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Magnolia MedLink

Linking Physicians and MRHC

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Letter from CEO, Rick Napper

As the Healthcare Reform legislation continues to be developed we can expect that there will be a number of changes and adjustments as the different offices related to healthcare, create review and change, the guidelines which effect the final law for implementation. However, after my recent visit to Washington D.C., I felt some relief knowing that legislators understand the bill which passed continues to be incomplete and filled with challenges. The greatest of those challenges has recently been discovered as CMS scored the cost and found that the CBO had more than likely underestimated the cost of the plan. There is no doubt that as a medical community we will be facing challenges which present both opportunities and threats, it will be up to us to determine our direction and how to navigate the rough waters ahead. I feel confident that we have a solid foundation and through our continued focus on the initiatives already underway that we are up to the challenge. Clearly, patient satisfaction, clinical outcomes and information technology are at the core of future success. Before my visit to Washington my number one concern was the potential 21.5 percent cut to physician payments. After my visit, I feel somewhat relieved that there will be a temporary (one year) fix, to be followed by a five year plan. I know this is not a permanent fix but with the uncertainty of cost related to Healthcare Reform, it is a victory.

I encourage all physicians to continue to closely monitor the political environment and maintain close contact with our representatives in Congress. The situation remains fluid and will change frequently, therefore your efforts, although tiring, are needed, this is not a sprint but a marathon.

As always thank you for your dedication and service to your patients and our community.

Respectfully,

Rick Napper, CEO

A new project designed to foster better communication between physicians and nurses (both floor and case managers) is in the planning stages.

Vice-President, Medical Affairs
Gene Combest, MD

In a discussion with Neida uqua, Director of Case Management, I was informed that within the next few months the 5th Floor will become the initial focus of improved rounding techniques. The project will focus on improving nurse participation in physician rounding. If we establish a collaborative practice between the physician, his or her case manager and the nurses on the floor, we should see an improvement in patient satisfaction. This initiative will also aid in improving the smooth delivery of patient care. The goal is to better inform the patient and his or her family of reasonable goals and expectations of care during hospitalization with respect to treatment and discharge planning. Please do your best to include floor nurses and the patient's family in the rounding process when this new project begins.

Vice-President of Physician Operations, Don Lloyd

Whatever policy your practice develops to deal with patient no shows, make sure that it is widely publicized to all patients.

How to deal with Patient No Shows

Physician practices that track no shows and cancellations average less no shows and fewer cancellations, according to an MGMA information survey. To reduce the number of no shows, the following patient appointment reminder techniques were used:

- 75% had staff make reminder calls prior to the appointment
- 20% sent reminder postcards or mailers
- 18% had an automated attendant system make calls
- 6% used an outside vendor to handle reminders and confirmations

When patients missed an appointment:

- 70% of practices do not charge the patient
- 10% charge only for chronic no shows and cancellers
- 8.4% charge for the appointment (75% of these charge a flat fee rather than the full appointment charge)
- 7% charge after one missed appointment

In order to reduce the number of no shows, I recommend using the following practices:

- Develop customer friendly relationships with your patients to increase their commitment to your practice
- Schedule appointments within a reasonable time of the patient's call. The longer the lapse, the greater the chance of a no show
- Switch to open or advanced access scheduling to provide appointments the same day a patient is looking for an appointment
- Remind patients of their appointment and ask them to confirm their commitment to the appointment
- Monitor your no shows. Are they more apt to be covered by a payor based on the number of visits in a calendar year? Example, Mississippi Medicaid allows 12 office visit per year, or is there some other factor that prevents them from honoring their appointment
- Develop a policy for dealing with repeat offenders. Specify how future appointments will be handled

Charging patients who miss appointments is an option. Mississippi Medicare does allow physicians to charge Medicare patients directly for missed appointments, provided that they do not discriminate against Medicare patients but also charge Non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself, but rather a charge for a missed business opportunity. Other options include contacting the patient for reasons for missed appointments and reiterating the value of the physician's scheduled time, scheduling repeat offenders at times that will be less of an impact to the practice, including double scheduling their time and discharging the patient after multiple no shows with attempts by the practice to contact the patient. Whatever policy your practice develops, make sure that it is widely publicized to all patients. For more information on Practice Management best practices, please contact Magnolia Practice Solutions (MSO) at 293-7684.

Clinical Documentation Improvement

WELCOME, to the first edition of "CDI Corner".

MRHC recently embarked on a very important initiative called Clinical Documentation Improvement (CDI). While Quality Services and Health Information Management will be taking a lead role in this project, many of the initiatives within this project will depend upon physician participation, support, and leadership.

As the Clinical Documentation Specialist (CDS), you will begin to see me on the nursing units alongside Case Managers and Nursing staff. My unit visits will involve concurrent record review, in collaboration with physicians and allied health professionals, to ensure that the information in the medical record is accurate. My involvement with the medical coding staff will be to support that appropriate clinical severity is captured for the level of service given to our patients.

Accurate and complete documentation benefits everyone: the patient, the physician, and the hospital. The goal for our program is to develop and implement methods to improve inpatient documentation to accurately capture the acuity of patients admitted. Secondly, we want to produce clinical documentation that supports the high clinical quality care that is received by our patients here at MRHC, along with allowing appropriate code selection, valid patient acuity, and an appropriate case mix index. This all results in proper designation of severity of illness, risk of mortality, and reimbursement for the inpatient care provided. Additionally, accurate documentation reflects the expertise of the physicians providing care and helps to improve and maintain excellent results on the Physician and Hospital Scorecards.

As with the Core Measures initiative started just a few years ago, there will be some adjustments that must be made to ensure a successful program. (You all have done a great job increasing the Core Measures compliance scores!!)

Being new to this role, I am, of course, in training myself and would welcome any comments, suggestions, or examples of previous experiences from other facilities that you can provide. I look forward to working with each of you, and if you have any questions or feedback, please contact me at 293-1089 or ehamilton@mrhc.org, or Sue Dye, Director of Quality Services at 293-3381 or sdye@mrhc.org.

Look for more information and updates as the months progress!! Thanks for all that you do!

- Erik Hamilton,RN

Medical Trivia

Health care in Mississippi. It is by no means back-woods or antiquated, as is often Hollywood's interpretation.

In fact, Mississippi was home to the first-ever heart transplant … and the first-ever lung transplant … and the first-ever kidney autotransplant. All performed by Mississippian Dr. James Hardy, a surgeon at Mississippi's University Medical Center.

Yes, Mississippi. We were the first in the world to have a change of heart. Now isn't it time the rest of the world had a change of heart about Mississippi?

Physician and Staff Computer Access Request Update

In response to our recent security audit, MRHC's I.T. department has updated the Security Access Form (SAF) and the Information Security Agreement (ISA). All users are being ask to complete the forms so that our user database is up to date for the CPOE and the Single Sign-On projects. All physician offices have received copies of the new forms and we request they be completed and returned to the IT department by Friday May 7. Our response rate is currently at 47%. If you have not done so, please insure your office staff complete, sign and return the forms to the IT department. The forms may be dropped off, mailed to MRHC IT dept, 611 Alcorn Dr, Corinth, MS 38834, scanned and e-mailed to ithelpdesk@mrhc.org or faxed to 662-293-4286.

E-Safety First

Just as every construction project has a sound foundation upon which buildings are constructed, so does the medical staff project for documentation, ambulatory prescription management, and order entry. Physician Desktop and E-signature are essential foundations for successful implementation of CPOE (computerized physician order entry) and electronic documentation.

To date, 65 % of all active medical staff, residents, and medical students have been trained in the use of the physician portal for MEDITECH Physician Desktop and Clinical Review – and the training continues. This is an essential first step in preparing for Phase II of the Physician Care Manger which encompasses physician documentation, prescription order management, and physician order entry. Those physicians who utilize the desktop and become familiar with Clinical Review will have a distinct advantage over those who do not in advance of physician documentation and CPOE. If you have not yet been introduced to the physician portal and would like to view the functionality, you can call ext. 1723 to set up an appointment for a demonstration and coaching session scheduled at your convenience.

The ability to E-sign documents in MEDITECH means you'll rarely have to visit Joy Joyce in medical records again – unless you want to! As with the Physician Desktop, about 65 % of active staff physicians, residents, and medical students have enrolled in the E-signature functionality.

Used in conjunction with the MEDITECH Physician Desktop, physicians can view a list of all medical records that require their signature and be able to sign all documents by entering a 4-digit pin number. The physician merely pulls up a compiled list of tasks that needs to be signed. At this point, he/she has the ability to view the document, make edits, and/or sign. Multiple documents can be signed at one time saving the physician time and energy - fewer visits to medical records without suspensions of privileges until documents are signed! And this can be accomplished remotely – from your home or office. Imagine sharing breakfast with your family while you sign your medical reports for the day from your personal laptop! To enroll in e-signature functionality, contact Joy Joyce at ext. 1261. She will be happy to set you up and demonstrate use of your personal e-signature.

As with every construction project, the final product is only as good as the foundation upon which it is built. Physician Desktop and E-signature are essential prerequisites to all physician documentation through MEDITECH. By utilizing these building blocks, you are setting an example for others and demonstrating the type of leadership crucial to the implementation of this project as well as positioning yourself for success with CPOE.

What is Medical Necessity?

Medicare defines "medical necessity" as services or items reasonable and necessary for the diagnosis or treatment of a patient's illness or injury or to improve the functioning of a malformed body member. Claims for services which are not medically necessary will be denied but not getting paid isn't the only risk. If Medicare or other payors determine that services were medically unnecessary after payment has already been made, they treat it as an overpayment and demand that the money be repaid with interest. Additionally, if a pattern of such claims can be shown and the physician knows or should have known that the services were medically unnecessary, the physician can be prosecuted for fraud under the False Claims Act by the Office of Inspector General. Violators face penalties of up to $10,000 for each service, an assessment of up to three times the amount claimed, and exclusion from federal and state health care programs. This is happening all across America where physicians, hospitals, home health/hospice organizations, DMEs, etc. are being excluded from the Medicare and Medicaid programs.

Documentation plays a vital role in proving medical necessity. Journey back to grade school grammar lessons for a moment and think of the "interrogative pronouns" who, what, where, when and why:

- **Who** – Performing, supervising and referring practitioners.
- **What (and How Many)** – Services and quantities of services performed.
- **Where** – Place of service.
- **When** – Date of service.
- **Why** – Medical necessity and diagnosis.

Considering the potential financial and legal liabilities tied to mistakenly filing a claim the physician believes to be medically necessary, the question becomes what can be done to protect against claims which are denied for not meeting medical necessity. For a service to be considered medically necessary, it must meet all of the following:

- Appropriate in duration and frequency.
- Meets but does not exceed patient's medical need.
- Provided in accordance with accepted standards of medical practice.
- Not experimental or investigational.
- Performed by qualified personnel in an appropriate setting.

Medicare and the courts have concluded that it is reasonable to expect physicians to comply with published policies or regulations that are available with regard to medical necessity. If a physician does not read Medicare's publications but delegates that responsibility to others, the physician or professional corporation may still be held liable for what the physician should have known.

If you would like to have some recommendations regarding publications that deal with Medicare and Medicaid, please let me know and I will be glad to provide this information.

Renee Bullard, 293-7673
Compliance Officer

Attention All Ward Clerks and Nursing Staff:

The ADA (Diabetic) diet on the Medi Tec system has been adjusted 4/28.

Where you used to put in Diabetic under the diet drop down menu, you now must select Diabetic with a calorie count option 1200, 1500, 1800, 2000, 2200, 2400.

This change was made in both the Medi Tec and Gem Serve systems in order to better serve our patients dietary needs where carbs & sugars are concerned. Any questions, please feel free to call the diet office at 1134 and speak with Nena, Charity, Tammy or Vanda.

Thank You,

Vanda Lee
Food Service Director
Magnolia Regional Health Center

Xopenex Therapeutic Interchange with Albuterol

MRHC recently participated in a retrospective study comparing Xopenex and Albuterol. The data for the study was collected and the results were compiled by Healthtrust Purchasing Group. Seven published studies were reviewed as well as data submitted from various hospitals within our buying group.

The results from this retrospective study revealed there were no significant differences in the side effect profiles or efficacy when these two medications were given in equivalent doses. These findings were reported to the P & T Committee on March 2, 2010. After a discussion and review of these findings the P & T Committee approved the automatic interchange Xopenex (levalbuterol) with therapeutic equivalent dosing of albuterol. This initiative is to begin April 1, 2010.

On March 11, 2010, a letter to the Medical Staff was placed in the mailbox of each physician explaining the decision of the P & T Committee. The Medical Staff letter also contained dosing for therapeutic interchange. A copy of the Medical Staff letter is included here and is also available upon request from the Pharmacy Department. A copy of the results of the study is also available upon request from the Pharmacy Department.

Reporting of Medication Events to Physicians

Pharmacy is required to compile and grade Medication errors. This is a requirement of The Joint Commission (TJC). During a recent mock survey one of the surveyors discovered MRHC did not adequately identify when a physician is to be contacted in the event of a medication error. At MRHC, medication errors are graded with letters A, B, C, D, E, F.

The Medication Error Reporting Policy has been updated to include the following statement: "Proper channels include notification to the attending physician when the error is deemed clinically significant (and all errors rated C, D, E, or F)." The addition of this statement clarifies when the physician is to be notified of a medication error. A copy of this policy (Medication Error Reporting Policy # MM_004) can be found on the MRHC intranet.

List of Medication Shortages

1. (M.V. I) Multivitamin Injection – sporadically available through secondary medication suppliers. Projected availability is the end of April or early May. We have been able to keep adequate supply to meet the needs of our hospital.
2. Entsol Mist – Not available. Projected date of availability is the end of May. ENTSOL gel and packets are still available at this time.
3. Nimbex (cisatracurium) - Sporadically available through secondary medication suppliers. We have been able to keep a very limited supply.
4. Pentothal (thiopental) – Not available. Projected date of availability is the end of May. This date has been extended several times over the past few weeks.
5. Ephedrine Injection – Not available from our primary wholesaler. We currently have adequate supply. Projected availability date is August.
6. Keppra (levetiracetam) Injection only – Not available at this time. Projected availability date is the end of April. We currently have a limited supply of Keppra injection. If Keppra IV is needed, patients should be switched from IV to PO as soon as clinically possible.
7. Cerebyx (fosphenytoin) Injection - The manufacturer of the brand name product has discontinued making it. The generic product is only sporadically available. It is on long-term backorder. The earliest projected availability date is the end of May. We currently have a very limited supply.
8. Cancidas (caspogungin) Injection – A limited supply can be drop-shipped through our wholesaler. This is an echinocandin antifungal. We have Mycamine (micafungin), another echinocandin that is actually the preferred product when an echinocandin is appropriate. Cancidas is on long-term backorder with no release date available at this time.
9. Reglan (metoclopramide) Injection only – Sporadically available through secondary medication suppliers. Earliest projected availability date is the end of May.

Please keep in mind that the earliest projected availability date is not always accurate. These dates are often changed by the manufacturer. This information is provided because it is the most current information available. We will keep you updated on the status of these and other medication shortages as we receive new information.

CMS Tightens Signature Requirements: No Rubber Stamping

Medicare requires that services provided or ordered be authenticated by the author. The method used for authentication may be a handwritten or electronic signature. Rubber-stamp signatures are not acceptable.

All physician documentation must be authenticated, dated and timed. This includes physician orders for outpatient testing.

Verbal orders must be signed within 48 hours, including date and time.

Signatures must be complete and legible. If a signature is illegible, there must be a typed or printed name next to the signature.