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Letter from CEO, Rick Napper

It's time to welcome a New Year and prepare ourselves for the challenges that will follow. With 2010 in our rear view mirror and 2011 ahead, we see a big change in the political faces but the same challenges which face our country and industry remain. The cost of healthcare will continue to be a priority, as the first group of baby boomers reach the age of eligibility and their life span continues to lengthen. Our challenge remains clear - present a unified front which requires the medical staff and hospital to work together on a strategy which creates flexibility. Healthcare reform will once again be a cry from Congress, but I expect this process to be protracted and painful.

The new year brings more challenges for the Medical Executive Committee as Dr. Hsu and his committee assume the reigns. This year will be filled with success stories related to CPOE and other informatics initiatives. The impending challenges of individual physician quality and satisfaction measures will gain steam across our country as MRHCs VP of Organizational Excellence prepares the hospital and medical community to be on the leading edge of this challenge.

MRHC will continue to focus on growth in all aspects of healthcare while maintaining our financial security. Through a joint effort of the BOT, Medical Staff and Administration, we will tirelessly work to improve our organization's market position and monitor the state and federal issues which may impact our future.

Although the challenges are quite impressive, the strategic foundation we have built is secure in addressing future change, regardless of what may come our way. We have created a culture which affords us the ability to move in a number of directions while adjusting to the changing environment. As we proceed into the New Year, I believe that Richard Nixon made a very appropriate comment relative to the culture we find ourselves in. He said, "Any change is resisted because bureaucrats have a vested interest in the chaos in which they exist." As we reflect upon our current political process, the chaos we see challenges us to determine our path by which we must navigate the chaos. Thus our challenge is to project the future, establish a direction, utilize our compass (the patient) and set sail to a better environment of care. Happy New Year and thank you for all you do.

Respectfully,

Rick Napper, CEO



Vice-President of Physician Operations, Don Lloyd

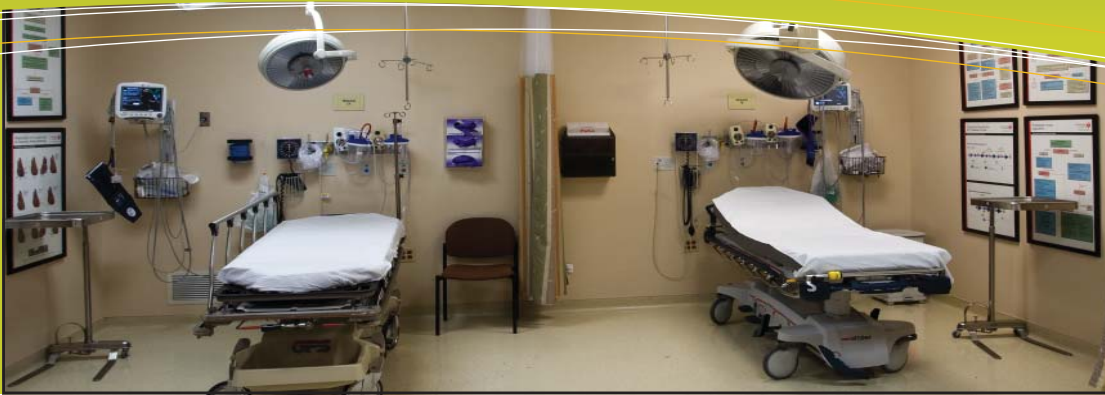
A Medicare overpayment is a payment that a physician has received in excess of amounts due under Medicare regulations.

Medicare Physician Billing Update “Overpayment”

A Medicare overpayment is a payment that a physician has received in excess of amounts due under Medicare regulations. Once a determination had been made, the amount of the overpayment becomes a debt owed by the debtor to the Federal government. Federal law requires the Center for Medicare & Medicaid Service to seek recovery of all identified overpayments. When Medicare discovers an overpayment of \$10.00 or more the overpayment recovery process is initiated. A demand letter will be sent requesting payment. The letter will explain that interest will accrue from the date of the letter if the overpayment is not received by the 31st day. If no response is received from the physician 30 days after the date of the first demand letter, a second demand letter will be sent. If full payment is not received 40 days after the date of the first demand letter, recoupment procedures will

begin on day 41. Recoupment means that the overpayment will be recovered from current payments due from future claims submitted. If a debt has not been paid or recouped (unless a valid appeal had been filed) a third demand letter will be sent 120 days indicating that the overpayment may be eligible for referral to the Department of Treasury for offset or collection. If the physician is unable to pay the entire amount of the overpayment, the physician can contact Medicare and request an extended repayment plan.

A physician may submit a rebuttal statement to Medicare 15 days from the date of the first demand letter. If the physician disagrees with the overpayment, they may also file an appeal with Medicare. The appeal must be filed 30 days from the date of the first demand letter. If you have questions about the Medicare overpayment process, please contact the TSPO office at (662) 287.6913.



Effective Communication in the Physician-Patient Relationship: Part Three

Last month's article introduced steps to maximizing the effectiveness of patient-physician communication and developing a therapeutic relationship. These initial steps were described as assessing what the patient already knows, what he wants to know, and the importance of speaking slowly and simply with empathy. This month we'll continue the advice offered by Travaline, Ruchinskas, and D'Alonzo (2005) on building rapport.

- Tell the truth. In addition to being truthful, it is important not to minimize the facts, especially when delivering bad news. Euphemisms may easily be misinterpreted and confusing. Although the "D" words (death, dying, died) may seem cold and unfeeling, when used appropriately they clearly convey the circumstances.
- Be hopeful. Never underestimate or discourage hope. In situations where death is imminent, great comfort can be conveyed by offering assurance that pain and suffering can be minimized.
- Be aware of body language. Images of facial expressions and body language have last-

ing impact. Nonverbal cues offer indications of emotion, level of understanding, and interest. And while researchers disagree on just how much human communication is accomplished non-verbally, most contend that over 50% of emotion and attitude is relayed in this manner. Recognize and respond appropriately to the patient's behavioral cues. It is equally important to be aware of one's own non-verbal expressions and the implicit messages they send.

- Be prepared for a reaction. The patient's reaction to physician communication may range from stoicism to a frank display of emotion. Recognize the response and allow sufficient time by listening attentively. Here again, body language can be crucial in conveying empathy.

Just as there are practical steps to improving rapport and communication skills, there are also barriers to building effective therapeutic relationships. These include using technical language, not listening or showing appropriate concern, failure to verify

understanding, being too impersonal or appearing apathetic, and not being sufficiently available.

Be aware that communicating the results of diagnostic testing is a physician responsibility, as nurses, therapists, and technicians are very limited in the information they can disclose to a patient. Relaying the results of tests should be tailored to the patient's level of understanding and desire for information. Results should also be shared with the patient and/or his designee in a timely manner. Patient satisfaction scores may be adversely affected if the patient perceives he has waited too long to receive findings.

In conclusion, communication is a skill that can be learned, practiced, and polished. Further, the information that is communicated can, and should, be customized to the individual patient and clinical situation. Finally, given current time constraints, the quality of communication is essential in all interactions.

Travaline, J.M., Ruchinskas, R., & D'Alonzo, G.E. (2005). Patient-Physician communication: why and how. *Journal of the American Osteopathic Association*, 105, 13-18.



E-Safety First

Okay, let's start from the beginning. I am going to go Dolly Parton on you and give you some "Straight Talk". You went to medical school and you graduated. You made it through residency and are now great doctors serving your community and saving lives and making things better. You shouldn't be bothered with all of these restrictions and guidelines. You just want to practice medicine.

Well, that's what we want for you too. But because the guidelines, restrictions and rules are in place, we want to help you as you document the way you care for your patients. We want the best for your patients also. They are our patients too. So, what is CPOE? Why are we, Magnolia Regional Health Center, implementing an electronic health record?

Computerized Physician Order Entry or CPOE is just that. Physicians, or in some cases, providers enter their orders through the computer. Well, that is what it meant when it first started. Now it can include others services that aid the physician with prescriptions, documentation, and discharge teaching and instructions. According to "Open Clinical: Knowledge Management for Medical Care", here are some definitions that you might find helpful:

CPOE systems are "clinical systems

that utilize data from the pharmacy, laboratory, radiology and patient monitoring systems to relay the physician's or nurse practitioners diagnostic and therapeutic plans and alert the provider to any allergy or contraindication that the patient may have so that the order may be immediately revised at the point of entry prior to being forwarded electronically for the targeted medical action."

"Computer-based Provider Order Entry-CPOE is the portion of a clinical information system that enables a patient's care provider to enter an order for a medication, clinical laboratory or radiology test, or procedure directly into the computer. The system then transmits the order to the appropriate department, or individuals, so it can be carried out. The most advanced implementations of such systems also provide real-time clinical decision support such as dosage and alternative medication suggestions, duplicate therapy warnings, and drug-drug and drug-allergy interaction checking."

The article goes on describe some CPOE functionality and benefits:

- Enables doctors to enter prescription, lab, test and other orders for patient care straight into a hospital

information system

- Replaces hand written orders (legibility, completeness, readily and quickly accessible, improved communications between physician and pharmacist; no delay or loss...)
- Supports ready access to patient data and patient assessment
- Can help improve patient safety and prevent medical errors and adverse drug events by checking the dosage etc. of medication given to patients by physicians or other health care professionals
- Supports improved recording, data trails, quality assurance and error awareness and reporting
- Potential to improve efficiency and resource usage by integrating different departments-laboratory, imaging, nursing and medication records
- Cost-effectiveness benefits:
 - » Can reduce additional and often unavoidable costs (clinical, litigation...) that can result from medication errors;
 - » Can show test and medication costs-potential to reduce prescription costs
 - » Can reduce the number of duplicate tests



E-Safety First

....continued

I can hear you now. Yes, I know that a computerized system can and does have some draw backs and in my effort with "Straight Talk", I will list some here:

- Risk of system generating medication errors e.g. through incorrect configuration of physician input
- Systems can't be bought "off the shelf" leading to integration issues with legacy systems-which may themselves need to be upgraded to support CPOE implementation
- A system may require a great deal of on-site customization prior to deployment to integrate with workflow processes of an individual hospital
- User resistance to introduction of computer based technologies
- May disrupt workflow for (and slow down) physicians, pharmacists and nurses, particularly if actions to try to ensure ready adoption in practice have not been carried out such as involvement of end users at development and implementation phases, usability testing with end-users, training, support
- May generate extra unnecessary information e.g. relatively unimportant alerts

But now that I have listed the issues, may I tell you what we are doing as a team to try to prevent or minimize these draw-backs? And maybe suggest how you as a physician can help too?

- The Physician Care Manager (PCM-what our CPOE system is called) core team is working hard to build a system that is user friendly, and built, as best we can, the way YOU want it. A Physician Advisory Committee (PAC) has been formed. It is made up of twelve practicing physicians, a nurse practitioner, and several chief officers. They have volunteered their time and expertise to make decisions as your representatives and help the team achieve consensus. Of course, if you have something you would like to suggest, we would love to hear from you.
- Some of the decisions we are taking to the PAC committee involve the Clinical Decision Support (CDS) rules. Clinical Decision Support includes: medication checks-drug dose, allergy, and interaction checking; duplicate order notification; access to clinical reference information. To minimize alert fatigue, we are asking the PAC committee what information that they feel would be the most helpful to you as you practice. We want to eliminate anything that you might feel unnecessary.
- Knowing how to use the system and practicing it will help eliminate entry errors. I'm here to help you learn any new functionality that we offer. Please utilize that training

option so that you will be more prepared when the system goes live. You will be given an opportunity to practice in Test prior to the roll-out. There will be 24/7 support when the roll-out begins. There is an on-call person available to you nights and weekends.

- Your work flow will be disrupted. You will probably have to learn a new work flow. Your rounding will take more time (at least in the beginning). If you will hang in there and spend that time in the beginning, we feel that after the new system is learned that your time will factor out as neutral if it doesn't make your processes quicker. Remember that you will save time waiting for labs, charts, and other test results. When you enter the order, the middle guys are cut out. Your order goes straight to the source and should be carried out more quickly.

I hope you will appreciate my candor and even if you don't see the light at the end of the tunnel will you trust us to be your guide into the future of medical documentation in a technological world?

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CPOE Physician Advisory Committee

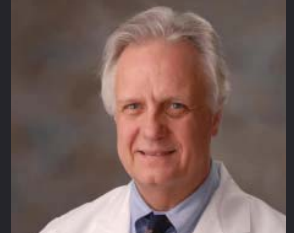
MEET YOUR TEAM



William Bell, MD
Emergency Medicine



Gene Combest, MD
VP of Medical Affairs



James C. Gilmore, MD
Cardiothoracic Surgery



Randall Frazier, MD
Orthopaedic Surgery



Michael Hawley, DO
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Patrick Hsu, MD
Obstetrics & Gynecology



James Jacque, MD
Anesthesiology



Mathew D. Johnson, MD
General Surgery



Carla Bray, FNP
Family Medicine



Robert McKinney, MD
Internal Medicine/Peds



Oneka Richardson, MD
Internal Medicine/Hospitalist



John W. Prather, MD
Cariology



Carl Welch, MD
Family Practice



Corporate Compliance

Lab Requisitions

On December 20, 2010, I sent out a memo to physicians and non-physician practitioners (NPP's) that beginning January 1, 2011, physicians and NPP's must sign all lab requisitions according to the final 2011 Medicare Physician Fee Schedule. On or about December 22, 2010, CMS delayed enforcement of the lab requisition signature requirement until April 1,

2011, so that providers would have more time to educate their medical staff and other facilities such as nursing homes.

It appears that the American Hospital Association, along with several other healthcare organizations, sent letters to CMS opposing what they termed "redundant and burdensome" signature requirements on a lab requisition which is generated from an Order

for the lab test in the patient's chart. CMS has announced on its website that it will spend the first quarter of 2011 educating providers. Providers are basically in a wait-and-see mode and the educational material should help predict which way things will go. I will keep you updated regarding this issue.

Renee Bullard, 7673
Compliance Officer/Risk Manager

CDI Corner

This month's topic is focused on BMI and the reporting of severity that accompanies either the greatly elevated or decreased BMI values of a patient.

The BMI is calculated in Meditech by the height and weight that is entered on admission. Obviously, this number will vary per patient, per admission and can have a significant effect on the care that is provided while admitted. If your patient has a BMI value of < 19 or ≥ 40 , then corresponding documentation of patients appearance, nutrition status, etc. will help in the clarification of the clinical picture. Please remember to note the BMI of your patient in your documentation, especially if it falls within the parameters listed above. This will help reinforce

the complexity of care for the malnourished / obese patient.

Documentation should be specific, clearly written, and repeated throughout the medical record. This helps the coders who depend on this documentation to provide the information needed to accurately "transform" the visit into codes. These codes ultimately reflect the severity of illness, which reflects on the time and resources utilized in the care of the patient.

"Rule of Thumb for Documentation" If it isn't documented, it can't be coded, it didn't happen.

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