

NOVEMBER/DECEMBER 2008

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Health First medical quality initiatives

For Medical Staff members
at CCH, HRMC, and PBH

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Quality Leads: Facilitating critical physician documentation

By Jim Palermo, MD, HF Chief Quality Officer

The goal of the **Clinical Documentation Improvement Specialists Program** at all three HF hospitals is to clarify ambiguous, partial, or omitted information through a **query process** designed to positively impact the quality and quantity of physician documentation in the medical record at the point of service. [Read complete article](#)



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

The new "For Physicians" web page is a physician-centric, centralized access point for use by clinicians across the Health First system. [Read complete article](#)

Patient Safety: 2009 changes to the National Patient Safety Goals

By Jim Palermo, MD, HF Chief Quality Officer

In July, **The Joint Commission** announced the **2009 National Patient Safety Goals (NPSGs)** and related patient safety practice requirements. [Read complete article](#)

CMS Update: Hospital-acquired conditions (HACs)

By Jim Palermo, MD, HF Chief Quality Officer

The already busy 2008 Atlantic Hurricane Season reminds us of the critical need to prepare *before* a storm threatens. [Read complete article](#)

NEW Medical Transcription Services contact numbers: Phone: 434-1922 / Fax: 434-1967

[Read complete article](#)

Calendar Checkup:

December 2008/January 2009 CME offerings and medical staff meetings, etc. [Read complete article](#)

Quality Leads:

Facilitating critical physician documentation



By Jim Palermo, MD, HF Chief Quality Officer

The goal of the **Clinical Documentation Improvement Specialists Program** at all three HF hospitals is to clarify ambiguous, partial, or omitted information through a **query process** designed to positively impact the quality and quantity of physician documentation in the medical record at the point of service. Yellow queries are posted in the patient's chart and physicians are asked and expected to respond concurrently in physician Progress Notes.

One of the primary incentives for physicians to collaborate on accurate, timely documentation is to ensure that the severity of illness reflected by the MS-DRG is compatible with the level of service reflected in submitted CPT codes for professional reimbursement. The Federal Government has targeted identifying Medicare and Medicaid fraud as a priority strategy to cut healthcare spending.

Other important objectives are to:

- Capture information at the point of care accurately and compliantly
- Reduce patient risks from incomplete, unclear, or illegible charting
- Provide accurate data for compliance with Medicare Conditions of Participation
- Meet Joint Commission standards for clinical documentation
- Provide optimal clarity and accuracy of code designation at time of discharge
- Improve and reflect on "Best Practices"
- Reflect core measure compliance
- Reflect acuity of illness balanced with intensity of service for accurate Case Mix Index (CMI)
- Ensure that all co-morbidities and complications are apparent

Key words and phrases that often require more specific clarification to be considered as appropriate documentation for accurate coding include:

- **Insufficiencies**—Renal, respiratory, etc., will be targeted for concise diagnoses, staging of disease, or explanation. (If $p\text{CO}_2 > 50$, profound hypoxia, with $\text{pH} < 7.35$ query for **respiratory failure** will be posted.)
- **Treating "empirically"**—Physicians will be asked to state WHAT is being treated empirically. Without more detail

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related to empiric treatment and why it's indicated, the level of care cannot be determined.

- **The phrase "Process"**—such as "*Pneumonic Process*" will be queried for definitive diagnosis.
- **Arrows up and down**—are not recognized as acceptable documentation, and clarification will be requested. (\downarrow NA will be queried for hyponatremia). Please spell out.
- Diagnoses for **"present on admission" (POA)** or "not apparent on admission" that later becomes apparent. Physicians will be asked to comment on POA.
- **"Urosepsis"** terminology means UTI to CMS. If a patient has more than a UTI, such as UTI with associated sepsis, it must be documented as "*UTI with Sepsis*."
- **Post-operative bleeding** or **GI bleed** resulting in anemia with receipt of blood products is an "acute" situation in the hospital setting and should be reflected in the medical record either as "Acute Blood Loss Anemia" or "Precipitous Drop in Hematocrit."
- **Pathogens**—If the patient has an infection or sepsis, include the pathogen with the diagnosis, if known. (e.g., *Pseudomonas pneumonia*, *E. Coli UTI*, Gram-negative wound infection, etc.)
- **"Troponin leaks"**— If there's a changing pattern of troponin levels in the face of increased demand, as in sepsis or tachyarrhythmia, a query will be made for non-ST elevation MI due to whatever the inciting factor is.
- **Heart failure**—All patients with an EF below 40 percent will be queried for ACE/ARB per core measure parameters. Per criteria established by CMS, anyone with a history of heart failure is considered to need evaluation and management to include documentation of the type/etiology of the heart failure and EF%. Therefore, EF% and type of failure will be queried.
- **Surgical debridement (done in the OR or at the bedside)**—Document if excisional and if done sharply, and the depth of debridement.
- **Specificity of malnutrition**—clarify *mild*, *moderate*, or *severe protein caloric malnutrition*.

These are just a few of the queries you may see in your patients' charts. Please thoughtfully consider the requests made by our Clinical Documentation and Core Measure Specialists, and constructively collaborate to ensure clear, explicit, timely documentation that best reflects each of your patients' conditions and affords accurate and comprehensive coding.

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e-Physician

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

Our new "For Physicians" web page

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



The new *For Physicians* web page is a physician-centric, centralized access point for use by clinicians across the HF system. It was designed to replace the "For Our Physicians and Associates" web access link, which contains certain information and a number of links that are not all pertinent to physicians. This new web page serves as a gateway to HF's core clinical IT applications, such as Sunrise Clinical Manager (SCM) and also includes announcements, medical news, medical information source links, as well as links of general interest to our medical community (e.g., medical group electronic medical record [EMR] links). The clinical news content will be updated approximately once a week. Announcements and other dynamic information will be updated periodically, but also urgently (same-day updates) if needed.

The new *For Physicians* web page basic features will include:

1. Single sign-on access to core clinical applications
 - After your initial standard log on, no additional authentication is needed for certain clinical IT applications, including SCM and First Access.
2. General links
 - Links to physician group EMRs
 - Physician Toolbox
 - IT training tutorials
3. Medical news
 - Clinical content, including links to Physician's First Watch (from publishers of the *New England Journal of Medicine*), a free, high-quality, timely, concise information source
 - Patient safety and care quality information links
 - Regulatory information links (e.g., CMS initiatives, core measures, "never events")

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4. Health First (HF) announcements
 - General HF-centric announcements, including CME schedules, hospital quarterly meeting announcements, and hurricane updates
5. *Physician e-Xcellence* online newsletter
6. Clinical information physician links
 - Links to clinical information resources such as Ovid, *The Source*, HF antibiograms
7. Feedback
 - Input forwarded to Drs. Palermo and Hurwitz

(See screen shot of *For Physicians*
web page on next page)

The *For Physicians* web page can be accessed at <https://icintranet.health-first.org/physicians/index.cfm>. This will bring up a log-in screen that requires the user to enter his or her user name and password.

The *For Physicians* web page is an evolving work that has tremendous potential to simplify information access and will serve as a vehicle for updating and informing physicians about issues relevant to the medical community. Future additions under consideration include links to department and hospital meeting minutes, real-time hospital bed status updates, discussion boards, etc. Physician feedback is critical to optimize the appearance, content, and functionality of *For Physicians*, so you'll find a simple feedback form online to facilitate your input. I look forward to hearing from you about this new benefit for medical staff colleagues at HF hospitals.

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Pictured below: A partial screen shot view of the *For Physicians* web page

Health First **FOR PHYSICIANS**
SYSTEM ACCESS AND INFORMATION

Thursday, December 4, 2008 **LOG OUT**

SCM
PACS CARDIOLOGY
PACS RADIOLOGY
OB-LINK
FIRST ACCESS
REMOTE ACCESS PORTAL

LINKS

Additional resources, links and healthcare reference material for our physicians.

- [Physician Toolbox](#) - Additional Physician resources on the Health First Intranet
- [Osler System](#)
- [MIMA Logician](#)
- [Health First Physicians \(Centricity\)](#)
- [MAB eClinicalWorks](#)
- [Education/Physician Tutorials](#)
- [GroupWise Email](#)

NEWS

Journal Watch® [Lung Scarring Associated with Increased Cancer Risk in Ipsilateral Lung](#)

Journal Watch® [Ginkgo Doesn't Prevent Dementia](#)

Journal Watch® [ACP Offers Guidelines on Second-Generation Antidepressants](#)

Journal Watch® [Genetic Scores vs. Clinical Risk Factors in Predicting Type 2 Diabetes Risk](#)

Journal Watch® [No Haemophilus Increase - Yet - Despite Vaccine Shortage](#)

Journal Watch® [Electronic Health Records Linked to Fewer Malpractice Claims](#)

Journal Watch® [FDA Approves New Analgesic, Tapentadol](#)

FDA MedWatch [Phenytoin \(marketed as Dilantin, Phenytek and generics\) and Fosphenytoin Sodium \(marketed as Cerebyx and generics\)](#)

With DVT and PE affecting between 350,000 and 600,000 Americans annually, and CMS preparing in 2009 to withhold payment from hospitals when Medicare patients develop DVT following knee- or hip-replacement surgery, see link below for info. [Current Standards on How to Prevent and Diagnose VTE Complications](#)

Wall Street Journal , October 29, 2008 [Hospitals seek to Better Manage Transfusions Based on Evidence-Based Blood Product Utilization.](#) New efforts to recycle blood and treat anemia are aimed at cutting patient risk and overall costs.

HEALTH FIRST ANNOUNCEMENTS

SCM Upgrade: SCM will be undergoing an upgrade to version 5.0 on December 10th. Additional details to follow.

Medical Transcription Services- New Contact Numbers: Medical Transcription Services are now consolidated in one location at HRMC. Effective 11/17/08, please

NEWSLETTER

Physician Excellence [Latest Issue](#)

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Patient Safety:

2009 changes to the National Patient Safety Goals



By **Jim Palermo, MD,**
HF Chief Quality Officer

In July, **The Joint Commission** announced the **2009 National Patient Safety Goals (NPSGs)** and related patient safety practice requirements. The NPSGs promote specific improvements in patient safety by providing healthcare organizations with proven solutions to persistent patient safety problems. These Goals apply to the more than 15,000 Joint Commission-accredited and certified healthcare organizations and programs. Compliance with the requirements is a condition of continuing accreditation or certification for Joint Commission-accredited and certified organizations.

Major changes for 2009

In 2009, major NPSG changes will include three *new* hospital requirements related to preventing deadly healthcare-associated infections due to:

- multiple drug-resistant organisms (MDROs);
- central line-associated bloodstream infections; and
- surgical site infections.

These additions build on an existing NPSG for reducing the risk of healthcare-associated infections, recognizing that patients continue to acquire preventable infections at an alarming rate within hospitals. The **new requirements related to central line-associated bloodstream infections** also will take effect for ambulatory care facilities and office-based surgery practices, home care organizations, and long-term care organizations. These new infection-related requirements have a one-year phase-in period that includes defined milestones, with **full implementation expected by January 1, 2010**.

Other 2009 NPSG additions and revisions

Additionally, revisions and additions to existing NPSGs also included:

- A revision to the existing **Medication Reconciliation NPSG** based on feedback obtained from a Medication Reconciliation Summit convened in late 2007
- A requirement to **eliminate transfusion errors related to patient misidentification in hospitals,**

critical access hospitals, ambulatory care facilities, and office-based surgery practices

- New requirements for **better engaging patients in their care regarding infection control, prevention of surgical adverse events, and the patient identification process**
- Revisions in requirements associated with the existing **Universal Protocol**, initiated to help prevent errors in surgical and non-invasive surgical procedures. These changes, which address the topics of **procedure verification, marking the procedure site, and conducting a “time out” immediately prior to starting procedures**, were based on feedback received at the Wrong Site Surgery Summit in 2007.

The development, annual review, and modification of The Joint Commission NPSGs, first introduced in 2003, is overseen by the Sentinel Event Advisory Group, a panel that includes widely recognized patient safety experts, nurses, physicians, pharmacists, risk managers, and other professionals with hands-on experience in addressing patient safety issues in hospitals and other healthcare settings. Each year, this panel works with The Joint Commission to undertake a systematic review of the literature and available databases to identify potential new Goals and requirements. The Joint Commission also conducts an extensive field review and seeks input from practitioners, provider organizations, purchasers, and consumer groups, among others. The Joint Commission's Board of Commissioners approves the Goals and requirements each year.

At Health First, we assign each new NPSG to a subcommittee of our Patient Safety Committee for review of existing policies and practices associated with the Goal, and revision or development of any new policies, procedures, or practices needed to comply with the elements of performance. Watch for updates on any changes made as a result of this review process. The Joint Commission's 2009 NPSGs can be viewed online at: <http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/>. **They are also separately attached as a one page printable insert to this issue.**

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CMS Update: Hospital-Acquired Conditions (HACs)



By Jim Palermo, MD,
HF Chief Quality Officer

The Centers for Medicare & Medicaid Services (CMS) has included 10 categories of conditions in its **2009 Hospital-Acquired Conditions (HACs) payment provision.**

HACs are considered:

- high cost or high volume or both;
- to result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and
- reasonably preventable through the application of evidence based guidelines.

It's no longer enough to assume that a certain number of occurrences of HACs are to be expected as a "nature of the condition" or "unpreventable." In light of well-established national expectations for standard of care and evidence-based practices, each HAC occurrence now requires due diligence and close scrutiny to identify gaps in practice.

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As of October 1, 2008, CMS stopped providing higher payments for the following 10 Hospital-Acquired Conditions (HACs):

1. **Foreign Object Retained After Surgery**
2. **Air Embolism**
3. **Blood Incompatibility**
4. **Stage III and IV Pressure Ulcers**
5. **Falls and Trauma events resulting in:**
 - Fractures
 - Dislocations
 - Intracranial Injuries
 - Crushing Injuries
 - Burns
 - Electric Shock
6. **Manifestations of Poor Glycemic Control including:**
 - Diabetic Ketoacidosis
 - Nonketotic Hyperosmolar Coma
 - Hypoglycemic Coma
 - Secondary Diabetes with Ketoacidosis
 - Secondary Diabetes with Hyperosmolarity
7. **Catheter-Associated Urinary Tract Infection (UTI)**
8. **Vascular Catheter-Associated Infection**
9. **Surgical Site Infection following:**
 - Coronary Artery Bypass Graft (CABG) — Mediastinitis
 - Bariatric Surgery, including:
 - ❖ Laparoscopic Gastric Bypass
 - ❖ Gastroenterostomy
 - ❖ Laparoscopic Gastric Restrictive Surgery
 - Orthopedic Procedures of the Spine, Neck, Shoulder, or Elbow
10. **Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following:**
 - Total Knee Replacement
 - Hip Replacement

Although most of these conditions occur as a result of an in-hospital complication, a select few of these conditions may be **present on admission (POA)**. It's imperative that the initial evaluation of each patient admitted to the hospital is comprehensive and includes documentation of POA conditions such as a UTIs, pressure ulcers, DVTs, or a PE.

NEW Medical Transcription Services contact numbers

Medical Transcription Services are now consolidated in one location at HRMC. Please make a note of these new numbers:

Transcription Services at HRMC:

Main phone: 434-1922

Fax: 434-1967

The existing phone and fax numbers will remain in operation along with the new numbers until the end of the year to provide a smooth transition for physicians and your staff members. However, **as of January 1, 2009**, the old numbers will be discontinued. For more information regarding the new Medical Transcription Services numbers, you can contact **Melissa Campion, HIM Transcription Operations manager**, at **434-8695**, or via email at Melissa.Campion@Health-First.org.

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Do a checkup on your calendar!

Calendar

December 2008

- 12** CME —VTE/PE Prophylaxis and Treatment: An Urgent Call to Action for a Common Preventable Disease, Joseph Caprini, MD, Northwestern University Feinberg School of Medicine, Evanston, Illinois (11:30 am to 1:30 pm, HRMC Auditorium)*
- 19** CME —HIPAA and Corporate Compliance: A Physician Update, Chris Sorensen, VP of Risk Management and Chief Compliance Officer and Stephanie Reid, Senior Compliance Analyst (11:30 am to 1:30 pm, HRMC Auditorium)*
- 26** No CME —Holiday weekend

January 2009

- 15** Mandatory Licensure Course: Two-hour Prevention of Medical Errors, Joe Putz, LHRM, FPIC (5:30 to 7:30 pm, HRMC Auditorium, with light snack at CCH, HRMC, and PBH beginning at 5 pm)*
- 16** CME —HIV/AIDS: 1-Hour Florida Medical Licensure Requirement, Barry Inman, BS, Brevard County Health Dept. (11:30 am to 1:30 pm, HRMC Auditorium)*

January 2009 continued

- 20** CCH General Medical Staff Meeting (6:30 pm, CCH Medical Plaza Conference Center)
- 22** B3 2009: Bomb, Blast, and Burn Mass Casualty Planning and Preparedness for Emergency Services and Healthcare Providers Workshop (7:30 am to 1 pm, CCH Medical Plaza). Call **Bea Conrad** at **434-1969**. Cost is \$25.

* For all CME sessions, lunch is from 11:30 am to 12:30 pm, and the presentation is from 12:30 to 1:30 pm. For information and CME records, call **Dee Rogers** at **434-1966**.

PLEASE NOTE: CMEs and Mandatories at the HRMC Auditorium are video-conferenced into the PBH Community Room and Medical Plaza Conference Room B at CCH.

NEW! Category 1 CME Credit will be provided for Medical Staff members who attend Tumor Board Meetings at CCH, HRMC, and at Melbourne Internal Medicine Associates.

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