care and structural indicators such as the investment and use of Electronic Health Records. The financial incentives are funded through withholding a portion of current payments or future payment increases to existing payments, or sharing savings that accrue through reductions in expenses. The financial incentives may take the form of an increased payment for each service delivered or a bonus. Payments are made based on an individual provider or a medical group having achieved performance thresholds of a targeted service. P4P programs are being tested widely in an effort to encourage improvements in the quality, safety and efficiency of delivered care by measuring performance, making information

about a physician's performance public, and by paying differentially for performance.

In 2006 the government enacted the Tax Relief and Health Care Act that required the establishment of a physician quality reporting system, including an incentive payment for physicians who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries. CMS named the program the Physician Quality Reporting Initiative (PQRI). To participate in the 2010 PQRI, physicians may choose to report information on individual PQRI quality measures or measures groups to CMS on a CMS 1500 claim form, report to a qualified PQRI Registry, or to CMS directly via a qualified electronic health record product. Reportable services for PQRI are for services furnished to Medicare Part B beneficiaries including Railroad Retirement and Medicare Secondary Payers. Medicare Part C- Medicare Advantage patients

are not included in the claims based reporting of individual measures or measure groups. Physicians who meet the criteria for satisfactory submission of PQRI quality measures data via one of the reporting mechanisms will qualify to earn a PQRI incentive payment equal to 2.0% of the estimated Medicare Part B allowed Physician Fee Schedule. There are currently 175 reportable quality measures. More information on PQRI is available at [www.cms.hhs.gov/pqri](http://www.cms.hhs.gov/pqri) or by contacting Magnolia Practice Solutions (MSO) at 293.7684.



## Joint Commission Survey on the Horizon



As our triennial Joint Commission (JC) survey looms on the horizon we are working diligently to ensure that MRHC is at a continued state of survey readiness (Last Survey – September 2007). We have approximately 17 JC committees composed of multiple members who meet at a minimum of monthly to focus on processes that are currently being identified as “problematic” standards. As part of the work of our Record of Care Committee we identified two **physician relevant** areas that recently surveyed hospitals are reporting as high target areas for the survey process—a comprehensive authentication of orders (signature, **date and time**) and timely authentication of verbal orders (**48** hours). Upon review of our internal data

for the fourth quarter 2009, **36.7%** of the charts reviewed had orders that did not meet the authentication requirements set forth by CMS. Below you will find the COP that outlines the requirements. We ask for your assistance in improving these areas in preparation for our survey process.

### **Authentication of Verbal Orders** -- §482.24(c) (1)

**482.24(c)(1)(i)** All orders must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in paragraph (c)(1)(ii) of this section.

**482.24(c)(1)(ii)** For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to write orders by hospital policy in accordance with State law. (No previous tag)

**482.24(c) (1) (iii)** All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours.

## Medical Trivia

If you listen to “Hollywood,” Mississippi should be the last place to turn to learn anything about medicine. They couldn’t be more wrong. When it comes to modern medicine, Mississippi wrote the book. Literally. While at the University of Mississippi Medical Center, Mississippian Dr. Arthur Guyton wrote the *Textbook of Medical Physiology*, used by medical students around the world since 1956. The best-selling physiology book ever published, the textbook may very well be the best-selling medical textbook of any kind. UMC physiologist, Dr. John Hall, assisted Dr. Guyton with the ninth and tenth editions of the textbook. Upon Dr. Guyton’s death in 2003, Dr. Hall took over the textbook, thus continuing to help educate the finest future physicians in the world...through a book written right here in Mississippi. Mississippi. You could say we’re a textbook case for advancing modern medicine.



## E-Safety First

### Physician Computer Access/Mobile PI team update

A hardware performance improvement and implementation team has been formed to address hardware needs throughout the hospital in advance of CPOE (Computerized Provider Order Entry). The foundation process of the PCM project is Computerized Physician documentation and order entry. That process involves physicians logging onto devices to document and enter orders. Our team’s goal is to make that process change as efficient as possible throughout the facility as well as remotely from offices or homes. Part of the team’s effort was the recent product fair held at the Medical Staff meeting and in the Physician’s lounge where you had the opportunity to review several different products.

The results of the product evaluation fair are in. The winner of the I-Touch was Dr. James Gilmore. Out of 21 physician evaluations received, the computer on wheels came out on top. Here are the stats:

- DELL MINI 10 LAPTOP (2)
- PANASONIC H1 TOUGHBOOK (4)
- FUJITSU LIFEBOOK T4410 (5)
- COMPUTER ON WHEELS (10)

Comments that put the computers on

wheels on top included:

- “Easy to use”
- “I don’t have to carry it around”
- There is a “place for the chart on the top”
- “it’s familiar”
- I like the “big keyboard” and the “separate mouse”
- “No worries about dropping”

Thanks again for your participation in this important task. The next step will be to assessing the facility and determining the actual needs by location. Members of the PI team will be shadowing physicians and asking for recommendations for access and hardware needs. All areas will be evaluated – anywhere that physicians would possibly document patient care. If you have concerns for computer access, this is the time to have those concerns addressed.

### PHYSICIAN DESKTOP (PWM) – Physician Workload Manager

Physicians continue to become adept to PCM, Phase I which consists of the physician desktop and Clinical Review. Familiarity with these screens and knowledge of the navigation of Physician Desktop is the first essential step to CPOE and physician documentation.

Without this building block, physicians will lag behind their peers when Phase II is implemented. If you have not received an introduction to Phase I or need further information, please call Ext. 1723 to set up an individualized meeting at your convenience.



## P and T at a Glance: Urgent Information Edition

### **Diprivan (propofol)**

Recently there was a massive national recall of propofol due to the discovery of metal pieces in the product. As a result, one manufacturer has discontinued production, leaving only one manufacturer. This recall has led to increased demand across the nation. We have returned all lots in our stock due to this recall. Available product from the remaining manufacturer has been depleted. Production is now continuous, but current demand far exceeds the available supply. As a result propofol is being allocated in small amounts, and our current allocation has been depleted. We are scheduled to begin receiving small amounts this month, but supply will be limited and sporadic. Hospira, the manufacturer, expects to be able to meet normal market demand by mid-February 2010. Until product is available, possible alternatives are:

- etomidate – general anesthesia
- Versed (midazolam) – sedation for mechanical ventilation

### **Multi-vitamin injection (MVI)**

There is currently a problem with the manufacturer's ability to supply MVI. According to our supplier, the problem is resolving, but product will not be available until at least mid-February 2010. We are

able to obtain MVI sporadically through secondary suppliers.

### **Vasotec (enalaprilat) Injection**

Enalaprilat IV is on short-term backorder with an estimated availability date of 1/11/10. We have been able to get a limited supply from alternate sources, but hopefully we will be able to obtain normal quantities of this item during this month.

### **Pentothal Injection**

There has been a manufacturing issue with this product. Production is projected to start again this month with deliveries by the end of February.

### **Heparin Drips**

Baxter Healthcare, has informed us that production of premixed heparin in D5W drips will cease for a limited time. MRHC uses this presentation of heparin in dextrose. Baxter does not anticipate any problems with heparin in 0.9% NS. As the heparin in dextrose becomes unavailable, facilities may decide to use the premixed heparin in saline hence causing a supply problem with that presentation as well. We are currently ordering extra supplies of the heparin we use in an attempt to make it through this time of short supply. Baxter will not define a timeframe for this

supply issue, so eventually our surplus will be depleted.

In the event our stock is depleted other options include using heparin in saline or mixing each drip on demand as it is needed.

MRHC Pharmacy is committed to providing the products our patients, physicians, and staff need. We will keep you informed on these shortages as the information becomes available to us. If you have any questions please contact Todd Cox, PharmD. The FDA website also provides information concerning current drug shortages.

### **COMMITTEE MEMBERS**

#### **Physician Members:**

Dr. Phil Mathis, Committee Chairman  
Dr. Zina Lee  
Dr. Graham Sexton  
Dr. Nanni Pidikiti  
Dr. Tina Jobe

#### **Non-Physician Members**

Ronny Humes, COO  
Shelia Calvary, RN, CNO  
Dr. Bill Jones, Director of Lab  
Katrina Taylor, PharmD  
Todd Cox, PharmD, Director of Pharmacy

## MEDICAL STUDENT PROGRAM:

Our current Fourth Year PCSOM students have matched into residency programs and will be leaving MRHC at the end of April. PCSOM graduation will be held May 8, 2010. Please join us in wishing them well.



Clacy Camel matched into a Psychiatric Residency at University Mississippi Medical Center in Jackson, MS.

Brian Lindsey matched into a General Surgery Residency at Michigan State University/Oakwood SouthShore Medical Center in Trenton, MI.

Amanda Johnson matched into a Transitional Rotating Internship (with a Radiology focus) at Samaritan Health Hospital in Watertown, New York .



## Osteopathic Medical Education

### Medical Staff

We would like to take this opportunity to say Thank you to all of our preceptors for making this a terrific academic year and invite you to our "Fiesta" on April 15th. Please join us to celebrate the graduation of our Medical Students and to recognize our residents & physicians. The Fiesta will be held on Thursday, April 15th at 6:00 p.m. at the Nappers' home located at 100 Covewood Lane. Please RSVP by calling 662-293-1142.

This is our time to recognize our Graduating Medical Students and Resident Level Advancement and to Thank YOU for all you are doing to help us fulfill our departmental mission, which is: produce skilled, competent, ethical, compassionate

physicians through an academically rigorous training program as it relates to the prevention, diagnosis and treatment of diseases, while utilizing osteopathic principles centering on treating the whole person

### INTERNAL MEDICINE RESIDENCY

It is MATCH SEASON and MRHC has extended contracts to 6 residents for the upcoming year. We will post our incoming resident information in the next newsletter.

Medical Staff: Please tell us who you think should receive the Resident and Intern of the Year Award. Who, in your opinion, stands out above the others because of: knowledge base, enthusiasm, dependability, professionalism and eagerness (or any additional qualities you deem important not mentioned)

Please return BY April 10th to Gena Lindsey or call 662-293-7686. Your votes will be tabulated and the acknowledgement made at our Fiesta.

Person who should be named Intern of the year:

- Michael Hawley
- Charles Swanson
- James Delgadillo

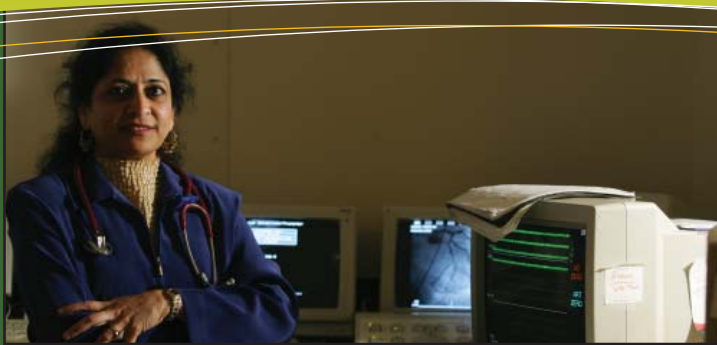
Person who should be named Resident of the Year:

- Aaron Earles
- Christina Brown
- Baron Herford

## NOVA Faculty Agreement

It is not too late to return your Nova Preceptor Faculty Agreement. Your password will be sent via email.

By agreeing to participate with the student and resident program you will receive an UP TO DATE Subscription, CME credit and Faculty Membership to add to your CV.



## Order Set Development

Even though CPOE implementation and roll-out to physicians does not begin until April, 2011, the planning and analysis phase of the project is well underway. This phase is the foundation upon which CPOE, physician documentation, and ambulatory prescription management are built. If the planning phase is successful, it will lead to a smooth implementation and end user convenience. Remember "Failing to plan is planning to fail."

The planning phase of CPOE begins with order set standardization and development on paper before converting to electronic order entry. A sub-committee of the PCM (Physician Care Manager) Core team has been formed to address order set development, deployment, and governance. Members of the team are Angela Jackson, Chief of Organizational Excellence; Rebekah McPheters, RN, Clinical Analyst, Order Set Development Project Leader; Elwanda Whitaker, Director of Quality Services; Dr. Gene Combest, CMO; Joy Joyce, Director of Health Information Management; Todd Cox, Director of Pharmacy; Ginger Robinson, RN,

Nurse Manager; Christi Rousseau, RN, Clinical Analyst, PCM Project Manager; John Lentz, RN, Clinical Analyst, Physician Documentation Project Manager; Sue Dye, Quality Services; and Steve Burton, Pharmacist. This team will be working closely with all physicians to devise standardized order sets for use during CPOE implementation.

MRHC has contracted with ZYNX Health to provide physicians with clinical decision support with access to current regulating body recommendations (CMS, Joint Commission, etc.) and current evidence-based practices. Owned and lead by the quality department and case management, the project consists of a review of current physician order sets with a comparison to ZYNX's recommended order sets based on patient diagnosis or DRG. The case managers will then work one-on-one with physicians to determine if they want to modify their orders based on these recommendations. This will be a huge benefit for physicians in meeting core measures and decreasing length of stay. Training for the builders of the electronic order sets was completed in March,

and order set development has begun.

Standardization of order sets based on diagnosis will also be addressed as this is the foundation for CPOE. Order sets are being reviewed for commonalities based on an 80/20 rule of order frequency. Your input on order set development and standardization is crucial to ease of use when CPOE is implemented. The target date for completion of order set development is August 2010. With over 400 current MRHC order sets to review, the team is faced with a monumental project in a small amount of time.

This is YOUR project – it will only succeed with your involvement.