June 2013

Volume 2, Issue 6

Beebe Medical Center
LEWES, DE

Medical Staff Office Update

Beebe Medical Center's Medical Staff Services Update

Upcoming Events!

> Medical Staff Meeting on June 20th at 5:30pm

> Med Staff CERNER Kick-off at Fish On July 10th at 5:30 Celebrate with cocktails, hors d' oeuvres and preview stations of CERNER. (Fire Marshal would not let us have a McKesson bonfire as well!)

Beebe welcomes Michael J. Maksymow, Jr. VP/ Chief Information Officer

In this role, Mr. Maksymow will provide vision and leadership for the continual development and implementation of Beebe Medical Center's information technology initiatives. These initiatives include the secure electronic medical record system being expanded to better serve our patients with up-to-date medical information to the physicians, nurses and other clinicians providing them care.

Mr. Maksymow joins the Beebe Medical Center Executive Staff and reports to Paul Minnick, RN, MSN, NEA-BC, Executive Vice President/Chief Operating Officer.

Mr. Maksymow brings to Beebe more than 15 years of experience in progressive information technologies. Of those years, more than 10 were in the healthcare environment where he led IT and telecommunications teams in providing services for administrative and clinical operations for acute care hospitals. He has presented information at national healthcare industry conferences about organizational quality and patient privacy.

He joins Beebe Medical Center from Continuum Health Alliance LLC in Marlton, New Jersey where he served as Director of IT Operations. Previously, he served as the Director of Information Services and Telecommunications for Robert Wood Johnson University Hospital in Hamilton, New Jersey.

Mr. Maksymow has a Bachelor of Science degree in Finance from Rider University and an MBA in Technology Management from the University of Phoenix. He is a Certified Professional in Healthcare Information and Management Systems and is a Fellow Member of the Healthcare Information Management Systems Society. He serves on the Board of the New Jersey Chapter of the Healthcare Information Management Systems Society.

CERNER is coming, CERNER is coming!

The Contract was signed and executed May 17, 2013 for $18.2 million over seven (7) years. This does not include implementation costs totaling $15.6 million, the bulk of which is in FY2014.

Cerner is a world-class EMR product and is being implemented at Beebe by some of the best talent in the country.

Cerner Go Live is March 10, 2014 and allows Beebe to qualify for Meaningful Use Stage 1.

A Physician Communication Plan is being developed to keep providers up-to-date which will include:

PAG (Physician Advisory Group), the MEC, General Med Staff meetings, this monthly newsletter as well as flyers/ posters in the doctors' lounge.

To ensure a quality go live on a strong platform, we will utilize Cerner's proven "MethodM" methodology for implementation which includes 97.6% of content being based on Cerner's customers' best practices.

Progress Status –

The work with pharmacy, nursing and analysts has started. Network and desktop teams are collaborating with Cerner and the "Single Sign On" teams to develop plan around infrastructure needs and timing.

A physician-based decision document is being created and requires collaboration and input with Physician Team via PAG.

Order Set development and review process has been developed by Nursing Informatics, IT, Quality & Physician Leadership.

Upcoming Efforts –

Device Assessment – Cerner to be onsite June 12th to determine the site readiness assessment for device types, counts and availability.

A team consisting of selected physicians, administration, ancillary departments, facilities, IT and Cerner, will be rounding nursing units to identify opportunities to create an effective work environment in a crowded space.

Physician KickOff event is being planned; see above.

A Physician Strategist & Physician Executive – (To be assigned shortly) – to collaborate EMR strategy with physicians.

Inside this issue:

Meet our Newest Members

Madan Joshi, MD is a Pulmonologist joining BPNI
Charlene Madant, NP is joining BPNI to work in the Clinical Decision Unit (Obs)
Please help us make these newest additions to our Beebe Team feel welcome!

Meera Joshi, MD is a Hospitalist joining BPNI
Taylor Keen, CRNA is joining Delaware Anesthesia Associates

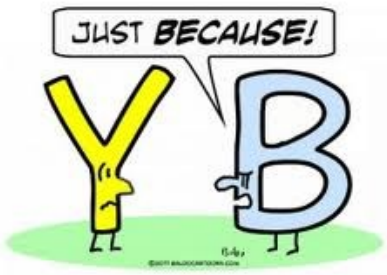
Health Information Management/Medical Records Department Update

I would like to take this opportunity to update you on some initiatives we currently have going on in the Health Information Management/Medical Records Department .

In order to provide better services to our physicians, we are currently scanning outpatient procedures of our patients into the electronic medical record. Our physicians are now able to view PFT, EEG, Dialysis, and Pulmonary Rehabilitation Records via the physician portal . Additionally, we are currently scanning all 2013 Vascular Records with a plan to back scan all vascular records to September 28, 2009 which was our "go live" date with McKesson. These records can also be viewed via the physician portal. And finally, effective June 3rd, physicians will also have the ability to view patients' Emergency Room records via the portal.

You access these records in Portal under the Medical Records Tab, Entire Chart section.

Why, it is Because… - Mike Salvatore, MD



Physicians often fail to demonstrate any rationale for many things they do. Many of the medical records I review in appealing Medicare denials fail to document why the physician is doing what they are doing:

Why does a patient with CHF in the ER need to be admitted?

Why is the Hospitalist admitting a patient with COPD?

Why does the post-op patient still require hospitalization?

Why is the patient with near-syncope being observed?

Why does the patient with syncope need carotid studies?

There is a simple cure for why; it is called **because**. Every ER note, every H&P, and every progress note should state that you are doing what you are doing **because**…

Being rational, we should be able to give a reason why for what we are doing. For example, I am writing this little article because there is no because in many ER notes, H&Ps, consults, and progress notes.

So please say **"why"** you are doing whatever you are doing for or to your patient – just say **because…**

Because if you say "because," your documentation will be better and you won't have to read annoying articles like this.

"Medicare contractors are doing prepayment denials very shortly after discharge, if no OP Note is discovered, an audit of the surgeon may follow. "

In the 'Medicare World' No OP Note = No Operation!

If a surgeon is found to have billed for a surgery and has not dictated an OP Note by then, they may find themselves charged with fraud.

Medicare contractors are doing **prepayment denials** very shortly after discharge, if no OP Note is discovered, an audit of the surgeon may follow.

If the OP Notes are dictated weeks after surgery or not dictated by the time of the audit, the issue of fraud may be raised. This is a very ugly thing, both painful and costly.

Please inform your colleagues that those who dictate their notes at the last minute to avoid fines are taking a significant risk of an audit or worse, a fraud investigation.

It is a very uncomfortable thing to explain to someone from the OIG or FBI how you can recall exactly what you did in an operation a month previous.

CLINICAL DOCUMENTATION IMPROVEMENT

Newsletter

Vol 1. Issue No. 4 June 2013

We have added a new member to the CDI team!

Please welcome

Rebekah Elbourn!

Why do we place queries?

- Clarification of diagnosis in CMS terms.
- Clarification for ambiguous/conflicting documentation.
- Further specificity required for accurate coding.
- Documentation of diagnosis based on clinical indicators.
- Assignment of POA.

CONGRATULATIONS!

Documentation Superstar:

Kristie Zangari, MD

"Her documentation is on target!"
CDI Team

Beebe Medical Center

Documentation Tip of the Month

Sepsis vs. Severe Sepsis vs. SIRS

Some definitions on differentiating these terms for your documentation.

Severe Sepsis: A systemic inflammatory response syndrome due to an infectious process with evidence of organ dysfunction (e.g., oliguria, hypoxemia, lactic acidosis, altered cerebral function)
SIRS: Systemic Inflammatory Response Inflammatory Response Syndrome is the body's systemic response to infection, trauma, burns, pancreatitis, major surgery, or other insult/injury.
SEPSIS: SIRS due to an infection (either suspected or confirmed) Excludes SIRS due to other causes.

Clinical Criteria for SIRS/Sepsis:

- **Ill-appearing**: While not a specific requirement for the diagnosis, a patient with sepsis ought to be ill-appearing in some manner, but would not have to be specifically described as "septic" or "toxic"
- **Some (two or more) of the following indicators**:
  * **Fever** (≥ 101F or > 38.3 C) or
  * **Hypothermia** (<96.8 F or <36.0C)
  * **Tachycardia** (heart rate >90)
  * **Tachypnea** (respiratory rate >20)
  * **WBC** >12,000 or < 4,000 or bands > 10%

Other indicators include:

- Altered mental status
- Persistent hypotension
- Hypoxia
- Elevated lab values for lactate (lactic acid) and/or C-reactive protein (CRP)
- Mottling of the skin or prolonged capillary refill
- Non-diabetic hyperglycemia (blood sugar>120)
- Evidence of **acute organ dysfunction**, which may be the earliest evidence of sepsis in elderly or immune-suppressed patients and also indicates "severe sepsis"

Documentation issues:

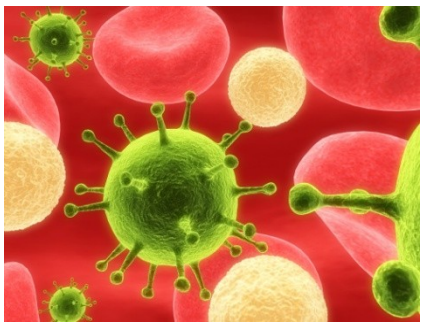
Urosepsis – Urosepsis is a nonspecific term. **Please document UTI or Sepsis due to urinary tract infection.**

Sepsis Syndrome – Sepsis syndrome is a poorly defined term. **Please document the specific condition(s) the patient has.**

Bacteremia – Bacteremia is defined as bacteria in the blood (i.e., positive blood culture). **It does not constitute sepsis and should rarely be assigned.**

Sepsis as a complication – Sepsis is frequently due to the presence of a urinary catheter or vascular device. **When documenting please document a relationship.**

Reference: CDI Pocket Guide 2013 Richard D. Pinson, MD, Cynthia L. Tang, RHIA



Who will be next month's Superstar?????

WE ARE HERE FOR YOU!!!! Clinical Documentation Specialists

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House Bill 178— Board of Medical Licensure & Discipline

We met with the Deputy Secretary of State a few months ago about the problems in getting a state license. The following was introduced in the Delaware State House that might improve these processes.

Section One of this bill **removes the requirement** that applicants for licensure as medical doctors undergo a personal interview by a Board member as a prerequisite to obtaining licensure.

Section Two also applies to new applicants before the Board of Medical Licensure and Discipline. Currently, if a person seeking certification had direct access to patients or staff or admitting privileges at a health care facility within the past 5 years, the applicant must obtain a service letter from each such facility as a prerequisite to obtaining licensure. This section lowers that number to a **three year look back**.

Department of State
Division of Professional Regulation
Our mission is to credential qualified professionals to ensure the protection of the public's health, safety, and welfare.

THE POWER OF ONE

Eliminating preventable harm is a top priority. Electronic Submission of events is one of the mechanisms Beebe Medical Center utilizes to obtain knowledge of Adverse Events. It also is how we tract the actions, that team members and Medical Staff have initiated, as a result of the event. The electronic submission reporting tool we use is the Safety Tracking Tool ("STT").

Risk Management Specialists review each event, as well as a member of Leadership whose department was impacted by the event.

We recognize Near Misses as "Good Catches" monthly as they contribute to the safety of our Patients and Team Members. Recognizing near misses can contribute to a higher level of awareness in our organization.

Bi-annually Risk Management will identify "Extra" Good Catches that prevent patients from potentially significant injury from adverse events. These are considered "Great Catches."

The "Great Catch" winner will be awarded the **"Power of One"** cake in their department and receive an 8hr PTO day as well.