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For Medical Staff members
at CCH, HRMC, and PBH

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Health First medical quality initiatives*



Quality Leads: Value-Based Purchasing: The impact on medical liability

By HF Chief Quality Officer Jim Palermo, MD

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Federal government’s quality/safety agencies, including the Agency for Healthcare Research & Quality (AHRQ).

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e-Physician: The Persistent Medical Record (PMR): A new patient care tool at Health First

By HF Medical Director of Clinical Informatics David P. Hurwitz, MD, FACP



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multi-system acute and chronic illness who are receiving a large number of medications, undergoing procedures, and often have in place invasive devices such as an indwelling Foley catheter. [Read complete article](#)

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Physician e-Xcellence is published by Health First for physicians on the Medical Staffs at Cape Canaveral Hospital (CCH), Holmes Regional Medical Center (HRMC), and Palm Bay Hospital (PBH).

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Quality Leads:



Value-Based Purchasing: The impact on medical liability

By HF Chief Quality Officer Jim Palermo, MD

Over the past decade, healthcare quality “standards” have been established by the Federal government’s quality/safety agencies, including the Agency for Healthcare Research & Quality (AHRQ), governmental payors such as the Centers for Medicare & Medicaid Services (CMS), and accrediting agencies such as The Joint Commission. With the Obama Administration and Congress committed to rapid healthcare reform, these practice standards are being incorporated into the Federal government’s “Value-Based Purchasing” pay-for-performance formulas. Before now, the incentive to comply with evidence-based core measures and national patient safety practices has been based primarily on the practitioner’s or provider’s commitment to doing the right thing for the right patient to achieve the best clinical outcomes. Value-Based Purchasing introduces a monetary incentive that’s projected to enhance compliance with these established ‘Best Practices,’ hopefully resulting in better outcomes.

A key element of this strategy has the potential for a far-reaching impact on medical liability. The government and the healthcare industry are including the occurrence of specific **hospital-acquired conditions (HACs)** in the Value Based Purchasing formula, resulting in a “standard of care” when it comes to preventing certain “avoidable complications that are reasonably preventable through proper care.”

10 hospital-acquired conditions (HACS) to watch

In light of well-established national expectations for standard of care and evidence-based practice, each HAC occurrence now requires due diligence and close scrutiny to identify gaps in practice and determine how best to protect our patients from harm related to these ten conditions:

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Stage III and IV pressure ulcers
5. Falls and trauma
6. Manifestations of poor glycemic control
7. Catheter-associated urinary tract infection
8. Catheter-associated blood stream infection
9. Surgical site infection
10. Deep vein thrombosis (DVT)/pulmonary embolism (PE)

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It’s no longer enough to assume that a certain number of occurrences of HACs are to be expected as “nature of the condition” or “unpreventable.”

A Never-Event case for concern

There has been grave concern on the risk management and medical liability fronts that Plaintiff attorneys may start filing cases based upon the occurrence of a “Never Event” under the *res ipsa loquitor* theory, which means “the thing speaks for itself.” In other words, the occurrence of a Never Event, in and of itself, means there was negligence on the part of the healthcare provider.

In a recent medical liability case, *Sides v. St. Anthony Medical Center*, the Supreme Court of Missouri held that a Plaintiff may file a malpractice case under the theory of *res ipsa loquitor* based upon the presence of a post-operative infection. This is significant because most states have ruled that a post-operative infection alone could not give rise to an inference of negligence, and the Plaintiff would still have to prove there was negligence by the Defendant.

Further the Missouri court ruled that expert testimony can be offered that the post-surgical site infection would not have occurred absent negligence, rather than requiring direct evidence or testimony showing the specific negligence that caused the infection. This is significant because the burden of proving negligence as the cause of a post-operative infection was a difficult hurdle for the Plaintiff to overcome.

The Plaintiff in the *Sides v. St. Anthony* case argued that each of the Defendants controlled or could control the instrumentalities that caused the infection; that the infection

would not have occurred in the absence of negligence (her expert testified to this); that she could not have contributed to the infection as she was under anesthesia; and that she suffered damage as a result of the infection. In proffering these arguments, the Plaintiff successfully satisfied the three elements required to establish *a res ipsa loquitur* in the court's opinion.

Summary and Recommendations

This ruling is troublesome news for hospitals that are already dealing with potential lack of reimbursement for any “Never Event,” and for physicians involved in these cases. More concerning is that this may just be the first step in pleading “Never Event” cases on the theory of *res ipsa loquitur*, for which no expert testimony has traditionally been required. The next step will most likely be filing of *res ipsa loquitur* a case on the mere occurrence of a “Never Event” without an expert witness.

Although the cases involving HACs or “Never Events” appear to be the most vulnerable, the risk of litigation is significant even if there is a bad outcome in a patient with a core measure condition who may not have received the established evidence-based complement of intervention/care. It's recommended that you:

- 1. Re-double efforts to document all conditions that are present on admission, and;**
- 2. Continue to thoroughly document patient assessments and compliance with all evidence-based practices designed to prevent a “Never Event” or treat a patient with a core measure condition (AMI, CHF, Pneumonia, and Stroke).**

e-Physician

What IT can do for YOU, and what YOU can do with IT

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The Persistent Medical Record (PMR): A new patient care tool at Health First



By HF Medical Director of Clinical Informatics David P. Hurwitz, MD, FACP

Physicians often require a large amount of complex medical information to manage hospitalized patients, particularly those with multi-system acute and chronic illness who are receiving a large number of medications, undergoing procedures, and often have in place invasive devices such as an indwelling Foley catheter. Access to the right medical information at the right time is crucial for effective clinical decision making. Some information is most relevant to a specific hospitalization, such as lab test results, while other data is important across a number of hospitalizations (eg, immunization information, problem list).

Paper vs. PMR

In recent years, physicians have been asked to provide documentation pertinent to hospital core measures and immunization status. Many of us are familiar with these paper forms, which need to be filled out multiple times over multiple hospitalizations. This current paper-based system, however, is inefficient and decentralized.

As an example, a physician is required to repeatedly document adult immunization status across multiple hospitalizations without efficient access to previously documented immunization information. This results in physician frustration, unnecessary use of paper forms in the chart, potential unnecessary administration of vaccine (eg, multiple pneumococcal vaccinations), which may cause patient harm and inappropriate utilization of hospital resources.

Medical information such as core measure

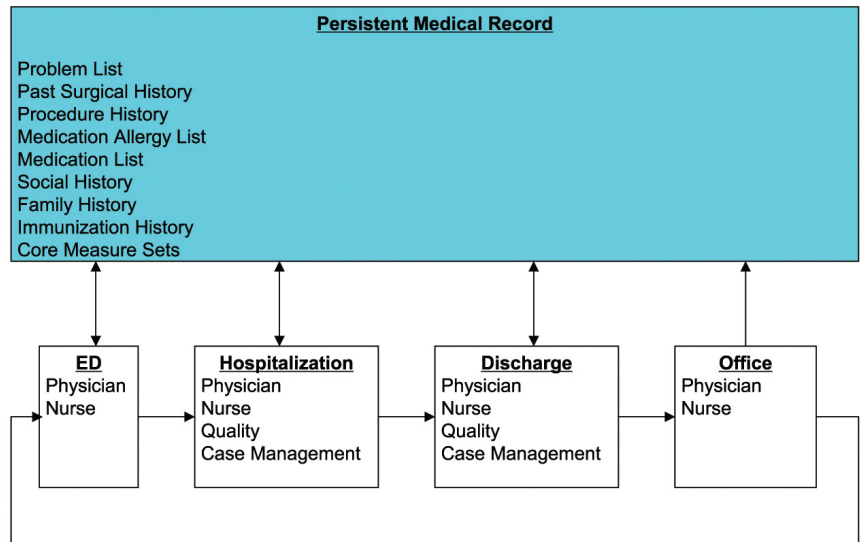
elements and immunizations are not specific to one hospitalization, but are useful for documentation and clinical decision making across multiple hospitalizations and care access points (Emergency Department, inpatient, and outpatient). In the electronic world, once captured in the electronic health record, this information can “persist” for reference going forward.

Collectively, such persistent medical information data can be termed the “**Persistent Medical Record,**” or **PMR**, which has been driven by physicians and can be summarized as:

“...a succinct, organized, up-to-date set of well-defined patient medical information elements (eg, immunizations, core measures, problem list, past medical history, surgical history, procedure history, current medications, allergies, etc.) that are utilized by physicians and other clinicians. Once documented, these elements persist across future patient encounters (inpatient or outpatient) and care access points (ED, inpatient, cath lab, etc).”

Note: For the purpose of this definition, the PMR is in computerized form and resides in Sunrise Clinical Manager (SCM).

High-level conceptual depiction of the PMR



Potential benefits of PMR

- **Centralized data** can be presented to multiple audiences for a variety of purposes.
- **More efficient care processes**, such as access to PMR summary screen may help physicians unfamiliar with a particular patient “get up to speed” more rapidly.
- **More efficient end-user documentation:** For example, the integration of the problem list and core measures into physician electronic ordering and progress notes facilitates documentation and ordering in the same workflow.
- **More efficient use of hospital resources:** For example, CHF-PMR documented ejection fraction might result in fewer unnecessary echocardiograms; immunization documentation might result in fewer unnecessary vaccinations. (See example screen below).
- **Computerized decision support:** PMR elements can be utilized in Medical Logic Modules (MLMs) to drive clinical alerts.
- **Analytics:** Well-defined, standardized encoded (eg, SNOMED-CT, NORIC, etc.) PMR data elements can be utilized to run complex queries on a centralized PMR repository for clinical research, quality, and utilization review purposes.
- **Interoperability:** As data standards evolve, the PMR may eventually be exportable to other clinical information systems and vice versa for clinical information exchange, e.g. Continuity of Care Document (CCD).

Over time, additional types of clinical information will be added to the PMR, further increasing its value to physicians, who need rapid and efficient access to this important core set of portable data elements at the right place and time.

[Return to main menu](#)

The screenshot displays a medical software interface for a patient named John R. Smith. The window title is "Smith, John R - Sunrise Acute Care". The interface includes a menu bar (File, Registration, Edit, View, GoTo, Actions, Preferences, Tools, Help) and a toolbar with various icons. Patient information is shown: "Smith, John R", ID "578 / 10000000991", "Hurwitz, David", "80y (Mar-12-1928)", and "Male". Allergies are listed as "No Known Allergies". The interface has tabs for "Patient List", "Results", "Documents", "Summary", "Patient Info", "Clinical Summary", "Flowsheets", and "Orders". The "Clinical Summary" tab is active, showing a "View" dropdown set to "Physicians", a time filter of "2 hours", and a date range of "Mar-11-09 08:57 To Mar-11-09 10:57". Below this are two tables: "Problem List" and "Significant Events".

Health Issue	Description	Event	Type	Onset Date	Description
CHF		Pneumococcal Vaccination	CM- Immunization	2005	
Atrial Fibrillation		LV Function Assessment	CM- Heart Failure	Jan-06-2009	EF = 35%
Coronary Artery Disease					
Hyperlipidemia					
Hypertension					

Below the tables are sections for "Documents", "Lab Results - Report By Order", and "Radiology - Report By Order", each with a table header. The "Documents" table has columns: Document Name, Author, Entered date. The "Lab Results" table has columns: Result, Value, Abn, Range, Result. The "Radiology" table has columns: Result, Value, Result Date, Text.

PMR Problem List Sample Screen

Do a checkup on your calendar!

Calendar

September 2009

- 22** CCH General Medical Staff Meeting, 6:30 pm, CCH Medical Plaza Conference Center
- 25** CME — **Probiotics: Clinical Efficacy**, Norman P. Tomaka, CRPh, LHRM, HRMC (11:30 am to 1:30 pm, HRMC Auditorium)**

October 2009

- 2** CME — **Innovative Radiation Modalities with a Focus on Rapid ARC**, Nanialei Golden, MD, HRMC (11:30 am to 1:30 pm, HRMC Auditorium)**
- 5** PBH Medical Staff Meeting, 6 pm, PBH Cafeteria
- 6** PBH Department of Medicine Meeting, 5:30 pm (dinner served at 5 pm), PBH Private Dining Room
- 9** **Life Keep It Going Organ and Tissue Donation—ALL-DAY Program** (7:30 am to 4 pm, HRMC Auditorium)**
Pre-registration is required. Category 1 AMA Credit available (6 hours). Participant must attend entire conference (no partial credit).
- 12** PBH Department of Medicine Meeting, 5:30 pm (dinner served at 5 pm), PBH Private Dining Room
- 16** CME—**Antimicrobial Stewardship and Infection Control Issues in the Era of Antimicrobial Resistance**, Robert Rapp, PhD, University of Kentucky Medical Center (11:30 am to 1:30 pm, HRMC Auditorium)**
- 20** HRMC General Medical Staff/Department Meeting, 5:30 pm, Hilton Rialto Place*
- 23** CME—TBD
- 30** CME—**Rheumatoid Arthritis: Early Diagnosis and Optimal Management Improve Patient Outcomes**, Yusuf Yazici, MD, New York University School of Medicine (11:30 am to 1:30 pm, HRMC Auditorium)**

November 2009

- 6** CME—**Autism**, Rebecca Landa, PhD, CCC-SLP, John Hopkins University School of Medicine (11:30 am to 1:30 pm, HRMC Auditorium)**
- 13** No CME
- 20** CME—**Analgesic Overdose**, Dean G. Olsen, DO, New York College of Osteopathic Medicine (11:30 am to 1:30 pm, HRMC Auditorium)**
- 20** HRMC General Medical Staff/Department Meeting, 5:30 pm, Hilton Rialto Place*
- 27** No CME — **Holiday Weekend**

December 2009

- 4** CME—**An Evidence-based Approach to Lyme Disease**, Gary Wormser, MD, Westchester Medical College (11:30 am to 1:30 pm, HRMC Auditorium)**
- 10** HRMC General Medical Staff/Department Meeting, 5:30 pm, Hilton Rialto Place*
- 11** CME—**Advances in the Management of Atrial Fibrillatio**, Warren M. Jackman, MD, FACC, FHR, University of Oklahoma Health Sciences Center (11:30 am to 1:30 pm, HRMC Auditorium)**
- 18** CME—**Better Outcomes in STEMI: Moving from “Awareness” to Implementation” of New Guidelines**, Michael C. Kontos, MD, University/Medical College of Virginia (11:30 am to 1:30 pm, HRMC Auditorium)**
- 25** No CME— **Holiday Weekend**

* The HRMC General Staff Meeting will begin at 5:30 pm followed by Department Meetings at 6:30 pm.

** PLEASE NOTE: Lunch is served from 11:30 am to 12:30 pm, and the presentation begins at 12:30 pm. For information and CME records, call Dee Rogers at 434-1966. CMEs at the HRMC Auditorium are video-conferenced into the PBH Community Room and Medical Plaza Conference Room B at CCH.